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	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Ridge Care Center	396 Dorsey Dr 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately and consistently monitor fluid intake status for one of three sample residents (Resident 1).This failure had the potential to delay care and treatment and adversely affect Resident 1's hydration status.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted on [DATE] with diagnoses which included displaced intertrochanteric fracture of right femur (fracture on upper part of thigh bone), dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing).During a review of Resident 1's Order Summary Report (OSR), the OSR indicated Resident 1 had an order of Hydration-Notify MD (doctor) if Weekly (7 days) fluid intake average is less than 1500 mL/day (milliliters/day)During a review of Resident 1's Nutritional Risk Assessment (NRA), dated 3/5/26, NRA indicated Resident 1 had a goal of .fluid at least 1500 mL/day to meet nutrition and hydration needs.During a review of Resident 1's Care Plan (CP), the CP indicated Resident 1 was at risk for malnutrition and dehydration, with interventions that included .monitor intake and output.provide nutritional/dietary supplements as ordered.During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/1/26-3/31/26, the MAR indicated there was missing documentation for the amount consumed for the following:237 mL house nourishment on 3/12, 3/17 and 3/18 at 1800; and240 mL of fluid for hydration with medication pass on 3/11, 3/12, 3/17, 3/18 and 3/19 at 2100.Total Intake and output every shift on 3/11, 3/12, 3/15 evening shift and 3/5, 3/11 and 3/12 night shift.During a review of Resident 1's CNA (certified nursing assistant) Fluid Intake documentation (CNA-ID), CNA-ID indicated there was one missing documentation on 3/18/26.During a review of Resident 1's Nursing Weekly Summary (WS), dated 3/15/26, the WS indicated that Resident 1's average 24-hour intake was .approx. 1000.During a review of Resident 1's Discharge Summary and Post-Care Instructions (DS), dated 3/21/26, the DS indicated Resident 1 was discharged on 3/21/26 at 1300. Resident 1 was seen at the emergency room on 3/22/26 at 8:17 p.m.During a concurrent interview and record review on 4/3/26 at 10:16 a.m. with Director of Nursing, Resident 1's chart was reviewed. DON stated there was no total daily fluid intake calculated; intake was calculated per shift on the MAR based on CNA intake documentation and the fluid nursing has given. Discrepancies were identified in the total fluid intake documented on the MAR, as the totals did not match the combined amounts recorded by the CNAs and nursing staff. The DON stated nurses averaged fluid intake weekly and had an order to notify the physician if the average weekly intake was less than 1500 mL/day. The DON stated Resident 1's weekly summary on 3/15/26 indicated that he had an average intake of 1000mL/day, and there was no documented evidence the physician was notified of this.During an interview on 4/3/26 at 10:24 a.m. with DON, DON stated if residents did not meet their daily fluid intake, she and the MD should have been notified in order to implement appropriate interventions.During a concurrent interview and record review on 4/3/26 at 11:40 p.m. with DON, Resident 1's CNA-ID was reviewed. The DON stated that all residents were placed on I&O monitoring for 14 days, during which nurses documented on the MAR, after the 14-day period, CNAs were expected to continue documenting I&O under tasks. The DON confirmed there was missing (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation for fluid intake and stated documentation should be complete to ensure an accurate assessment of the resident's status, as incomplete documentation could affect outcomes and care provided.During a review of Resident 1's History and Physical (H&P) from the Acute Care Hospital, dated 3/22/26, the H&P indicated Resident 1 was discharged from [skilled nursing home name] to home and became extremely lethargic the next day. H&P indicated that on 3/22/26, Resident 1's sodium level was 171. The H&P also indicated .patient was found to have evidence of severe dehydration with elevated BUN level, acute kidney injury, very dry mucous membrane.During a telephone interview on 4/8/26 at 1:54 p.m. with Attending Physician (AP), AP stated that a sodium level of 171 could not have occurred overnight and would have developed gradually that can be due to inadequate fluid intake.During a telephone interview on 4/8/26 at 2:20 p.m. with Registered Dietician, RD stated that the 1500 mL/day fluid intake goal for Resident 1 was calculated based on his needs and weight and represented the amount required for adequate nutrition and hydration. The RD stated that goals were measured based on weekly intake summaries and intake & output (I&O) monitoring. The RD stated that accurate documentation was important, as it was used to guide care and interventions.The facility failed to accurately monitor and document Resident 1's fluid intake, as intake totals were inconsistent and incomplete, including missing documentation and failed to notify the physician as ordered when average intake was 1500mL/day. The DON and RD indicated that complete and accurate documentation was necessary to guide care and interventions for nutrition and hydration.During a review of the facility's policy and procedure (P&P) titled, Intake and Output, revised 10/20, the P&P indicated, .intake and output shall be recorded by each shift.nursing assistant shall measure and record oral fluids taken by the resident during meals and during care. the licensed nurse shall measure oral fluid taken by the resident during medication pass.the license nurse shall record intake consumed during medication pass.licensed nurse shall document resident's intake and output at the end of each shift on the intake and output record.intake and output record shall be reviewed by a designated licensed nurse on a weekly basis to determine adequate hydration and fluid balance. deficiencies in fluid intake or fluid balance shall be reported to the physician by the licensed nurse.