| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681<br><br>Based on observation, interview, and record review, the facility failed to ensure care and services were provided according to accepted standard of practice for three of 26 sampled residents (Resident 50, Resident 88, and Resident 74) when:<br><br>1. Resident 50's medications were left at bedside;<br><br>2. Resident 88 had no physician's order on the use of neck brace; and<br><br>3. Resident 74's order to check placement of resident's Gastrostomy Tube (GT, tube inserted into the stomach to deliver nutrition, and medications) was not followed.<br><br>These failures had the potential to negatively impact the physical, mental, and psychosocial wellbeing of Resident 50, Resident 88, and Resident 74.<br><br>Findings:<br><br>1. A review of the clinical records indicated Resident 50 was admitted [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), post- traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and mental disorder (a condition that affects thinking, feeling, mood, and behavior).<br><br>A review of Resident 50's Minimum Data Set (MDS- federally mandated resident assessment tool) dated 2/25/25 indicated Resident 50 had moderate cognitive impairment with a score of 11 out of 15 in the Brief Interview for Mental Status (BIMS- an assessment tool used to screen and identify memory, orientation, and judgement status of the resident).<br><br>A review of Resident 50's physician order dated 5/19/25 indicated Amoxicillin-Pot (Potassium) Clavulanate (antibiotic) 875-125 mg (milligram, unit of measurement) give one tablet by mouth two times a day for sinusitis (inflammation of the sinuses or the hallow spaces in the bones surrounding the nose) for 10 days.<br><br>(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 |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview conducted on 5/20/25 at 8:58 a.m., inside Resident 50's room. Observed a medication cup containing eight medications in Resident 50's meal tray. Resident 50 stated the medications were given this morning. Resident 50 further stated he had an antibiotic, a decongestant, two of his vitamins he brought with him, a stool softener, and 3 other medications he was not able to identify inside the medication cup.<br><br>In a subsequent observation and interview on 5/20/25 at 9:01 a.m., Resident 50 took out a medication bottle from his closet. The medication bottle indicated cholecalcif [sic, cholecalciferol] 25 mcg [microgram- unit of measurement] (D3- 1,000 units). The label on the bottle indicated to take one tablet every other day for Vitamin D supplementation. Resident 50 stated the medication came from home and he was supposed to take it every day.<br><br>A concurrent interview and record review was conducted on 5/20/25 starting at 9:19 a.m. with Licensed Nurse 4 (LN 4). LN 4 confirmed he gave Resident 50's medications at around 7:55 a.m. LN 4 opened the electronic Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and he stated he gave Resident 50 a total of eight pills namely Vitamin B12 (Cyanocobalamin-keeps nerve cells healthy), docusate sodium (stool softener), Men's vitamins (provides essential vitamins and minerals), Amoxicillin, Mucinex (helps reduce chest congestion), Multivitamins with minerals, Vitamin D3 (for healthy bones) and Osteo joint health triple strength (to support joint health). LN 4 stated he observed Resident 50 take his medications this morning.<br><br>In an interview on 5/20/25 at 9:27 a.m., LN 4 stated he saw Resident 50 take his antibiotic and the rest of his medications were set side by resident.<br><br>In an interview on 5/20/25 at 9:29 a.m., LN 4 stated they were not allowed to leave medications at bedside and since Resident 50 was waiting for the food, LN 4 left seven pills at bedside.<br><br>In a concurrent interview, and record review on 5/20/25 at 9:32 a.m., LN 4 stated he took the antibiotic from the bubble pack and the count sheet for Resident 50's antibiotic was signed by LN 4 on 5/20/25 at 8:20 a.m.<br><br>A follow up observation and interview was conducted on 5/20/25 at 9:33 a.m. inside the room with LN 4 and Resident 50. LN 4 saw the medication cup in Resident 50's meal tray. LN 4 stated he saw Resident 50 take his antibiotic and Resident 50 responded he did not take any medications. LN 4 clarified he gave the medication cup to Resident 50 and LN 4 did not see [Resident 50] take his medications. LN 4 further stated Resident 50 told LN 4 he wanted to take his medications with meals.<br><br>A follow up interview was conducted on 5/20/25 at 9:38 a.m. with LN 4 outside Resident 50's room. LN 4 stated Resident 50 specifically wanted his privacy, and resident would refuse medications if [LN 4] was with him. LN 4 confirmed there was a bottle of Vitamin D3 medication in Resident 50's room and he was not aware of it. LN 4 further stated he cannot leave medications at bedside. LN 4 stated Resident 50 was by himself in the room, nobody can take the medications, and he trusted Resident 50.