

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Watsonville Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Auto Center Drive Watsonville, CA 95076	
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to manage pain for four of 18 residents (4, 6, 46, and 47) when license nurses did not administer pain medication according to the pain level ordered by the physician. This failure had the potential for the residents to experience avoidable pain and could negatively affect their quality of life. Findings: 1. Review of Resident 6's admission Record indicated she was admitted to the facility on [DATE] with pain in right hip diagnosis. Review of Resident 6's physician order, dated 7/5/23, indicated she had an order for acetaminophen (a drug that reduces pain and fever) 325 milligrams (mg, a metric unit of mass) 2 tablets every 4 hours as needed for mild pain level 1-3. Review of Resident 6's Medication Administration Record (MAR), from 10/2025 to 12/2025, indicated two tablets of acetaminophen 325 mg were administered to Resident 6 when her pain level was higher than 3 on 10/5/25, 10/18/25, 11/8/25, 11/24/25, and 12/7/25. During an interview with the director of nursing (DON) on 1/9/26, at 12:33 p.m., he reviewed Resident 6's 10/2025 - 12/2025 MARs and confirmed that Resident 6 was administered with two tablets of acetaminophen 325 mg when her pain level was higher than 3 on 10/5/25, 10/18/25, 11/8/25, 11/24/25, and 12/7/25. 2. Review of Resident 4's admission Record indicated he was admitted to the facility on [DATE] with phantom limb syndrome with pain (the feeling of pain or discomfort in a limb that has been amputated) diagnosis. Review of Resident 4's physician order, dated 10/20/25, indicated he had an order for acetaminophen 500 mg every 6 hours as needed for mild pain level 1-3. Review of Resident 4's MARs, 11/2025 and 12/2025, indicated acetaminophen 500 mg was administered to Resident 4 when his pain level was higher than 3 on 11/6/25 and 12/20/25. During an interview with the DON on 1/9/26, at 12:41 p.m., he reviewed Resident 4's 11/2025 and 12/2025 MARs and confirmed that Resident 4 was administered 500 mg acetaminophen when his pain level was higher than 3 on 11/6/25 and 12/20/25. 3. Review of Resident 46's admission Record indicated she was admitted to the facility on [DATE] with chronic pain diagnosis. Review of Resident 46's physician order, dated 1/1/26, indicated she had an order for acetaminophen 500 mg every 4 hours as needed for mild pain level 1-3. Review of Resident 46's 1/2026 MAR indicated acetaminophen 500 mg was administered to Resident 46 when her pain level was higher than 3 on 1/2/26. During an interview with the DON on 1/9/26, at 12:42 p.m., he reviewed Resident 46's 1/2026 MAR and confirmed that Resident 46 was administered 500 mg acetaminophen when her pain level was higher than 3 on 1/2/26. 4. Review of Resident 47's admission Record indicated he was admitted to the facility on [DATE] with left hip osteoarthritis (a degenerative joint disease where cartilage wears down, causing joint pain, stiffness, and swelling) diagnosis. Review of Resident 47's physician order, dated 5/23/25, indicated he had an order for acetaminophen 500 mg every 6 hours as needed for mild pain level 1-3. Review of Resident 47's MARs, from 9/2025 to 1/2026, indicated acetaminophen 500 mg was administered to Resident 47 when his pain level was higher than 3 on 9/23/25, 9/24/25, 10/3/25, 10/4/25, 10/18/25, 10/24/25, 10/30/25, 10/31/25, 11/1/25, 11/3/25, 11/7/25, 11/8/25, 11/9/25, 11/14/25, 11/15/25, 12/17/25, 12/26/25, 12/30/25, 1/2/26, and 1/3/26. During an interview with the DON on 1/9/26, at 12:45 p.m., he reviewed Resident 47's 9/2025 - 1/2026 MARs and confirmed that Resident 47 was administered 500 mg acetaminophen when his pain level was higher than 3 on 9/23/25, 9/24/25, 10/3/25, 10/4/25, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055240
		If continuation sheet Page 1 of 13

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/18/25, 10/24/25, 10/30/25, 10/31/25, 11/1/25, 11/3/25, 11/7/25, 11/8/25, 11/9/25, 11/14/25, 11/15/25, 12/17/25, 12/26/25, 12/30/25, 1/2/26, and 1/3/26. The DON stated the licensed nurse should follow the physician order and inform the physician of the residents' pain level. Review of the facility's policy, Pain Assessment and Management, dated 10/2022, indicated . 12. The medication regimen is implemented as ordered.