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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Re-certification Survey conducted from 8/26/13 to 8/29/13. Entity Reported Incidents 347228, 359167, 360759, and 361877 were investigated during the survey. No deficiencies were issued for Entity Reported Incidents 347228, 359167, 360759, and 361877. Representing the Department: 27886, HFEN 31602, HFEN 29391, HFEN 22707, HFEN 29340, HFEN Census: 86 Sample size: 18	F 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	**F279** -Care plans have been appropriately updated for all residents affected	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jake Moore — TITLE: Administrator — (X6) DATE: 9/19/13

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.

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Implement a care plan for Resident 11's nephrostomy tube (a tube into the kidney to drain urine). 2. Develop a care plan for Resident 7's behaviors related to urinary track infections. 3. Implement care plan for Resident 15 related to availability of call light and bed alarm. These failures had the potential for the resident's needs not to be met and for their health status to decline for three of 18 sampled residents. Findings: 1. On 8/26/13, Resident 11's medical record was reviewed. On 12/20/12, Resident 11 was admitted to the facility with diagnoses which included renal failure, metastatic prostate cancer, and left nephrostomy tube. Resident 11's Minimum Data Set (MDS), an assessment tool, dated 5/31/13, noted that Resident 11 had no memory or behavior issues.	F 279	**F279(cont.)** -All residents have the potential to be affected by this deficient practice. -Implement standardized long and short term care plan templates for nursing to use and personalize to each resident. -In-service staff regarding proper use of long and short term care plan templates and personalization of care plans to residents' needs. -Licensed staff on floor to develop and implement short term care plans based on resident needs. -MDS staff/designee to develop and implement long term care plans based on resident needs. -Medical records/designee to perform random audits of patient care plans to ensure proper implementation of developed plan of care -Director of nursing/designee to report findings of care plan audits to QA committee monthly X 3 months.	9/20/13

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 During an interview on 8/27/11 at 11 am, Resident 11 stated that he went to his doctor's office every week to have his nephrostomy tube checked/and or changed and the dressing was also changed at that time. In further reviewing the medical record for Resident 11 there was not a care plan to address the Resident's nephrostomy tube care being provided weekly at an off-site medical facility. On 8/28/13 at 7:15 am, the Director of Nursing (DON) confirmed that Resident 11's care plan did not reflect the care being provided to Resident 11 at an off site medical facility for his nephrostomy tube. 2. On 8/26, Resident 7's medical record was reviewed On 12/20/12, Resident 7 was admitted to the facility with diagnoses which included depression, anxiety, and dementia with behaviors. Resident 7's Minimum Data Set (MDS), an assessment tool, dated 5/31/13, noted that Resident 7 had short term and long term memory problems and behavior issues. Resident 7 required extensive assistance in all functional activities. The medical record noted that Resident 7 had a urinary tract infection (UTI - bacteria in the urine) confirmed on 7/22/13 and on 5/16/13. The nursing progress notes for both of these dates noted an increase in behaviors prior to the urine test for UTI. A review of the short term care plans for Resident 7's UTIs did not contain a reference to the increased behaviors prior to the urine test. The Resident's care plan did not reflect a long term care plan for the observation	F 279	**Page intentionally left blank**	

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 of an increase in behaviors. On 8/28/13 at 11 am, the DON confirmed that the behavior care plan for Resident 7 did not include the monitoring of an increase in behaviors as sign of a potential UTI. 3. Resident 15 was re-admitted to the facility on 10/15/12 with heart failure, muscle weakness, brittle bones and a history of falls. On 8/26/13 at 10:16 am, Resident 15 was observed lying in her bed with oxygen flowing through a nasal tube. She stated that she sometimes felt like she was unable to breathe. Resident 15 was observed to be unable to locate her call light. On 8/26/13 at 10:16 am, Acting Medical Records Director (AMRD), confirmed that Resident 15's call light button was on the floor outside of Resident 15's reach. Resident 15's record was reviewed 8/28/13. A care plan for fall risk, dated 10/13/12, read that Resident 15 was at risk for falls and fractures. The care plan interventions included, "Keep call light in reach at all times" and to use a, "Personal alarm for safety." On 8/28/13 at 4:20 pm, no personal alarm was observed in use for Resident 15. Licensed Vocational Nurse (LVN) A stated that resident 15 was not on her list for needing a personal alarm and that she did not have one in her room. On 8/29/13 at 9 am, Director of Nursing (DON) stated that Resident 15 should have had her call	F 279	**Page intentionally left blank**	

