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 12/28/2023

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

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public health during an abbreviated standard survey for one complaint. Complaint Number: 874127 Representing the Department: 47442, Health Facilities Evaluator Nurse The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint 874127 at F755.	F 000	CA DEPT OF PUBLIC HEALTH CHCQ Field Operations North Division- Chico Received Date: 1.8.24 Compliance Date: 1.9.24 Approved Date: 1.18.24 Approved By: David Lister HFES	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roman Aguirre | TITLE: Administrator | (X6) DATE: 1/8/24

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.

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F 755	Continued From page 1 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one out of three sampled residents (Resident 1), received medication and blood sugar monitoring (checking the level of sugar in the blood for diabetics) at the correct time as ordered by the physician when: 1. Famotidine (medication to decrease stomach acid) was not administered to Resident 1 at 6:00 am for 6 out of 15 days in December 2023 (12/1, 12/7, 12/8, 12/9, 12/13, 12/14.) This failure caused Resident 1 to experience burning in his stomach and made it hard for Resident 1 to eat his meals. 2. Blood sugar monitoring was ordered by the physician 4 times a day for Resident 1 and the facility was monitoring Resident 1 ' s blood sugar 3 times a day. This failure had the potential for Resident 1 to have untreated high or low blood sugar levels. Findings:	F 755		

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F 755	Continued From page 2	F 755		

1. During a review of Resident 1 ' s record titled, "Admission Record," dated 9/9/2022 indicated Resident 1 was admitted to the facility on 9/9/2022 and had a diagnosis of Crohn ' s disease (disease that is long term and causes inflammation to the lining of the digestive tract), gastro-esophageal reflux disease (GERD, a disease that occurs when stomach acid or bile flows up into the esophagus and irritates the lining; symptoms include burning and heartburn), incisional hernia (tear in muscle or tissue that allows part of your organs to bulge out), colostomy (an opening on the abdomen created for stool to pass), and type 2 diabetes.

During an interview on 12/15/2023 at 10:15 am, with Resident 1, Resident 1 stated sometimes the nurse would not give him the scheduled Famotidine medication in the morning before his meal. Resident 1 stated he knew what his Famotidine pill looked like, and sometimes the Famotidine pill was not in the medicine cup given to him by the nurse. Resident 1 stated on the days he did not receive Famotidine, he had increased pain and burning in his stomach from acid build up which made it hard for him to eat breakfast.

During a review of the facility ' s policy and procedure titled, "Administering Medications," dated October 2022 (revised), indicated medications must be administered in accordance with orders, including any required time frame.

During a record review of Resident 1 ' s record, "Order Summary Report," dated 9/14/2022, indicated Resident 1 had a physician ' s order for Famotidine 20 milligrams by mouth two times a

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F 755	Continued From page 3	F 755		

day for GERD.

During a review of the facility ' s record, "Medication Administration Record (MAR)," dated 12/1/2023-12/15/2023 indicated, Resident 1 was expected to receive Famotidine at 6:00 am and 4:00 pm, each day. On the MAR, Famotidine had 2 boxes next to it, one labeled 6:00 am and the other 4:00 pm for the licensed staff to record whether Famotidine was given or not given to Resident 1 at these times. The MAR indicated boxes for Famotidine at 6:00 am were blank on the dates of 12/1, 12/7, 12/8, 12/9, 12/13, and 12/14. The other boxes for Famotidine at 6:00 am had a check mark and initials. The MAR indicated on the bottom of the page that a check mark indicated the medication was given.

During a review of Resident 1 ' s record titled, "Care Plan," dated revised 9/22/2023, indicated:
a. Resident 1 was at risk for alteration in comfort/pain secondary to Crohn ' s disease as exhibited by gastrointestinal (stomach) pain. The care plan indicated the nurse was expected to monitor for stomach distress and give Resident 1 ' s medication as ordered.
b. Resident I was at risk for gastric distress due to Crohn ' s disease, GERD, and a colostomy. The care plan indicated the nurse was expected to give medication as ordered by the physician.

During an interview on 12/15/2023 at 12:25 pm, Licensed Nurse (LN) 2 stated the nurse was expected to make a selection for each box next to each medication they dispensed to residents. LN 2 indicated that each medication had a box next to the time it was due, and the nurse must put a "Y" or a "N" into the box. LN 2 stated if "Y" was chosen a check mark would populate into the

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F 755	Continued From page 4	F 755		

square indicating the med was given. LN 2 stated if "N" was chosen the computer prompts you to choose a reason why the medication was not given and then it would prompt you to make a narrative nurses note which would record in the resident ' s chart. LN 2 stated for example, if a resident refused a medication the nurse would choose the number 2 which corresponded to the populated choice for refusal and the number 2 would show up in the box instead of a check mark.