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure food served was palatable and attractive for three of fifty-one residents (Resident 2, Resident 17, and Resident 72). The failure had the potential to affect the amount of food residents consume, which could decrease their food intake and lead to poor nutrition. Findings: During an interview 1/5/26 at 12:30 p.m., with Resident 2, Resident 2 stated food tasted terrible especially chicken. During an interview on 1/5/26 at 3:24 p.m., with Resident 17, Resident 17 stated the food sometimes is good sometimes is not good. As a result of multiple resident complaints about the food, a test tray evaluation was conducted during the lunch service on 1/7/26 at 1:08 p.m. The Registered Dietician (RD) and the Dietary Supervisor (DS) were in attendance when the test tray contents were sampled by two surveyors. One item on the regular test tray was green beans. The DS stated the green beans are a little bit overcooked and need a little bit of salt, the DS further stated they don't have a steamer. The RD tasted the green beans, and she agreed the green beans are overcooked and stated that it will affect the nutritive value of the food if it is overcooked. Review of the facility's policy and procedure titled, Food and Nutrition Services, revised October 2017 indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. the food appears palatable and attractive, and it is served at a sale and appetizing temperature. A review of Resident 72's clinical record indicated he was initially admitted on [DATE]. Further review of the clinical record indicated Resident 72 was on fortified/high protein diet regular texture. During an interview with Resident 72 on 1/7/26 at 12:51 p.m., he complained that the facility's food was terrible. Resident 72 further described the texture of the green beans served at the facility as soaked and slumpy. During an observation and concurrent interview on 1/7/26 at 1:08 p.m., two surveyors, along with the Registered Dietitian (RD) and Dietary Manager (DM), conducted a taste test of the food the facility served the residents for lunch that day. The facility's menu indicated the lunch consisted of greens for regular diet. During the food tasting the RD, and DM stated the green beans were overcooked. The RD also stated that overcooked green beans could affect the nutritive value of the food.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items were stored and prepared in accordance with professional standards for food safety when there was unsanitary baking equipment in the kitchen, four base plate, deformed, dented and discolored covers. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the seventy-nine residents who received food from the facility kitchen. Findings: 1. During the initial kitchen tour observation on 1/5/26 at 10:31 a.m., with the Dietary Supervisor (DS) and the Registered Dietitian, observed four baking pans with blackish discolorations and brownish spots in them. The DS stated they use it for baking and she removed the baking pan to wash it. During a follow-up interview on 1/8/26 at 1:31 a.m., with the Dietary Supervisor (DS), the DS stated the four-baking pan will be replaced with new baking pan. 2. During tray line observation on 1/7/26 at 11:50 a.m., Observed four base plate covers were dented, deformed, and discolored, the staff used it to serve food to residents during lunch. During a concurrent observation and interview on 1/8/26 at 10:29 a.m., with the DS and the RD about the dented, deformed, and discolored base plate covers, the DS confirmed the finding, she stated the base plate covers should be remove and replacing it with new one, then they start checking and removing all base plate covers with dented, deformed, and discolored. Review of the facility's policy and procedure titled, Sanitation, revised 11/2023 indicated, .2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair. 12. Plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure infection control practices were implemented when: 1.Resident 13 were not placed on Enhanced Barrier Precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes.) signage posted and there was no available PPE (Personal Protective Equipment, refers to specialized gear like gloves, gowns, masks, and eye protection that creates a barrier to shield healthcare workers from infectious materials, preventing disease transmission to themselves, patients, and others by stopping contact with germs, blood, or body fluids); 2. Facility unit refrigerator had a box of chicken and mashed potatoes for resident and it was not stored in the freezer as per manufacturing label to keep frozen.3. Licensed vocational nurse A (LVN A) did not sanitize his hands after removing gloves;4. Treatment nurse B (TN B) opened the trash bag with his hand during the treatment on Resident 2's pressure ulcers (areas of damaged skin and tissue caused by sustained pressure);5. Certified nursing assistant D (CNA D) placed Resident 19's soiled linen on top of the trash can and against the wall;6. Resident 46's nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) mask and tubing were not store in the bag ; and7. The filter of Resident 47's oxygen concentrator was dusty. These failures had the potential to cause foodborne illnesses to residents, spread infections to residents, staff, and visitors.Findings: 1.During a review of Resident 13's clinical record, it indicated Resident 13 was admitted to the facility