STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056437	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Ridge Care Center	1501 Skyline Drive Monterey, CA 93940

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36044 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to outline dysphagia ((difficulty of swallowing) care for one of three sampled residents (2) when she had a newly added diagnosis of dysphagia after her hospital admission. This failure potentially affected Resident 2's quality of care for prevention of aspiration or choking in the facility. Findings: Review of Resident 2's acute hospital discharge summary, dated 3/22/24, indicated her baseline was with severe psychiatric issues and refused majority of care for chronic medical conditions. She was found to have altered mental status, decreased responsiveness, oxygen saturation decreased to 83% room air and blood pressure was 90 over 33 upon change of condition on 3/13/24. The hospital course documented that She is at high risk of aspiration pneumonitis. Review of Resident 2's dysphagia progress notes, dated 3/20/24, indicated she had seen Speech and Language Pathologist (SLP) for a dysphagia follow-up for diet tolerance. SLP recommended to have puree diet and nectar thick liquids. Review of Resident 2's plan of care indicated there was no care plan developed with interventions to address her dysphagia status to help prevent aspiration or choking in place. During an interview on 4/8/24, at 1:20 p.m., with the licensed vocational nurse B (LVN B), she stated, Resident 2 always stayed in bed to have meals and had coughing during mealtime. During a follow-up observation on 4/8/24, at 1:27 p.m., Resident 2 was lying in bed in flat position. During an interview on 4/8/24, at 3:50 p.m., with the director of nursing (DON), he stated, Resident 2 used to eat meals in bed and refused to be in upright position because she likes to keep her bed in flat position. During an interview on 4/17/24, at 12:52 p.m., with the speech therapist (ST), she stated, Resident 2 was appropriate for puree diet, and she was able to upgrade her liquids from nectar thick to thin liquid after discharging from the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 5/2/24, at 2:45 p.m., with the assistant director of nursing (ADON), he confirmed there was no care plan developed for Resident 2's dysphagia. He stated, he should have developed a comprehensive person-centered care plan and implemented interventions in place to prevent aspiration or choking events for Resident 2 after being discharged from the hospital. Review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, updated 9/2013, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 36044 Based on observation, interview, and record review, the facility failed to follow care plan and physician's order to apply Triamcinolone cream (a corticosteroid used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) to one of three sampled residents (1). This failure had a potential to delay the improvement and/or resolution of Resident 1's skin problem. Findings: Review of Resident 1's admission record indicated he admitted facility on 1/20/10 and had diagnoses including rash and other nonspecific skin eruption. Review of Resident 1's physician order, dated 11/29/22, indicated physician prescribed, Triamcinolone Acetonide Cream 0.1 % (Triamcinolone Acetonide (Topical)) apply to affected area topically every day and evening shift for general for general body rashes. Apply to legs, arm creases and any areas of rash /redness. Review of Resident 1's plan of care for generalized body rash, dated 9/28/22, indicated to provide treatment per physician's orders. Review of Resident 1's three months' electronic treatment administration record (ETAR) from 4/1/24 to 4/8/24, 3/1/24 to 3/31/24 and 2/1/24 to 2/29/24, the eTAR indicated he was scheduled to have Triamcinolone cream at 9 a.m. and 6 p.m. There were no documented evidence indicating Resident 1's had been applied the treatment nor any refusal for applying Triamcinolone Acetonide Cream on 4/7/24 and 4/8/24 at 9 a.m., 3/1/24, 3/3/24, 3/4/25, 3/7/24, 3/8/24, 3/12/24, 3/14/24, 3/15/24, 2/26/24 and 2/27/24. During an interview on 4/8/24, at 3:25 p.m., with the registered nurse A (RN A), he confirmed that he did not apply Triamcinolone Acetonide External Cream to Resident 1 in the morning for 4/8/24 and he was uncertain what type of cream (Triamcinolone cream) Resident 1 need to be applied every morning. During an interview and observation on 4/8/24, at 3:37 p.m., with Resident 1, he stated that he had an anti-itching cream (Triamcinolone cream) that should be applied twice a day, but staff did not apply Triamcinolone cream to him in the morning on 4/7/24, and 4/8/24 and also in the past. Resident 1 was observed lying on his side, with back exposed, noted pink rashes all over his back. During an interview on 4/17/24, at 10 a.m., with the director of nursing (DON), the DON stated, he had provided in-service to nursing staff regarding applying Triamcinolone cream to Resident 1. During an interview and record review on 5/2/24, at 11 a.m., with the assistant director of nursing (ADON), Resident 1's ETAR were reviewed from February to April 2024. The ADON confirmed there were missing treatment not done and he stated staff should have followed physician's order to apply Triamcinolone cream to Resident 1. He further stated, Triamcinolone cream normally should be applied by treatment nurse and the floor nurse would apply them to Resident 1 when the treatment nurse was not around. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure (P&P) titled, Registered Nurse Job Description, dated 9/2018, the P&P indicated, Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled. Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and that such care is provided in accordance with the resident's wishes.