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	12/04/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45315 The facility failed to follow their medication administration policy and procedure (P&P) for one out of three sampled residents (Resident 1) when Licensed Nurse (LN) A documented that LN A had administered medication to Resident 1 when another nurse administered the medication on LN A ' s behalf. This failure resulted in inaccurate documentation and could cause confusion. Findings: A review of the facility ' s P&P titled, Administering Medication, revised 12/1/22, indicated, medication would be administered in a safe manner. The P&P indicated, The individual administering the medication must note the administration on the eMAR [electronic medical record] after giving medication. The P&P indicated, the eMAR would include The signature and title of the person administering the drug. A review of the undated Admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses of type 2 diabetes (body had hard time controlling blood sugar levels) with diabetic neuropathy (nerve damage caused by diabetes) and major depressive disorder (a sad mood). A review of the annual (yearly) Minimum Data Set (MDS, an assessment tool), dated 9/26/24, Section C, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident ' s ability to recall information and memory. The test was scored from 0-15 where 0 meant the resident was not able to remember and 15 meant the resident had intact memory) and scored a 15. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/3/24 at 4:28 pm, Resident 1 ' s Medication Administration Record (MAR), dated 11/1/24 through 11/30/24 was reviewed. LN A confirmed, on 11/29/24, LN A was Resident 1 ' s nurse and the signature on the MAR belonged to LN A. LN A stated, Resident 1 has an issue with me and doesn ' t like me, Resident 1 refused to work with LN A, and LN A was not welcome into Resident 1 ' s room. LN A was asked how LN A was able to provide medications to Resident 1, when Resident 1 did not allow LN A into the room. LN A stated, at the beginning of the shift, LN A would have the Certified Nurse Assistant (CNA) go into Resident 1 ' s room to obtain vital signs (blood pressure, heart rate, temperature). LN A stated the CNA would ask Resident 1 if it would be okay for LN A to administer medications or did Resident 1 want another nurse. LN A stated, Resident 1 always told the CNA no, and Resident 1 wanted another nurse. LN A stated, LN A would prepare Resident 1 ' s medication, in the presence of another LN, and the LN that observed LN A prepare the medications would administer the medications to Resident 1. LN A stated, LN A would then sign the medications out on the MAR. A request was made for the name of the LN that would administer medications to Resident 1 on LN A ' s behalf. No name was provided. During a concurrent interview and record review on 12/4/24 at 8:25 am, with the facility ' s Director of Nursing (DON), Resident 1 ' s MAR, dated 11/29/24 and 12/2/24 was reviewed. DON confirmed, the MAR indicated, LN A had administered Resident 1 ' s medication. DON stated, the LN who administered the medication to the resident was expected to sign the MAR. A review of Resident 1 ' s MAR, dated 11/1/24 through 11/30/24, indicated, LN A signed the MAR, indicating LN A administered Resident 1 ' s medication eight out of 30 days. A review of Resident 1 ' s MAR, dated 12/1/24 through 12/3/24, indicated, LN A administered Resident 1 ' s medications on 12/2/24.

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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** 45315 Based on observation, interview, and record review, the facility failed to ensure medication was stored safely for one out of three sampled residents (Resident 1) when Resident 1 stored medication in an unlocked drawer of the bedside table. This failure had the potential for unauthorized persons to have access to medication that was not prescribed to them. Findings: A review of the facility ' s policy and procedure (P&P) titled, Storage of Medications, revised 4/1/19, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The P&P indicated drugs would be stored in locked compartments. A review of the undated Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses diastolic congestive heart failure (the heart's main pumping chamber becomes stiff and unable to fill properly) personal history of other venous thrombosis (blood clot that usually occurred in the leg or arm) and embolism (blood clot in the lung). A review of the annual (yearly) Minimum Data Set (MDS, an assessment tool), dated 9/26/24, Section C, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident ' s ability to recall information and memory. The test was scored from 0-15 where 0 meant the resident was not able to remember and 15 meant the resident had intact memory) and scored a 15. During a concurrent observation and interview on 12/3/24 at 1:16 pm, Resident 1 was observed opening a drawer of the bedside table and produced a small clear container (the container was used by the facility during medication administration). The container had two capsules that were blue and peach in color. The blue half of the capsule had DAB printed on it and the other half of the pill, peach in color, had 150 printed on it. A small white pill was observed in the drawer of the bedside table. Resident 1 stated, he took a medication that thinned his blood and that he was to receive 150 milligrams (mg, unit of measure), two times daily. Resident 1 stated, the capsules with the 150 printed on them was his blood thinner, and the small white pill (he thought) was a blood pressure pill. Resident 1 stated, previously, the blood thinner medication was provided as two 75 mg tablets and changed to one 150 mg capsule. Resident 1 stated, reviewing