with diagnosis including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications. During a review of Resident 13's physician order indicated an order, dated 12/30/25 Stage II pressure injury (a shallow open sore involving partial-thickness skin loss, appearing as a pink or red wound bed (dermis exposed) or a serum-filled blister, indicating damage to the epidermis and upper dermis but not deeper tissues like fat or bone.) to right heel: clean with NS (normal saline) pat dry, apply Santyl (a prescription topical ointment that enzymatically removes dead (necrotic) tissue from wounds, like ulcers and severe burns, to promote healing and new skin growth without harming healthy tissue, working by breaking down collagen in the dead tissue) and Gentamicin (used to treat serious bacterial infections in many different parts of the body) and cover with foam dressing. During an observation on 1/6/2026 at 12:22 p.m., outside Resident 13's entrance door there was no blue sticker next to Resident 13's name, indicated Resident 13 was not place on EBP. During an interview and record review on 1/08/2026 at 1:59p.m., with the infection control preventionist (IP), the IP reviewed Resident 13's clinical records and confirmed Resident 13 has stage II pressure injury to right heel, the IP stated Resident 13 was not on EBP, the IP further stated resident with stage II pressure injury they should have EBP and she missed this one. During a review of the facility's policy and procedures titled, Enhanced Barrier Precautions, revised 6/2024, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.5.EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.6.EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 2. During a concurrent observation and interview in resident's refrigerator unit at station AA on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/8/26 at 1:03 p.m., with the Infection Control Preventionist (IP), found inside the refrigerator a box of chicken & mashed potatoes, dated 5/25/24 with name of Resident 8, on the manufacturing box indicated Perishable. Keep Frozen. [NAME] Thoroughly. The IP stated it should be stored in the freezer. During a follow-up interview on 1/9/26 at 10:13 a.m., with the IP about Resident 8's box of chicken and mashed potatoes stored in the refrigerator, the IP stated she asked the staffs, and they don't know since when it was stored in the fridge, The IP further stated it should be stored in the freezer and it was thrown away. During an interview on 1/9/26 at 1:37 p.m., with the Dietary Supervisor (DS), the DS reviewed state phone's photo of Resident 8's box of chicken and mashed potatoes, the DS stated the 5/25/24 is the date of received and should be in the freezer, if in the fridge it should have thawing date. During a review of facility's policy and procedure titled Food Receiving and Storage, revised 11/2022, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices.Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) .8. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. 3. During a medication pass observation on 1/5/26, at 11:58 a.m., after administering 12 units of insulin aspart (used to control blood sugar) to Resident 30, LVN A removed his gloves then charting on the computer on his medication cart without sanitizing his hands. During a concurrent interview with LVN A, he stated he should sanitize his hands after removing his gloves. Review of the facility's policy, Handwashing/Hand Hygiene, dated 10/2023, indicated . 1. Hand hygiene is indicated: . g. Immediately after glove removal. 4. During treatment observation on Resident 2's left ischium (sit bone in the lower part of the hip) and right hip pressure ulcers on 1/8/26, at 10:03 a.m., after removing the old dressings and gauze from Resident 2's wounds, TN B washed his hands and put on gloves. TN B cleansed Resident 2's wounds, opened the trash bag with his hand to throw the soiled gauze in there, patted dry the wounds, opened the trash bag with his hand to throw the soiled gauze in there, then continued to apply Dakin (used to clean infected topical wounds) moistened gauze into the wound bed and apply dry gauze. During an interview with TN B on 1/8/25, at 10:35 a.m., TN B confirmed that his hands were contaminated during the treatment on Resident 2's wounds because he had to open the trash bag with his hand every time, he threw soiled material in there. Review of the facility's policy, Handwashing/Hand Hygiene, dated 10/2023, indicated . 1. Hand hygiene is indicated: . c. After contact with blood, body fluids, or contaminated surfaces. 5. During an observation and interview with CNA D in Resident 19's room on 1/5/26, at 10:51 a.m., soiled linen was placed on top of the trash can and lying against the wall. CNA D stated she prepared Resident 19 for shower, and the soiled linen should not be placed on top of the trash can and lying against the wall. CNA stated the soiled linen should be put in the soiled linen bin. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the infection preventionist (IP) on 1/8/26, at 2:08 p.m., she stated the soiled linen should not be placed on top of the trash can and lying against the wall. The soiled linen should be put in the soiled linen bin. Review of the facility's policy, Laundry and Bedding, Soiled, dated 9/2022, indicated . a. Contaminated laundry is bagged or contained at the point of collection. 6. Review of Resident 46's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 46's physician order, dated 1/2/26, indicated she had an order for ipratropium-albuterol (used to open up the airways) 0.5-2.5 milligrams (mg, a metric unit of mass)/3 milliliters (ml, a metric unit of volume) inhale via nebulizer every 6 hours as needed for shortness of breath. During an observation and interview with LVN A on 1/5/26, at 11:30 a.m., Resident 46's nebulizer mask was in drawer of the cabinet next to her bed and the nebulizer tubing was hanging down in front of the cabinet. LVN A stated that the nebulizer mask and tubing should be stored in the bag. During an interview with the IP on 1/8/26, at 2:10 p.m., she stated that the nebulizer mask and tubing should be stored in the bag. 7. Review of Resident 47's admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 47's physician order, dated 10/15/24, indicated he had an order for oxygen 2 liters (L, a metric unit of volume) per minute as needed for oxygen saturation (blood oxygen level) less than 92%. During an observation and interview with LVN A on 1/5/26, at 11:19 a.m., the filter of Resident 47's oxygen concentrator was dusty. LVN A stated the filter of the oxygen concentrator should have been cleaned every week. During an interview with the IP on 1/8/26, at 2:12 p.m., she stated the filter of the oxygen concentrator should be kept clean and cleansed every week.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on observation, interview and record review, the facility failed to ensure one of 19 sampled residents (Resident 61) completed a Level II Mental Health Evaluation as part of the pre-admission screening and resident review (PASRR, a federal requirement to help ensure that individuals who have mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care). This failure had the potential for inaccurate care and services provided to residents with mental disorder, intellectual disability, or related conditions. Findings: Review of Resident 61's clinical indicated he was admitted to the facility with diagnoses including paranoid schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Review of Resident 61's preadmission PASRR Level 1 screening, dated 11/26/25, it was indicated Resident 61 had a positive Level I screening which indicated he should have a Level II Mental Health Evaluation. Review of Resident 61's letter from the California Department of Health Care Services (DHCS) with a subject, Notice of Attempted Evaluation, dated 11/29/25, indicated a Level II evaluation was not completed. It indicated a Level II evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. During an interview on 1/09/2026 at 11:13 a.m., with the Administrator-in-Training (AIT), the AIT stated Resident 61 PASSR Level II evaluation was not completed, the AIT further stated the facility should have follow up with PASSR. Review of the facility's policy, PASSR, revised 1/2024 indicated, The facility must not admit, on or after January 1, 1989, any new residents with a mental disorder as defined, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission. PASRR requires that 1)all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plan for one of 28 sampled residents (Resident 35) when Resident 35's care plan did not reflect his noncompliance behavior to safety and well-being. This failure had the potential to compromise the facility's ability to implement interventions. Findings: During a concurrent observation and interview with the IP on 1/6/26 at 12:47 a.m., in resident's room, the IP confirmed the extension cord, phone charger, bags, clothes, papers, power wheelchair battery charger, and plastic bags were placed under Resident 35's bed. The IP described Resident 35's had behavior for noncompliant. The IP further stated that noncompliant behavior should have been documented and care planned. During a concurrent interview and record review with the DON on 1/7/26 at 11:18 a.m., the DON explained that Resident 35 preferred to put everything on his bed and described Resident 35 as noncompliant to potential accident hazard. The DON confirmed that there was no care plan in place addressing Resident 35's noncompliant behavior to removal of potential accident hazard of power strip, excess electrical cords, and power wheelchair battery charger in resident 35's bed. A review of Resident 35's clinical record, indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis of four limbs), C1-C4 incomplete; chronic pain syndrome; major depressive disorder (mental disorder), recurrent, unspecified; other abnormalities of gait and mobility; personal history of other mental and behavioral disorders; obesity, unspecified; acquired absence of left leg above knee. The record also indicated Resident 35 had a BIMS (Brief Interview for Mental Status) score of 15, dated 10/8/25 (a score of 15 indicates the resident's cognition is intact). A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2023, the P&P indicated, 7. The comprehensive, person-centered care plan: (b.1.) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but not provided due to the resident exercising his or her rights, (e) reflects currently recognized standards of practice for problem areas and conditions.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that meet professional standards for two of 18 sampled residents (2 and 26) when: 1. Zinc Oxide cream (used to treat and prevent diaper rash) was left on top of Resident 26's bedside drawers; and 2. Treatment nurse B (TN B) used Dermal Wound Cleanser (a liquid used to gently clean and helps remove dirt and debris from chronic and acute wounds) to cleanse Resident 2's wounds instead of normal saline (NS, a mixture of water and salt with a salt concentration of 0.9%) as ordered by the physician. These failures had the potential to negatively affect the wound healing, and the residents might access the medication. Findings: 1. During an observation and interview with licensed vocational nurse A (LVN A) on 1/5/26, at 11:10 a.m., a medicine cup with white substance inside was on top of Resident 26's bedside drawers. LVN A stated it was the cup of zinc oxide cream for Resident 26's treatment, and it should not be left with the resident. Review of the California Board of Registered Nursing website, California Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725(b)(2), indicated registered nurses should ensure the safety, protection of residents; administration of medications, and therapeutic agents, necessary to implement a treatment, disease prevention, ordered by and within the scope of the licensure of a physician. 2. Review of Resident 2's admission Record indicated she was admitted to the facility on [DATE] with pressure ulcer (areas of damaged skin and tissue caused by sustained pressure) of right hip and left buttock diagnoses. Review of Resident 2's physician orders, dated 12/16/25 and 12/24/25, indicated she had orders for the licensed nurse to cleanse her right hip and left ischium (lower-rear portion of the hip bone) pressure ulcers with NS, pat dry, apply Dakin (a strong topical antiseptic solution) moistened gauze into wound bed, apply dry gauze, cover with border foam dressing two times a day and as needed. During a treatment observation with TN B on 1/8/26, at 10:03 a.m., TN B cleansed Resident 2's right hip and left ischium pressure ulcers with dermal wound cleanser not NS. During an interview with TN B on 1/8/26, at 10:35 a.m., he reviewed Resident 2's physician orders and confirmed that the physician ordered to cleanse Resident 2's right hip and left ischium pressure ulcers with NS, but he cleansed them with dermal wound cleanser. TN B stated he should use NS to cleanse Resident 2's wounds as ordered by the physician. Review of the facility's policy, Wound Care, dated 2/2024, indicated . 9. Apply treatment as indicated.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Watsonville Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Auto Center Drive Watsonville, CA 95076	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two residents (19) receive care and services for the provision of dialysis (procedure to remove waste or toxins from the blood and adjust fluid and electrolyte imbalances) consistent with professional standards of quality when licensed vocational nurse C (LVN C) did not know how to check Resident 19's bruit (an audible vascular sound associated with turbulent blood flow usually heard with the stethoscope). This failure had the potential for delayed detection, reporting, and management of complications from the dialysis shunt for the residents. Findings: Review of Resident 19's admission Record indicated she was admitted to the facility on [DATE] with dependence on renal dialysis diagnosis. Review of Resident 19's physician order, dated 12/21/25, indicated she had an order for the licensed nurse to monitor bruit and thrill (the normal, buzzing vibration felt over a dialysis shunt) of dialysis shunt every shift. During an interview with LVN C on 1/8/26, at 4:08 p.m., she stated she checked Resident 19's both bruit and thrill by feeling the dialysis shunt with her fingers. Review of the facility's policy, End-Stage Renal Disease, Care of a Resident with, dated 9/2010, indicated . 2. Education and training of staff includes, specifically: . g. The care of grafts and fistulas .		