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	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Ridge Care Center	396 Dorsey Drive 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from abuse when Resident 2 hit Resident 1 on the left side of the face.This failure resulted in Resident 1 sustaining a discoloration on the left jaw and had the potential for Resident 1 to experience fear or distress.Findings:During a review of Resident 1's admission record, the record indicated Resident 1 was admitted to the facility in September 2024 with diagnoses that included cerebral atherosclerosis (a condition where plaque builds up in the brain's arteries, narrowing and blocking them) and dementia (a progressive state of decline in mental abilities). Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 1 had severe cognitive impairment and had behaviors of wandering that occurred daily.During a review of Resident 2's admission record, the record indicated Resident 2 was admitted in March 2024 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (brain tissue dies due to a lack of blood supply), depression, and adjustment disorder (a condition where a person has difficulty coping with or adjusting to a specific stressful life event or change). Resident 2's MDS indicated Resident 2 was cognitively intact.During a review of Resident 3's admission record, the record indicated Resident 3 was admitted in June 2025 with diagnosis that included intracapsular fracture of left femur (a break in the bone within the joint capsule of the hip, specifically involving the neck of the thigh bone). Resident 3' MDS indicated Resident 3 was cognitively intact. During a review of Resident 1's Change in Condition (CIC) notes, dated 7/22/25, the notes indicated, . [Resident 1] was struck one time by another resident [Resident 2] while standing in the hallway in front of the other resident's room and witnessed by another resident [Resident 3], staff immediately responded and re-directed the incident and was able to remove [Resident 1] and was assessed for injury, small red mark was noted to left jaw.During a review of Resident 1's care plan, initiated 7/22/25, the care plan indicated, [Resident 1] has a small red mark to left jaw and is at risk for bruising/swelling and emotional distress related to recipient of physical aggression.During a review of Resident 2's CIC notes, dated 7/22/25, the notes indicated, .[Resident 2] was seen to have struck at another resident [Resident 1] one time who was walking down the hallway in front of [Resident 2's] room.During a review of Resident 2's care plan, initiated 7/22/25, the care plan indicated, .[Resident 2] struck another resident and is at risk for injuring others.During an interview on 7/24/25 at 10:55 p.m. with Resident 2, Resident 2 stated, Guy [Resident 1] came in the room I told him to leave he didn't want to leave.[Resident 1] moved away and came back.It's not the first time.It was 11 in the evening.[Resident 1] came back at me.I kind of pushed him a little bit.During an interview on 7/24/25 at 11:48 a.m. with Resident 3, Resident 3 stated, .I was sitting on bed, the curtain and door was open, [Resident 1] was outside, two feet out from our door.I heard [Resident 2]. [Resident 2] then slap [Resident 1] on the side of the face.I physically saw him do it.[Resident 2] stepped out to hit [Resident 1].It was on the left side of the face.It was evening close to 11 o'clock Monday [7/21/25].[Resident 2] hit [Resident 1] one time.It was hard enough to hear it.[Resident 2] did not react, I would have reacted differently.I've seen and heard it. [Resident 1] is a wanderer.It was in the hallway.[Resident 2] is known to be kind of aggressive. During an interview on 7/24/25 at 1:06 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated, .It was around 10:55 p.m.[7/21/25], I heard a verbal altercation, I heard an audible sound like someone was hit, I heard [Resident 2] yelling.I was sitting charting at the nurses station.I saw both residents, [Resident 2] was yelling at [Resident 1], [Resident 1] was very upset.[Resident 2] was saying [Resident 1] was trying to go to [Resident 2's] room. [Resident 1] was in the middle of the hallway, [Resident 2] got really angry and said he was going to hit [Resident 1]. LN 1 stated she did an assessment on Resident 1 after the incident and Resident 1 pointed to his face on the left cheek. LN 1 added Resident 2 had a history of getting angry and upset, mostly about personal space.During an interview on 7/24/25 at 2:29 p.m. with the Administrator (ADM), the ADM stated LN 1 called him around 11:20 p.m. on 7/21/25 regarding the incident. The ADM stated, We are confident that it happened. The ADM stated Resident 2 had a resident-to-resident altercation before. The ADM further stated LN 1 have heard a little bit of a smack and the ADM stated, .There was a slight redness on [Resident 1's] left jaw. The ADM added, .We are aware that [Resident 2] gets frustrated sometimes.If [Resident 3] hadn't seen anything, we wouldn't even think there was a hit. The ADM stated he was confident it happened because of the history of Resident 2 and the statement of Resident 3 and stated, .I believe [Resident 3, the witness]. During a review of the facility provided document titled, Patients' Rights, undated