During an interview on 12/15/2023 at 12:00 pm, with LN 1, LN 1 stated she was unable to find nursing documentation indicating why the Famotidine boxes were left blank on Resident 1 ' s MAR. LN 1 stated if the square on the MAR was blank, and nothing was recorded or charted, the medication was not given. LN 1 expected the nurse to document in the box next to Famotidine at 6:00 am and not leave it blank.

2. During an interview on 12/15/2023 at 10:15 am, Resident 1 stated some nurses check his blood sugar correctly and some don ' t. Resident 1 stated his blood sugars were not being monitored correctly.

During a review of Resident 1 ' s record titled, "Order Summary," dated 9/25/2023 at 2:55 pm, indicated the physician ordered blood sugar monitoring before meals and at bedtime. The record indicated the frequency of monitoring entered was before meals. The record indicated the nurse was expected to take Resident 1 ' s blood sugar level before meals at 7:30 am, 11:30 am and 4:30 pm. The record did not indicate a time was entered for the bedtime blood sugar level to be monitored.

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F 755	Continued From page 5 During a review of Resident 1 ' s record titled, "MAR," dated 12/1-12/15/2023, indicated the blood sugar levels were to be monitored before meals and at bedtime but the time populated to monitor Resident 1 ' s blood sugar levels were 7:30 am, 11:30 am and 4:30 pm. The record indicated Resident 1 did not have a time ordered for the bedtime blood sugar levels monitored. The record indicated Resident 1 did not have any bedtime blood sugar levels monitored from 12/1-12/15/2023. During a review of Resident 1 ' s record titled, "Weights and Vitals Summary; Blood Sugar," dated November 2023 and December 2023, indicated Resident 1 did not have any bedtime blood sugar levels recorded in November or December as ordered by Resident 1 ' s physician. During an interview and record review on 12/15/2023 at 11:20 am, in the nurse ' s station reviewing Resident 1 ' s record, "Weights and Vitals Summary; Blood Sugar," with LN 1, LN 1 confirmed Resident 1 did not have bedtime blood sugar levels recorded. During a review of Resident 1 ' s record titled, "Care Plan," dated revised 9/22/2023 indicated, Resident 1 had a diagnosis of diabetes and was at risk for complications such as episodes of high or low blood sugar levels. The care plan indicated the nurse was expected to monitor blood sugar levels as ordered and report to the physician if levels are outside of the set parameters. During an interview on 12/15/2023 at 12:15 pm, with LN 1, confirmed Resident 1 ' s blood sugar was ordered by the physician to be monitored	F 755		

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F 755	Continued From page 6 before meals and at bedtime. LN 1 confirmed the order was incorrectly entered on 9/25/2023 at 2:55 pm, with the wrong frequency code, "before meals," that populated the times 7:30 am, 11:30 am and 4:30 pm. LN 1 stated the correct frequency code should have been "before meals and at bedtime," which would have populated the frequency time as "before meals and at bedtime-7:30 am, 11:30 am, 4:30 pm, and 9:00 pm."	F 755		

The preparation and execution of this POC does not constitute admission of guilt or agreement of findings by Crystal Ridge Care Centre. It is solely prepared to satisfy the requirements of provisions of state and federal regulations.

1. Resident 1 continues to reside happily at Crystal Ridge Care Center .

2. Resident 1 was evaluated by MD regarding allegations of heart burn episodes. Resident reported no issues with heart burn at this time, no new /additional medications were prescribed.

3. Resident 1's meal intake percentages for each meal that has followed a Famotidine administration time was reviewed; resident ate 70-100 % of his meals, even on the days that he alleged he could not eat due to heart burn.

4. Resident' 1's Medication Administration Record was reviewed with the nurse on duty. The nurse stated that the resident takes his pills from her and with no issues (he does refuse pills and blood sugar checks often for other nurses). The nurse in question said that she may have been behind on her eMAR audits (completion of late charting if needed) due to sick leave.

5. Resident 1's Blood sugar checks order was updated to reflect blood sugar checks at bedtime. Resident 1 agreed to have his bedtime blood sugar checked once since surveyor exited (?2 weeks). Resident 1 demanded to have finger sticks discontinued altogether. Resident 1 has orders for hemoglobin A1C to monitor his blood sugar control.

6. The nurse was counselled and coached regarding timely signatures/initialing within PCC (electronic medical record). The nurse was additionally coached on blood sugar checks documentation and orders' entries, with emphasis on documented refusals of care/meds etc and the appropriate education/ resident's response to education documentation.

7. No other residents were identified with similar issues at this time.

8. The medical record manager will audit night shift Emar and blood sugars to insure compliance for the next 30 days.

9. The DON will continue checking in with resident 1 daily as usual.