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of 28 sampled residents (Resident 1 and Resident 35) were free from unnecessary medications when: 1. Resident 1 received Nuedexta (used to treat pseudobulbar affect [PBA, a medical condition that causes involuntary, sudden, and frequent episodes of crying]) and was not monitored for episodes of crying. This failure resulted in the effectiveness of Nuedexta being undetermined, and Resident 1 might have unnecessary adverse effects. 2. Resident 35 did not have adequate monitoring for the side effect and adverse reaction of the antibiotic medication therapy. This failure had the potential for side effects and adverse reaction of the antibiotic to go undetected or recognized for timely interventions. Findings: 1. Review of Resident 1's admission Record indicated she was admitted to the facility on [DATE] with PBA diagnosis. Review of Resident 1's physician order, dated 7/29/24, indicated she had an order for Nuedexta 20 to 10 milligrams (mg, a metric unit of mass) two times a day for episodes of uncontrolled crying. However, there was no indication that Resident 1's episodes of uncontrolled crying were monitored. During an interview with the director of nursing (DON) on 1/9/26, at 1:02 p.m., he reviewed Resident 1's clinical record and confirmed that Resident 1's episodes of uncontrolled crying were not monitored. The DON stated Resident 1's episodes of uncontrolled crying should be monitored. Review of the facility's policy, Medication Therapy, dated 4/2007, indicated 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. A review of Resident 35's clinical record indicated he was admitted at the facility on 5/26/20 with diagnosis including carrier or suspected carrier of methicillin resistant staphylococcus aureus. Further review of Resident 35's clinical record, he had physician order dated 1/4/25, indicated Piperacillin Sod-Tazobactam Solution Reconstituted 3-0.375 gram intravenously (IV) every 6 hours for Carbapenem Resistant Pseudomonas Aeruginosa (CRPA) for 7 Days. During a concurrent interview and record review with the IP on 1/8/26 at 1:41 p.m., the IP stated that Resident 35 started the IV Piperacillin Sodium Tazobactam on 1/5/26. The IP confirmed that there were no monitoring in place for the side effect and adverse reaction of the antibiotic in Resident 35's medical record. A review of the facility's policies and procedures titled, Administering Medications, revised April 2023, and Medication Therapy, revised April 2007, the P&P indicated, As required or indicated for a medication, the individual administering the medication records in the resident's medical record: any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed.; Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether potential or suspected side effects are present. the staff and practitioner will review the medication regimen for continued indications, proper dosage, and duration, and possible adverse consequences.		

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NAME OF PROVIDER OR SUPPLIER Watsonville Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Auto Center Drive Watsonville, CA 95076	
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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the following multi-resident rooms provided less than 80 square feet per resident. Findings: room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 3 beds, 77.7 square feet per resident room [ROOM NUMBER], 2 beds, 74 square feet per resident room [ROOM NUMBER], 3 beds, 77.7 square feet per resident room [ROOM NUMBER], 2 beds, 76 square feet per resident room [ROOM NUMBER], 2 beds, 77 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 3 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 70 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 71 square feet per resident room [ROOM NUMBER], 3 beds, 74 square feet per resident room [ROOM NUMBER], 3 beds, 74 square feet per resident room [ROOM NUMBER], 2 beds, 76 square feet per resident room [ROOM NUMBER], 3 beds, 78.5 square feet per resident room [ROOM NUMBER], 2 beds, 71 square feet per resident room [ROOM NUMBER], 3 beds, 72 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 3 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 3 beds, 72 square feet per resident room [ROOM NUMBER], 2 beds, 73 square feet per resident room [ROOM NUMBER], 3 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 70.8 square feet per resident room [ROOM NUMBER], 3 beds, 73 square feet per resident room [ROOM NUMBER], 2 beds, 70.8 square feet per resident room [ROOM NUMBER], 3 beds, 70.5 square feet per resident room [ROOM NUMBER], 3 beds, 72.3 square feet per resident room [ROOM NUMBER]. During multiple observations on 1/5/2026 through 1/9/2026, none of the rooms were observed to inhibit the staff providing care. The staff and the residents moved freely in the rooms. The residents and the staff stated the square footage of the rooms was not a concern. Continuance of the room waiver is recommended.		