

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 01/09/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068 Based on interview and record review, the facility failed to ensure resident's right to be treated with dignity was rendered for one of two residents (Resident 1) when Resident 1's request not to move to another room was not followed. This failure had the potential to cause emotional distress and a feeling of less self-worth for Resident 1. Findings: Review of Resident 1's medical record indicated she was admitted to the facility on [DATE] with diagnoses that included encephalopathy (disorder or damage that affect the brain's structure or function), and psychotic disorder (a mental disorder that affects a person's ability to think and perceive reality) with delusions (having false and unrealistic beliefs). Review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 11/2/24 indicated her cognition (the mental process of thinking, learning, remembering, being aware of surroundings, and using judgement) was severely impaired but had a clear speech, made herself to be understood, and understood by others. During an interview with the Social Worker Staff (SWS) on 1/9/25 at 10:50 a.m., she stated that Resident 1 requested to be moved to another room in the morning of 1/3/25 due to previous roommate who passed away, but the notice of room change was not signed yet by Resident 1 at that time. SWS further stated that when she came back in the afternoon on same day to have the Resident 1 sign the notice of room change, Resident 1 was already transferred to another room, and Resident 1 refused to sign. During an interview with the Housekeeping Staff (HS) on 1/9/25 at 10:20 a.m., he stated that on 1/3/25 at around between 5:00 to 5:30 p.m., while helping the Assistant Director of Nursing (ADON) and Transportation Staff (TS) to move Resident 1 to another room, Resident 1 become upset, screaming, and crying and telling them she did not want to be moved to another room. The HS told ADON that it was not a good idea to move Resident 1 to another room at that time, but the ADON continued to instruct them to move Resident 1 to another room. Resident 1 was moved by the above three staff while lying in her bed to another room that time. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the TS on 1/9/25 at 10:44 a.m., he stated that on 1/3/25 at around between 400 p.m. to 5:00 p.m., while helping the ADON and HS to move Resident 1 to another room, Resident 1 become upset and was screaming and stated she did not want to move to another room. TS told ADON that Resident 1 was upset and screaming and did not want to move to another room, but the ADON told TS We have to. Resident 1 was moved by the above three staff while lying in her bed to another room that time. During an interview with the Director of Nursing (DON) on 1/10/25 at 2:13 p.m., he stated that the ADON should have not executed the room change on 1/3/25 at around between 5:00-5:30 p.m. when Resident 1 became upset, crying, and screaming and did not want to be moved to another room. DON further stated ADON should have waited for about 10-15 minutes for Resident 1 to calm down, then explained and tried the room change procedure again. The DON also stated ADON should have seek the assistance of other staff that are familiar and with good rapport with Resident 1 in order to move Resident 1 to another room smoothly. DON acknowledged ADON should have respected Resident 1's right request not to move to another room at that time because the facility is considered Resident 1's home. Review of revised facility's policy and procedures dated 12/2016 titled Resident Rights indicated Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; be treated with respect, kindness, and dignity .g. exercise his or her rights as a resident of the facility and be supported the facility in exercising his or her rights . Review of revised facility's policy and procedures dated 8/2009 titled Quality of Life-Dignity indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 1. Resident shall be always treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or herself esteem and self-worth .12. Staff shall treat cognitively impaired residents with dignity and sensitivity; for example: a. Addressing the underlying motives or root causes for behavior; and b. Not challenging the resident's beliefs or statements.		