<br><br>In a review of Resident 50's 'Medication Admin [Administration] Audit Report' dated 5/20/25, LN 4 documented the administration time for the eight medications was from 8:12 a.m. to 8:18 a.m. and the LN 4's documentation time was 5/20/25 at 8:20 a.m.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 5/21/25 at 4:32 p.m., LN 5 stated if a resident was admitted from the hospital, the admitting nurse sends a list of medications to the pharmacy and pharmacy delivered the medications. LN 5 further stated they never allowed medications to be kept at bedside including over the counter medications. LN 5 answered no when she was asked if residents can self-administer medication.<br><br>In an interview on 5/21/25 at 4:37 p.m., the Assistant Director of Nursing (ADON) stated the facility had one resident who can self-administer medications, and it was not Resident 50. The ADON further stated they have interdisciplinary (IDT) conference, care plan, and a physician order if a resident is able to self-administer medications.<br><br>In a subsequent interview on 5/21/25 with LN 5, LN 5 stated all medications refused by a resident were crushed and placed in a bottle stored in the narcotic box inside the medication cart. LN 5 further stated medications are not left at bedside.<br><br>A concurrent interview and record review was conducted on 5/21/25 at 4:42 p.m. with LN 5. LN 5 accompanied State surveyor in Resident 50's room. Resident 50 refused to talk to LN 5 and State surveyor. Once outside Resident 50's room, the State surveyor showed LN 5 the picture of Resident 50's medications taken on 5/20/25. LN 5 stated that's concerning when LN 5 saw the picture and LN 5 stated she would inform the Director of Nursing regarding the medications in Resident 50's room.<br><br>In an interview on 5/21/25 at 4:52 p.m., the Infection Preventionist (IP) stated she worked with Resident 50 since admission. The IP described Resident 50 as very delusional, resident comes off as very alert and oriented but has extreme behaviors such as accusing kitchen of poisoning his food. The IP further stated Resident 50's capacity (ability to use and understand information to make a decision) was taken away and he was conserved (a legal process where court determines an individual cannot manage their own affairs and appoints a conservator on their behalf).<br><br>A review of Resident 50's Attending physician's notes dated 5/22/25 indicated, .Records show that currently [Resident 50] is conserved because has been determined that patient does not have capacity.<br><br>In an interview on 5/23/25 at 9:49 a.m., the Director of Nursing (DON) stated her expectation was for licensed nurses to stay at bedside and make sure resident swallowed the medications before leaving the resident's room. The DON further stated the signing of the eMAR should be done after the resident had taken the medications. The DON further expected licensed nurses (LNs) to not leave medications at bedside and if a resident refused, LNs should take away the refused medications.<br><br>A review of the facility's policy and procedure revised October 2024 and titled, Administering Medications indicated, Medications are administered in a safe and timely manner, and as prescribed .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall make a note in the eMAR .Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.<br><br>45770<br><br>2. A review of an admission record indicated Resident 88 was admitted in March 2025 with diagnoses that included cervical [neck] disc disorder after a cervical spine fusion.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 5/20/25 at 9 a.m. Resident 88 was observed wearing a cervical collar while lying in bed. According to Resident 88 the nurse told him to always wear the collar per doctor's order due to the surgical incision at the back of his neck.<br><br>A review of Resident 88's Order Summary Report (OSR) indicated an order for the use of a cervical collar dated 3/26/25 and an order to discontinue its use dated 4/24/25.<br><br>A review of Resident 88's Skin/Wound Note dated 4/24/25 indicated that Resident 88's surgical incision at the back of the neck has been resolved and no further treatment was ordered by the doctor.<br><br>In a concurrent interview and record review on 5/21/25 at 11:50 a.m. with MDS Coordinator 2 (MDSC 2) Resident 88's OSR and Progress Notes were reviewed, MDSC 2 confirmed Resident 88 wears a cervical collar. MDSC 2 added that the order for the use of the cervical collar had been discontinued.<br><br>In an interview on 5/23/25 at 9:07 a.m. with the DON, the DON stated the nurse should have clarified the order, nurses should follow the doctor's order to safely care for the residents.<br><br>A review of the facility's policy titled Physician Orders revised in October 2024 indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician order . The licensed staff shall carry out physician/nurse practitioner's orders as prescribed.<br><br>39489<br><br>3. A review of Resident 74's Admission Record, indicated Resident 74 was admitted to the facility on [DATE] with diagnosis that included, Dysphagia, Oropharyngeal Phase, (swallowing disorder that affects the ability to move food from the mouth to the throat).