each medication on his own prior to taking the medication and noticed sometimes, there were two 150 mg capsules instead of 1. Resident 1 stated, sometimes the nurses would leave the container full of medication at his table and not observe Resident 1 take his medication. Resident 1 stated, when the nurse was not present and the wrong dose or wrong medication was provided, Resident 1 would remove the medication and place it in the unlocked drawer of the bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review, on 12/3/24 at 1:48 pm, with Licensed Nurse (LN) B, located in Resident 1 ' s room, a clear plastic bag, that contained the word biohazard written on it, was observed when Resident 1 handed the clear plastic bag to LN B. LN B confirmed, the clear plastic bag contained nine pills: four blue and peach capsules a described above, four small white pills, and one beige colored capsule. LN B confirmed, the medications appeared to be medications that would be provided to Resident 1. LN B stated, medications were kept in the locked medication cart and should not be stored in resident rooms. During a concurrent observation, interview, and record review on 12/3/24 at 2:20 pm, LN B stated, LN B was not aware that Resident 1 had medication stored in Resident 1 ' s room. LN B was observed comparing the medication found in Resident 1 ' s room to Resident 1 ' s medication that was stored in the medication cart. Utilizing the appearance of the medication and pharmacy label (the label identified the resident ' s name, medication name, dose, and instructions for administration) on the blister pack (a card that contained a months ' worth of medication), LN B identified the blue and peach colored capsules as Pradaxa (blood thinner, used to prevent blood clots) 150 mg. LN B identified the small white pill by comparing color, size, and imprinted numbers on the pill, as furosemide (a diuretic, used to treat congestive heart failure and removed excess fluid from the body) 20 mg. LN B identified the beige colored capsule utilizing a side by side comparison of the medication, as Align (a probiotic taken for gut health). LN B confirmed, the medications found in Resident 1 ' s room, were medications the facility ' s physician had prescribed to Resident 1. During a concurrent interview and record review, on 12/3/24, at 3:44 pm, with the facility ' s Director or Nurses (DON), photos of the medications that were removed from Resident 1 ' s room was reviewed. DON confirmed, medication was to be stored and locked in the medication cart and not in the resident ' s room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to maintain a sanitary environment for one out of three sampled residents (Resident 1) when the floor was sticky through out the room. This had the potential to spread infection. Findings: A review of the facility ' s policy and procedure titled, Infection Prevention and Control, revised 11/1/23, indicated, the facility had established an infection prevention program that helped prevent the spread of infection and residents would be provided a safe and sanitary environment. A review of the undated Admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses of diastolic (congestive) heart failure (when the heart did not adequately pump blood) and had a history of falling. A review of the annual (yearly) Minimum Data Set (MDS, an assessment tool), dated 9/26/24, Section C, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident ' s ability to recall information and memory. The test was scored from 0-15 where 0 meant the resident was not able to remember and 15 meant the resident had intact memory) and scored a 15. During a concurrent observation and interview on 12/3/24 at 1:16 pm, the floor in Resident 1 ' s room was observed to be sticky. Footprints and tracks from the wheels of a wheelchair were visible on the floor. Resident 1 stated, the floor was always sticky. During an interview on 12/3/24 at 1:43 pm, housekeeper (HK) confirmed the floor in Resident 1 ' s room was sticky and stated it had been sticky for several months. HK stated, Resident 1 would spill his urinal (plastic container that contained urine) on the floor. HK stated, Resident 1 ' s roommate would urinate all over the floor and track urine across the floor with his wheelchair. HK stated, despite mopping Resident 1 ' s floor daily, and sometimes more than once a day, the floor remained sticky. During a concurrent observation and interview on 12/3/24 at 1:48 pm, Licensed Nurse (LN) B confirmed, Resident 1 ' s floor was sticky and stated, LN B was unsure why. During the interview with LN B, at 2:11 pm, two housekeeping carts were observed outside of Resident 1 ' s room and a wet floor sign was placed at the entrance of the door. During a concurrent observation and interview on 12/3/24 at 2:34 pm, LN D was observed walking into Resident 1 ' s room. LN D confirmed, housekeeping had recently mopped the floor and the floor was still sticky. LN D stated, Resident 1 always dropped his urinal onto the floor, and the floor was always sticky. During an interview on 12/3/24 at 2:37 pm, Certified Nurse Assistant (CNA) C stated, Resident 1 ' s floor was always sticky despite the floor being mopped daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 3:11 pm, the facility ' s Infection Preventionist confirmed, Resident 1 ' s floor was sticky and stated, the sticky floor was an infection control concern. During an interview on 12/3/24 at 3:31 pm, the facility ' s Housekeeping Supervisor (HS) stated, the floor in Resident 1 ' s room became sticky after Resident 1 moved into the room several months ago. HS stated, HS had no knowledge that Resident 1 would drop the urinal on the floor until today, after talking with housekeeping staff. HS confirmed, Resident 1 ' s sticky floor was an infection control issue.