

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

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Form Approved OMB
No. 0938-0391

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 07/16/2026
NAME OF PROVIDER OR SUPPLIER Crystal Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interviews and record reviews, the facility failed to administer medication as prescribed for one of 27 sampled resident (Resident 45) when fluoxetine (a medication used to treat depression) was unavailable during scheduled medication administration on two consecutive days. This failure resulted that Resident 45 missed one scheduled dose of fluoxetine on the first day and received a dose borrowed from another resident on the second day. Findings: A review of Resident 45's admission record indicated that the resident was admitted on 01/25 with diagnoses included depressed mood disorder (feeling unusually sad or depressed while coping with a stressful life event or major change). A review of Resident 45's Order Summary Record (OSR) indicated that Resident 45 had a physician order, dated 6/8/26, for fluoxetine oral capsule 20 mg (milligrams, unit of measurement) to take one capsule by mouth in the morning for depression. A review of Resident 45's Medication Administration Record (MAR) for July 2026 indicated that on 7/15/26 at 9 a.m. the fluoxetine was not given by Licensed Nurse (LN) 1 because the medication was not available. During an interview on 7/15/26 at 11:44 a.m. with Resident 45, Resident 45 stated that he did not receive his dose of fluoxetine that morning. During an interview on 7/15/26 at 2:45 p.m. with LN 1, LN 1 confirmed that fluoxetine was not given because the medication was not available. LN 1 stated that she expected all her medications to be available during medication administration and that nurses should order medications once there were five tablets left in the medication bubble pack. During an observation on 7/16/26 at 10:30 a.m. in Resident 45's room, the Department heard LN 1 told Resident 45 that she had borrowed the fluoxetine from another resident for his administration. During an interview on 7/16/26 at 10:50 a.m. with LN 1, LN 1 confirmed that she borrowed the fluoxetine from another resident with the same dose and administered the medication to Resident 45. LN 1 acknowledged that she should not have borrowed medication from another resident. LN 1 explained that she was trying to appease Resident 45. During a concurrent interview and record review on 7/16/26 at 11:52 a.m. with the Director of Nursing (DON), the DON stated that nursing staff were expected to order medications timely and that nurses should not borrow medications from another resident. The DON reviewed Resident 45's MAR and confirmed that the medication was not given on 7/15/26 and was documented as given on 7/16/26. During a phone interview on 7/16/26 at 1:09 p.m. with the Pharmacist (RPh), the RPh stated that they missed the refill request on 6/28/26 and were not able to deliver the fluoxetine refill. A review of the facility's policy and procedure (P&P) titled Administering Medications, dated 12/25, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour before and one (1) hour after the prescribed time. A review of the facility's P&P titled Emergency Kits, dated 11/25, indicated, 2. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or from the provider pharmacy.		

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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