<br><br>During a concurrent observation and interview with LN 1 on 5/21/25 at 1:45 p.m., LN 1 took out the medications for Resident 74 from her medication cart, prepared the medications to be given via GT, and went inside Resident 74's room. LN 1 connected the 60 ml Enteral Syringe (ES, device used to administer nutrition and medications) to the GT, and poured the crushed pill, mixed with water into the ES. LN 1 did not check the placement of the GT and did not flush the GT with 30 cc of water before medication administration as ordered by the physician. LN 1 stated she forgot to bring her stethoscope (instrument used to listen of someone's heartbeat or breathing), however, she decided to administer Resident 74's medication via GT without knowing if the GT is in the correct position inside Resident 74's stomach. LN 1 acknowledged she did not do a pre flush to the GT prior infusing Resident 74's medication. LN 1 stated, for Resident 74's safety, she should have checked the placement of the GT and flushed the GT with water before giving his medication.<br><br>During an interview with the DON on 5/23/25 at 7:45 a.m., the DON stated, the licensed nurses must follow the physicians' orders. The parameters indicated in the physician's order must be followed for the resident's safety. The DON continued, nurses must check the placement of the GT, flush the GT with water before and after medications administration and practice infection control to promote quality of care.<br><br>A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding.<br><br>A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O [cubic centimeters, measurements, water] BEFORE AND AFTER EACH MEDICATION ADMINISTRATION .<br><br>A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O BEFORE AND AFTER EACH MEDICATION ADMINISTRATION.<br><br>A review of the facility's policies and procedures, titled, enteral Feedings, revised September 2024, indicated, Purpose To ensure the safe administration of enteral nutrition . The facility will remain current and follow accepted best practices I enteral nutrition . 1. Always maintain strict aseptic technique when working with enteral nutrition systems . Preventing misconnection error . 2. Regularly inspect tubing for proper and secure connections . Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555283 | A. Building<br>B. Wing | 05/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Ridge Care Center | 396 Dorsey Drive<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>45770<br><br>Based on observation, interview, and record review the facility failed to promote safety measures for one of 26 sampled residents (Resident 82) when Resident 82's order for the use of a wanderguard (a device that activates sensors on doors to alarm, alerting staff to intervene when wandering residents attempt to elope) was not followed.<br><br>This failure increased Resident 82's risk for elopement.<br><br>Findings:<br><br>A review of an admission record indicated Resident 82 was admitted in September 2024 with diagnoses including dementia (a progressive state of decline in mental abilities) with behavioral disturbance.<br><br>During an observation on 5/20/25 at 8:40 a.m. Resident 82 was noted pacing up and down the hallway. Resident 82 was observed being redirected by staff to keep him from wandering to other resident's rooms.<br><br>A review of Resident 82's Order Summary Report (OSR) dated 4/15/25 and 5/16/25 indicated an order for Resident 82 to wear a wanderguard bracelet to the right ankle for safety related to wandering/exit seeking behavior. The order directed nursing staff to check placement of the wanderguard every shift.<br><br>A review of Resident 82's Medication Administration Record (MAR) dated 5/20/25 morning (a.m.) shift indicated the a.m. nurse signed the MAR that Resident 82 was wearing his wanderguard.<br><br>In a concurrent observation, interview, and record review on 5/20/25 at 1:25 p.m. Resident 82's OSR, MAR, and care plans were reviewed. Resident 82 was observed seated in front of the nurse's station and had no wanderguard bracelet to the right ankle. Minimum Data Set (MDS, a federally mandated resident assessment tool) Coordinator 1 (MDSC 1) and MDSC 2 who were both present confirmed that Resident 82 was not wearing the wander guard bracelet. MDSC 2 stated Resident 82 must have taken it off.<br><br>In an interview on 5/23/25 at 9:07 a.m. with the Director of Nursing (DON), the DON stated Resident 82 should always have the wanderguard on as ordered for proper monitoring and to keep the resident safe.<br><br>A review of the facility's policy titled Wandering and Elopements revised in October 2024 indicated The facility will identify residents who are at risk of unsafe wandering and provide interventions to decrease the risk and keep residents safe.<br><br>A review of the facility's policy titled Assistive Devices and Equipment revised in September 2024 indicated Devices and equipment that assist with resident . safety .are provided for residents. These include . wanderguard. |