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 bell in reach and a personal alarm on for safety as was written in her fall risk care plan.	F 279	**F329** -For residents affected, monthly psychotropic summaries have been updated with cumulative tabulation of behaviors in a consolidated manner for comparative analysis. -All residents on psychotropic medications are at risk of being affected by this deficient practice. -In-service for psychotropic IDT members regarding requirement of cumulative tabulation of behaviors in a consolidated manner on all monthly psychotropic summaries. -Monthly review of monthly psychotropic summaries by IDT to ensure compliance. -Social services/designee to audit monthly psychotropic summaries to ensure compliance with cumulative tabulation of behaviors. -Social services/designee to report findings to QA committee monthly X 3months.	9/20/13
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide adequate psychotropic drug monitoring for three of 18 sampled residents when monthly psychotropic medication summaries did not include cumulative tabulation	F 329		

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 5 of behaviors in a consolidated manner for comparative analysis for Residents 2, 5, and 17. This failure had the potential for the use of unnecessary psychotropic medication. 1. Resident 2's record was reviewed on 8/27/13. Resident 2 was admitted to the facility on 11/29/12 and most recently re-admitted on 4/11/13 for physical rehabilitation, after an acute psychiatric hospitalization for medication adjustment, with diagnoses that included Parkinson's disease, bipolar disorder, anxiety, depression, and chronic pain. Resident 2 was on five psychotropic medications that required monitoring; Celexa for depression, Seroquel for psychosis, Depakote for Bipolar/ mood disorder, Doxepin for anxiety, and Trazadone for insomnia. On 8/27/13 at 10:15 am, the Director of Nurses stated that when she started her position in 7/2013, she found that the monthly psychotropic reviews were inconsistently done. On 8/27/13 at 3 pm, during an interview, and concurrent record review, Director of Social Services (DSS) stated that she had been involved in Resident 2's psychotropic medication meetings held over the past year. She stated that no monthly tabulation was made of behavior data for 1/3/13, 2/5/13, 3/22/13, and 6/5/13. She acknowledged that the record did not reflect cumulative monthly data for comparison of the effectiveness of the medications Resident 15 was taking. On 8/29/13 at 10:50 am, Consultant Pharmacist (Ph) stated that he had made at least four	F 329	**Page intentionally left blank**	

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 requests over the past year for the facility to develop a system for monthly psychotropic drug review. 2. Resident 5 was admitted on 8/10/12 with diagnoses that included Alzheimer's disease, bipolar disease, depression, and anxiety. A review of Resident 5's Minimum Data Set (MDS - an assessment tool), dated 7/5/13, indicated he had memory problems and had occasional hallucinations. Resident 5 was prescribed Prozac, an antidepressant and Seroquel, a medicine for bipolar disease. A review of Resident 5's medication monitoring form indicated the monitoring had been sporadic and did not indicate what kind of behaviors the resident had exhibited. There was no monthly tabulation of how many behaviors the resident exhibited. During an interview with the DON on 8/28/13 at 2 pm, she stated there was no consistent method for tabulating the number of behaviors per month. 3. Resident 17 was originally admitted to the facility on 2/10/10 with diagnoses that included dementia with bipolar disorder, psychosis, and anxiety. A record review conducted on 8/28/13, indicated that Resident 17 was taking Risperdal (an antipsychotic drug used to treat mood and mental disorders) since her admission on 2/10/10. The record review also indicated that antipsychotic behavior monitoring was not documented in a consolidated monthly format. In an interview and concurrent record review	F 329	**Page intentionally left blank**	

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 conducted on 8/29/13 at 2:00 pm, Pharmacist produced a Monthly Regimen Review, dated 11/2012, that indicated consolidated monthly behavior monitoring was not made available for facility residents taking psychotropic medication. He stated that he gave the recommendations monthly to the DON. In an interview conducted on 8/29/13 at 10:45 am, DON validated that consistent monthly monitoring was not done for Resident 17 with regard to antipsychotic drug therapy.	F 329		
F 455 SS=E	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the backup generator with emergency fuel. This failure had the potential for the facility backup generator to be unable to provide power for the facility during both a power and natural gas supply failure.	F 455	**F455** -The backup generator emergency fuel tank was filled. -All residents have the potential to be affected by this deficient practice. -Maintenance director/designee to perform weekly check and documentation of the emergency fuel tank levels to the backup generator to ensure sufficient fuel. -Maintenance director/designee to report emergency fuel tank levels findings to the QA committee monthly X 3 months.	9/20/13

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 _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 455	Continued From page 8 Findings: On 8/28/13 at 7:20 am, an environmental tour was conducted with Acting Maintenance Supervisor (AMS). AMS stated that he did the routine generator tests for the facility but did not check for fuel levels in the backup propane tank that was attached to the generator for power if the city's natural gas line was also compromised. AMS stated that he was not aware of any regular deliveries to keep the backup propane tank full. He confirmed that the tank was at the bottom of the fuel gage indicating a near empty state. On 8/28/13 at 12 pm, Administrator (Admin) stated that the backup propane tank should have been monitored and fuel levels maintained. The facility policy "Internal Disaster Loss of Electricity," undated, indicated "The alternate power system is automatic, however the Maintenance Supervisor must make sure the alternate power system is operating."	F 455		