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	05/21/2024

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to provide safe discharge to one of three residents (1) when the physician indicated that Resident 1 could not be discharged home for self-care, but Resident 1 was discharged home without a caregiver readily available for her upon her discharge to home. This failure had the potential to jeopardize the resident's health, safety and well-being. Findings: Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] and discharged from the facility on 2/26/24. Review of Resident 1's Minimum Data Set (MDS, a clinical assessment tool), dated 2/1/24, indicated her cognition was moderately impaired. Review of Resident 1's Encounter Notes, dated 2/22/24, at 5:45 p.m., the physician indicated that Resident 1 needed a safe placement and could not be discharged home for self-care. Review of Resident 1's clinical record indicated Resident 1 was discharged to home and was given the pamphlets on caregiving services. However, there was no indication that the facility confirmed the caregiving services had already been set up or available before Resident 1 was discharged home. During an interview with the social service director (SSD) on 2/29/24 at 4 p.m., she confirmed that she gave the pamphlets on caregiving services to Resident 1, but she did not confirm that the caregiving services had already been set up before Resident 1 was discharged . The SSD stated she should have confirmed that the caregiving services had already been set up before the facility discharged Resident 1 home. Review of the facility's policy, Discharge Summary and Plan, dated 11/2014, indicated The post-discharge plan will contain, as a minimum: . d. The identify of specific resident needs after discharge .

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the residents received the necessary care and services for four of six residents (2, 3, 4, and 5) when their wounds did not receive weekly assessment. This failure resulted in undetermined wound status and could negatively affect the progress of their wound healing. Findings: Review of Resident 2's Admission Record indicated he was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 2's 1/2024 Treatment Administration Record (TAR) indicated Resident 2 had a sacrococcygeal (the region at the base of the spine) wound during his stay at the facility. Review of Resident 2's clinical record indicated Resident 2 had only one Comprehensive Skin Evaluation/Assessment done on 1/24/24 and one Skin and Wound Evaluation done on 1/29/24. Review of Resident 3's Admission Record indicated she was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 3's 1/2024 and 2/2024 TARs indicated Resident 3 had a pressure injury (the breakdown of the skin due to pressure) on her left buttock during her stay at the facility. Review of Resident 3's clinical record indicated Resident 3 had no Comprehensive Skin Evaluation/Assessment and no Skin and Wound Evaluation done. Review of Resident 4's Admission Record indicated he was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 4's 12/2023 and 1/2024 TARs indicated Resident 4 had a pressure injury on his coccyx (the area at the small bone at the bottom of the spine) during his stay at the facility. Review of Resident 4's clinical record indicated Resident 4 had only one Comprehensive Skin Evaluation/Assessment done on 12/22/23 and no Skin and Wound Evaluation done. Review of Resident 5's Admission Record indicated she was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 5's TARs, from 2/2024 to 5/2024, indicated Resident 5 had a wound on her right coccyx buttocks during her stay at the facility. Review of Resident 5's clinical record indicated Resident 5 had no Comprehensive Skin Evaluation/Assessment done and had only one Skin and Wound Evaluation done on 4/15/24. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the director of nursing (DON), on 5/21/24, at 4:50 p.m., he confirmed that Resident 2 had only one Comprehensive Skin Evaluation/Assessment done on 1/24/24 and one Skin and Wound Evaluation done on 1/29/24; Resident 3 had no Comprehensive Skin Evaluation/Assessment and no Skin and Wound Evaluation done; Resident 4 had only one Comprehensive Skin Evaluation/Assessment done on 12/22/23 and no Skin and Wound Evaluation done; and Resident 5 had no Comprehensive Skin Evaluation/Assessment done and had only one Skin and Wound Evaluation done on 4/15/24. The DON stated the wound assessment/evaluation should be done every week. Review of the facility's policy, Skin Assessment: Best Practice, dated 9/8/22, indicated A weekly skin assessment is completed one a week and describes the current condition of the patient's skin.