

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Cypress Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the residents' pressure ulcers (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time) had weekly assessment for four of seven residents (1, 2, 3, and 4). This failure resulted in undetermined wound status and had the potential to negatively affect the healing of the wounds and/or to cause the deterioration of the wounds. Findings: Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including severe obesity, muscle weakness, and cognitive communication deficit. Review of Resident 1's clinical record indicated she had a pressure ulcer stage 2 (a partial-thickness skin loss that appears as a shallow, open wound with a red or pink wound bed) on her sacrum (a large, triangular bone at the base of the spine), but her sacral pressure ulcer was not assessed from 11/8/24 to 12/2/24. Review of Resident 2's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty in walking, iron deficiency, vitamin deficiency, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Review of Resident 2's clinical record indicated he had an unstageable pressure ulcer (a full-thickness pressure injury in which the base is obscured by soft, yellow, white and/or thick, dry, black, brown dead tissue) on his sacrum, but his sacral pressure ulcer was not assessed from 11/13/24 to 12/2/24. Review of Resident 3's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including severe obesity, muscle weakness, and peripheral vascular disease (the reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel). Review of Resident 3's clinical record indicated she had a deep tissue pressure injury (DTPI, a serious form of pressure injuries; the condition remains invisible for up to 48 hours and then progresses rapidly to full-thickness skin and soft tissue loss) on her right lateral foot, but her right lateral foot DTPI was not assessed from 11/13/24 to 12/2/24. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty in walking, and sepsis (a serious condition in which the body responds improperly to an infection; the infection-fighting processes turn on the body, causing the organs to work poorly). Review of Resident 4's clinical record indicated he had a pressure ulcer stage 3 (pressure injury extends through the skin into deeper tissue and fat) on his sacrum, but his sacral pressure ulcer was not assessed from 8/13/24 to 8/29/24, from 8/31/24 to 9/12/24, and from 9/14/24 to 10/21/24. During an interview with the director of nursing (DON) on 12/10/24, at 3:30p.m., he reviewed Resident 1's, Resident 2's, Resident 3's, and Resident 4's clinical records and confirmed that Resident 1's sacral pressure ulcer was not assessed from 11/8/24 to 12/2/24; Resident 2's sacral pressure ulcer was not assessed from 11/13/24 to 12/2/24; Resident 3's right lateral foot DTPI was not assessed from 11/13/24 to 12/2/24; and Resident 4's sacral pressure ulcer was not assessed from 8/13/24 to 8/29/24, from 8/31/24 to 9/12/24, and from 9/14/24 to 10/21/24. The DON stated the residents' pressure ulcers should be assessed every week. Review of the progress notes of the physician assistant-certified (PA-C) from Professional Wound Specialists organization where the facility sent its residents for pressure ulcer treatments indicated that the residents' pressure ulcers needed to be followed up, assessed, and evaluated in seven days.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37409 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. Certified nursing assistant A (CNA A) did not sanitize/wash her hands after removing the gloves which she wore during working with Resident 5; 2. CNA B walked out of Resident 6's room with gloves on and did not sanitize/wash her hands; and 3. CNA C walked out of Resident 7's room with gloves on. These failures had the potential to spread infection in the facility. Findings: During an observation on 12/2/24, at 4:05 p.m., CNA A was working with Resident 5 in his room. She removed and discarded her gloves and walked out of Resident 5's room and in the hallway without sanitizing/washing her hands. During an interview with CNA A on 12/2/24, at 4:10 p.m., she stated she was preparing Resident 5 and transferring him for shower in his room. CNA A stated she should sanitize/wash her hands when she walked out of Resident 5's room and in the hallway. During an observation on 12/2/24, at 4:20 p.m., CNA B was working with Resident 6 in his room. She walked out of Resident 6's room and in the hallway with gloves on, removed the gloves and threw them in the hamper, which was parked in the hallway, then walked in the hallway without sanitizing/washing her hands. During an interview with CNA B on 12/2/24, at 4:25 p.m., she stated she was transferring Resident 6 from chair to bed in his room. CNA B stated she should remove and discard her gloves in Resident 6's room and should sanitize/wash her hands when she walked out of Resident 6's room and in the hallway. During an observation on 12/9/24, at 1:50 p.m., CNA C was working with Resident 7 in his room. She walked out of Resident 7's room and in the hallway with gloves on, removed the gloves and threw them in the hamper, which was parked in the hallway. During an interview with CNA C on 12/9/24, at 1:55 p.m., she stated she was transferring Resident 7 from chair to bed, changed his brief, removed his pants, and put him to bed in his room. CNA C stated she should remove and discard her gloves in Resident 7's room. During an interview with the backup infection preventionist (BUIP) on 12/9/24, at 3:40 p.m., she stated staff should remove and discard their gloves in the residents' rooms and should sanitize or wash their hands when exiting the residents' rooms. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Personal Protective Equipment - Using Gloves, dated 9/2010, indicated . 2. Discard used gloves into the waste receptacle inside the examination or treatment room . 5. Wash hands after removing gloves. (Note: Gloves do not replace handwashing.)		