STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555283	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Ridge Care Center	396 Dorsey Drive Grass Valley, CA 95945

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43755 Based on observation, interview, and record review, the facility failed to provide an incentive spirometer (IS, a handheld device that helps patients improve lung function by teaching them to breathe in slowly and deeply) to meet the needs for one of four sampled residents (Resident 2). This failure had the potential to adversely affect the health and well-being of Resident 2. Findings: A review of the facility ' s policy titled Respiratory Care-Clinical Protocol revised 11/22, indicated The staff and physician/nurse practitioner will monitor the progress of individuals with respiratory conditions, including ongoing evaluation of condition changes. The physician/nurse practitioner will monitor the individual for beneficial and adverse effects of medications used to treat respiratory conditions. A review of the facility ' s policy titled Physician Orders revised 8/2024, indicated Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order. A review of Resident 2 ' s Admission Record (undated), indicated that Resident 2 was admitted to the facility on 11//15/24 with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), kidney failure, and dysphagia (difficulty swallowing). Resident 2 made her own decisions regarding her health care. During a concurrent observation in Resident 2 ' s room and interview on 11/26/24 at 10:15 am, Resident 2 ' s family member (FM) stated She (Resident 2) is supposed to have an IS but they have never given her one. FM indicated it was important for her lung function. Resident 2 confirmed that she had not received an IS and had not used one since being in the hospital. Resident 2 ' s room was observed, and no IS was seen. During a concurrent interview and record review on 11/26/24 at 11:42 am, Resident 2 ' s physician orders dated 11//15/24 were reviewed with Registered Nurse B (RN B). RN B indicated Resident 2 had an order for an Incentive Spirometer 4 times per day, 5-minute sessions for 14 days due to pulmonary dysfunction related to COPD. A review of Resident 2 ' s November Medication (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: 555283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Crystal Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 396 Dorsey Drive Grass Valley, CA 95945	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record (MAR, a record where staff documented a medication or treatment after it had been given) indicated Resident 2 had been receiving IS treatments as evident by nurses documenting treatments that had been given. During a concurrent observation and interview with RN B, FM, and Resident 2 on 11/26/24 at 11:46 am, Resident 2 ' s room was observed for an IS. Resident 2 told RN B that she had never received an IS since she had been in the facility. RN B confirmed that there was no IS in Resident 2 ' s room. FM indicated that it was important for Resident 2 to be doing the IS to prepare her for a surgery that was scheduled for the future. RN B indicated that the admitting nurse was supposed to have given Resident 2 an IS when she was admitted . RN B was unsure why the nurses were documenting the treatment was being done if they really had not been. During an interview with Licensed Vocational Nurse A (LVN A) on 11/26/24 at 1:10 pm, LVN A indicated that she had document that she had given Resident 2 her IS treatment but that she really had not. She thought the respiratory therapist was giving the treatment, so she signed the MAR as given. LVN A indicate she should not have documented on the MAR if she had not given the treatment.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure medications were administered per physician ' s orders when three of four sampled residents (Resident 2, 3, and 4) did not receive their morning medications in a timely manner as per professional standards. These failures resulted in the delay of prescribed medications being administered and the potential for negative outcomes that could affect residents ' health and well-being. Findings: A review of the facility ' s policy titled Physician Orders dated 8/2024, indicated The staff shall carry out physician/nurse practitioner ' s orders as prescribed. A review of the facility ' s policy titled Administering Medications revised 3/22/18, indicated Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. A review of Resident 2 ' s Admission Record (undated), indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), kidney failure, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints caused by too much uric acid that crystallizes and is deposited in joints), hypertension (high blood pressure). Resident 2 made her own decisions regarding her health care. A review of Resident 3 ' s Admission Record (undated), indicated that Resident 3 was admitted to the facility on [DATE] with diagnoses which included hypertension, glaucoma (an eye condition that can cause blindness), depression, allergic rhinitis (nasal allergies), arthritis (swelling and pain in the joints) , spondylosis of lumbar region (a breakdown of one or more of the disks in the lower back), and dementia. A review of Resident 4 ' s Admission Record (undated), indicated that Resident 4 was admitted to the facility on [DATE] with diagnoses which included diabetes (high sugar in the blood), heart disease, seizures, hypertension, gout, arthritis, and polyneuropathy (damage to nerves which cause pain, discomfort, and mobility difficulties). During an interview on 11/26/24 at 10:15 am, Resident 2 stated They have not given me all the medications today for this morning. During an observation on 11/26/24 at 11:15 am, Licensed Vocational Nurse A (LVN A) was observed talking on the phone and the medication cart was parked at the nurse ' s station. During an interview on 11/26/24 at 11:24 am, LVN A indicted she had been logged off of the computer software program that allowed her to pass medication and that she had not been able to finish the morning medication pass. She indicated there were some residents that she had not been able to dispense morning medications to yet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 ' s November 26, 2024, Medication Administration Record ' s (MAR) was reviewed at 11:26 am. The MAR indicated that the 8:00 am medications had not been signed as given. The medications were as follows: allopurinol (a medication that lowers uric acid in the body) 300 milligrams (mg)-give one tablet by mouth one time a day for gout, aspirin 81 mg-give one tablet by mouth one time a day for blood clot prevention, cyanocobalamin (vitamin B 12) tablet 1000 microgram (MCG)-give one tablet by mouth one time a day for vitamin supplement, metoprolol succinate ER (used to treat high blood pressure and reduce the risk of death or hospitalization for heart failure) tablet Extended release 24 hour (designed to slowly release a drug in the body over an extended period of time) 25 mg-give one tablet by mouth one time a day for hypertension. Resident 3 ' s November 26, 2024, MAR was reviewed at 11:26 am. The MAR indicated that one 8:00 am and 17 9:00 am medications had not been signed as given. The 8:00 am medication was as follows: cyclosporine emulsion (an eye medication that blocks swelling) 0.05% instill 1 drop in in both eyes two times day for dry eyes due to inflammation (swelling). 9:00 am medications were as follows: docusate sodium (stool softener) oral capsule 100 mg-give one capsule by mouth two times a day for constipation, acidophilus/pectin (medication to improve digestion) oral capsule-give one capsule by mouth one time a day for probiotic (live bacteria and yeasts that have a beneficial effect on the body, they help fight off the less friendly types of bacteria and boost the immunity against infections), allopurinol tablet 300 mg-give one tablet by moth one time a day for gout, fluticasone furoate (treats seasonal allergies) nasal spray-give two sprays in both nostrils one time a day for allergies, folic acid (treats low blood levels of vitamin B) oral tablet 1 mg-give one mg by mouth one time a day for supplement, Lasix (treats fluid retention) oral tablet 40 mg-give one tablet by mouth one time a day for congestive heart failure (CHF, the heart cannot pump blood well enough causing blood to build up in other parts of the body), multivitamin/minerals tab-give one tablet by mouth one time a day for supplement, niacin (vitamin B) ER oral tablet extended release 500 mg give one tablet by mouth one time a day for supplement, paroxetine (treats depression) HCL (hydrochloride, a salt) oral tablet 30 mg-give one tablet by mouth one time a day for depression, potassium chloride (a mineral to prevent or treat low levels of potassium) ER tablet extended release 10 mEq (milliequivalent, a unit of measurement)-give one tablet by mouth one time a day for supplement, terazosin (improves blood flow and lowers blood pressure) HCL capsule 1 mg-give one capsule by mouth one time a day for hypertension, vitamin B-12 oral tablet 1000 MCG-give two tablet by moth one time a day for supplement, aspirin tablet chewable 81 mg-give one tablet by mouth two times a day for blood clot prevention, combigan ophthalmic solution (eye drops that treat increased eye pressure from glaucoma) 0.2-0.5 % instill one drop in both eyes two times a day for glaucoma, ferrous gluconate (iron) tablet 324 mg-give one tablet by mouth two times a day for supplementation, vitamin C oral tablet-give 500 mg by mouth two times a day for wound healing nutritional support, gabapentin (nerve pain medication) capsule 100mg-give one capsule by mouth three times a day for nerve pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 ' s November 26, 2024, MAR was reviewed at 11:26 am. The MAR indicated that two 7:30 am, four 8:00 am, and eight 9:00 am medications had not been signed as given. The 7:30 am medications were as follows: metformin (medication to lower sugar in the blood) HCL oral tablet 850 mg-give one tablet by mouth two times a day for diabetes, Admelog (a fast acting insulin used to lower sugar in the blood) injection solution inject as per sliding scale (a scale to help individuals with diabetes determine the insulin dose needed before meals without negative effects): if 70-150=0, 151-200=2U (units, volume of measurement), 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, 401-500=12U and notify MD (medical doctor) for BS (blood sugar)> 400. The 8:00 am medications were as follows: hydralazine (relaxes blood vessels to improve blood flow) HCL oral tablet 25mg-give 25 mg by mouth three times a day for HTN, gabapentin oral capsule 300 mg-give300 mg by mouth three times a day for neuropathy (nerve pain), hydrocodone-acetaminophen (a narcotic pain pill) tablet 5-325 mg-give one tablet by mouth two times a day for pain, ferrous gluconate tablet-give 324 mg by mouth two times a day for anemia (low red blood cells). The 9:00 am medications were as follows: calcium and vitamin D3 tablet 600-10mg-mcg give one tablet by mouth two times a day for hypocalcemia (low calcium in the blood) , amlodipine besylate (lowers blood pressure) tablet 10 mg-give one tablet by mouth one time a day for HTN, Vitamin C 1000 mg tablet-give one tablet by mouth one time a day for supplemental, cyanocobalamin tablet 1000 mcg-give two tablets by mouth one time a day for supplemental, doxazosin mesylate (lowers blood pressure) oral tablet 4 mg-give one tablet by mouth one time a day for HTN, fish oil capsule 1000 mg-give one capsule by mouth one time a day for supplementation, folic acid tablet 400 mcg-give one tablet by mouth one time a day for supplemental, metoprolol tartrate oral tablet 25 mg-give one tablet by mouth one time a day for HTN. During a concurrent interview with the Director of Nursing (DON) and review of Resident 2, Resident 3 ' s and Resident 4 ' s MAR on 11/26/24 at 11:35 am, the Director of Nursing (DON) indicated that LVN A was having trouble logging onto the facility ' s computer software that was used to dispense the residents ' medications. The DON indicated she had helped LVN A earlier this morning with that issue. The DON reviewed the MARs for Resident 2, Resident 3 and Resident 4 which showed there was no documentation indicating the 7:30am, 8:00 am, and 9:00 am, medications had been given. The DON immediately left the room after reviewing the records. On 11/26/24 at 1:47 pm, the DON indicated that LVN A had been logged out of the computer software program three times this morning and was struggling to ger her medication pass done on time. On 11/26/24 at 2:30 pm, the DON indicated that the required time frame to give medications was one hour before or one hour after the prescribed time. The DON confirmed that the medications mentioned above had not been given on time as per policy and they should have been.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional standards when: 1. A discontinued medication was not removed and discarded from an active medication drawer in Medication Cart B2 (MC B2, a movable piece of equipment used to store, transport, and dispense medicines). 2. MC B2 was not locked and left unattended. 3. Physician ' s instructions on the Medication Administration Record (MAR) for Pradaxa (a medication used to prevent blood from clotting) and the pharmacy label instructions for Pradaxa did not match. These failures had the potential for medication errors and drug misuse. Findings: A review of the facility ' s policy titled Medication Labeling revised 2/2023, indicated Medications are labeled in accordance with applicable federal and state requirements and currently accepted Pharmacy practices. 8. If medication containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions. A review of the facility ' s policy titled Storage of Medications revised 10/2022, indicated The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 4. Discontinued, updated, or deteriorated drugs or biologicals are placed on designated appropriate bins for destruction. 7. Unlocked medication carts are not left unattended. 1. A review of Resident 1 ' s Admission Record (undated) indicated Resident 1 was admitted on [DATE] with diagnoses including type 2. diabetes (high sugar in the blood), liver failure, heart disease, and depression. During concurrent observation and interview with Licensed Vocational Nurse A (LVN A) on 11/26/24 on 9:50 am, LVN A was observed preparing Resident 1 ' s medications at MC B2. LVN A identified the pills in the medication cup to include, but not limited to, a glipizide (medication to control high blood sugar) 10 mg pill. LVN A examined Resident 1 ' s physician orders and indicated that glipizide had been discontinued and should not be in the medication cup to be administered. She indicated the discontinued medication, glipizide, was still in MC B2 and should not have been. She indicated she put the medication in the cup by mistake. 2. During an observation on 11/26/24 at 11:13 am, MC B2 was observed unlocked in the hallway near the nursing station. The unlocked medication cart was unsupervised. LVN A was observed talking on the phone. (continued on next page)

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Registered Nurse B (RN B) on 11/26/24 at 11:21 am, the MC B2 was observed unlocked and unsupervised. RN B confirmed that MC B2 was unlocked and unsupervised, and it should not have been. RN B was observed locking the cart. 3. During an interview on 11/26/24 at 9:32 am, Resident 1 stated I have to go thru my medications because sometimes I get short changed (missing some pills). During a concurrent observation and interview with LVN A on 11/26/24 at 9:50 am, the morning medication pass was observed. LVN A was preparing Resident 1 ' s medication. A physician order displayed on the MAR for Pradaxa read 75 mg, give two tablets by mouth once a day. The label on the Pradaxa blister pack (a card from the pharmacy that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles) read 150 mg give one tab. LVN A confirmed that the physician order and pharmacy label did not match and this could cause a medication error.