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	12/16/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly reconcile medications and wound care treatment orders upon admission from the hospital for one of three sampled residents (Resident 1). when:1.The wound care treatment order was not transcribed from the hospital discharge instructions from 9/5/2025 to 9/11/2025, which resulted in two missed wound care treatments.2. There was no documented evidence that wound care treatment was provided on 9/15/2025.3. Two insulin aspart orders were not transcribed from the hospital discharge instructions onto the facility's medication list from 9/5/2025 to 9/16/2025. As a result, blood sugar levels were not checked, and insulin was not administered per sliding scale orders during this period.These failures resulted in missed wound care treatments and unmonitored blood sugar levels, which had the potential to compromise Resident 1's health and well-being. 1. A review of Resident 1's clinical record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a chronic condition characterized by hyperglycemia due to the body's inability to use insulin effectively or produce enough insulin), skin ulcers, and a non-pressure chronic ulcer of the right ankle. A review of the hospital discharge instructions dated 9/5/2025 indicated wound care orders for the right lower extremity, with dressings to be changed on Monday, Wednesday, and Friday using the following materials:1) Prisma activated by saline2) Gauze3) Two ABD pads4) Kerlix5) ACE bandageA review of the facility's Treatment Administration Record (TAR) for September 2025 indicated a wound care treatment order for the right lower extremity that included Prisma (activated with saline), gauze, ABD pads, kerlix, and ACE wrap from below the knee. The order, scheduled for every Monday, Wednesday, and Friday on the day shift, was not entered until 9/12/2025.2. A review of the TAR of September 2025 and nursing progress notes from 9/5 to 9/17/2025 indicated no evidence that wound care treatments were provided on 9/8 (Monday), 9/10 (Wednesday), and 9/15 (Monday). During an interview and concurrent record review on 9/23/2025 at 2:20 p. m., Licensed Vocational Nurse (LVN) A reviewed the September 2025 TAR and nursing progress notes from 9/5 to 9/16. LVN A confirmed that the wound care order was not transcribed on admission [DATE]). The order was instead entered on 9/12/2025. LVN A acknowledged there was no documented evidence of wound care treatments on 9/8, 9/10, and 9/15. LVN A stated the wound care nurse should have transcribed the wound care treatment order on 9/5/2025 per the hospital discharge instructions and that the treatments should have been provided as ordered.3. A review of the hospital discharge instructions dated 9/5/2025 also indicated updated medication orders to carry over to the skilled nursing facility (SNF), including:1)Insulin aspart correctional scale, subcutaneously before meals (three times daily)2)Insulin aspart correctional scale, subcutaneously at bedtimeA review of the facility's medication list indicated insulin aspart (Novolog 100 units/mL) was not started until 9/17/2025. The order included a sliding scale:150-189 = 1 unit190-249 = 2 units250-309 = 3 units310-369 = 4 units370-429 = 5 units430-479 = 6 units480-500 = 7 unitsAbove 500 = call MDThe order also required blood sugar checks and insulin administration before meals and at bedtime.A review of Resident 1's blood sugar results on 9/17/2025 showed elevated values, including:12:52 p.m. - 174 mg/dL5:37 p.m. - 214 mg/dL9:40 p.m. - 228 mg/dL10:10 p.m. - 282 mg/dLDuring an interview on 9/23/2025 at 2:29 p.m., LVN A reviewed the above documents and confirmed that the insulin aspart orders should have been initiated on 9/5/2025. LVN A acknowledged that he reconciled medications using the hospital inpatient medication list instead of the discharge to SNF medication list, which resulted in a delay in entering the orders. He further confirmed that blood sugar checks and insulin administration were not completed from 9/5 to 9/16/2025. LVN A stated that if the orders had been entered on 9/5/2025, Resident 1's blood sugar levels could have been maintained within the normal range.A review of the facility's policy titled Reconciliation of Medication on admission (Revised July 2017) indicated:.use an approved medication reconciliation form or other record; list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders ('sources'). List the dose, route, and frequency for all medications.