STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Healthcare	315 Alameda Avenue Salinas, CA 93901

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview and record review, the facility failed to protect one of three resident (Resident 1) from misappropriation of property (unauthorized use of someone else's property) when Resident 1's controlled medication (medications that are regulated due to higher risk of misuse) Lorazepam (used to treat severe anxiety) with 19 tablets were missing or unable to be located.This failure resulted in Resident 1 missing two doses of the medication and potential adverse health outcomes and violated patient rights.During an interview with Registered Nurse (RN) A, on 12/2/25 at 1:30 p.m., RN A stated he was counting the narcotics (used to treat moderate to severe pain) in the Station 2 medication cart with the night shift nurse (RN B) on 11/30/25. RN A stated he could not find a bubble pack containing the medication named Lorazepam (a controlled medication used to treat severe anxiety) 0.5 milligrams (mg, unit of measurement) for Resident 1. RN A stated three medication carts and 48 resident rooms were checked but were not able to find the medication. RN A called the pharmacy for a replacement of the medication and received the replacement on 12/2/25. RN A confirmed Resident 1 missed two doses of the medication Lorazepam tablet 0.5 mg give 1 tablet by mouth one time a day on 11/30/25 and 12/1/25 at 9 a.m.During an interview with RN B, on 12/2/25 at 1:52 p.m., RN B stated she worked the night shift on 11/29/25. RN B confirmed all narcotic medications were accounted for at the beginning of her shift on 11/29/25. At the end of RN B's shift on 11/30/25 around 7 a.m., RN B stated that RN A noticed a bubble pack of Lorazepam was missing during the count of the narcotics. RN B stated the narcotic record book for Resident 1's Lorazepam indicated there were 19 tablets remaining. RN B looked for the missing medication with RN A but were unable to locate it. RN B stated she did not know how the medication went missing during her shift.During an interview with RN C, on 12/23/25 at 3:53 p.m., RN C confirmed he was working the evening shift on 11/29/25 prior to RN B's shift. RN C stated all narcotics were accounted for during the count with RN B. RN C confirmed Resident 1's Lorazepam medication was counted during the count at the end of the shift with RN B. RN C and RN B signed the narcotic book indicating no medications in the medication cart was missing.During an interview with the Minimum Data Set Coordinator (MDSC), on 12/2/25 at 12:34 p.m., the MDSC stated she found a torn label of a medication at the bottom drawer of a bedside table in an empty resident room. The MDSC confirmed the label was from the missing medication of Resident 1. The MDSC stated the 19 tablets of Lorazepam were not found.During a concurrent interview and record review with the Director of Nursing (DON), on 12/2/25 at 12:50 p.m., the DON confirmed RN B and RN C signed the narcotic record book on 11/29/25 indicating all narcotics were accounted for. The DON stated Resident 1's Lorazepam medication with 19 tablets was accounted for on 11/29/25. The DON confirmed Resident 1's Lorazepam medication was missing during RN B's night shift on 11/29/25. The DON also confirmed the torn label found was part of the bubble pack of Resident 1's missing medication. The DON confirmed that the 19 tablets of Lorazepam was not found.Review of the facility's policy and procedure (P&P), titled Controlled Substances, dated 4/19, indicated Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift.Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.Review of the facility's P&P, titled Resident Rights, dated 12/16, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Healthcare	315 Alameda Avenue Salinas, CA 93901

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be free from.misappropriation of property.Review of the facility's P&P, titled Investigating Incidents of Theft and/or Misappropriation of Resident Property, dated 14/17, indicated Residents have the right to be free from theft and/or misappropriation of personal property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Healthcare	315 Alameda Avenue Salinas, CA 93901

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 observation, interview and record review, the facility failed to meet the needs of one of three residents (Resident 1) when there was no accurate accountability of the controlled medication (medication that can be easily abused and are under strict government control) lorazepam 0.5 milligram (mg, unit of measurement) tablet.This failure resulted in Resident 1 not receiving two doses of the controlled medication.Findings:During an interview with Registered Nurse (RN) A, on 12/2/25 at 1:30 p.m., RN A stated he was counting the narcotics (used to treat moderate to severe pain) in the Station 2 medication cart with the night shift nurse (RN B) on 11/30/25. RN A stated he could not find a bubble pack containing the medication named Lorazepam (a controlled medication used to treat severe anxiety) 0.5 milligrams (mg, unit of measurement) for Resident 1. RN A stated three medication carts and 48 resident rooms were checked but were not able to find the medication. RN A called the pharmacy on 11/30/25 for a replacement of the medication. Per RN A pharmacy stated refill of the medication was too early and will need authorization from the Director of Nursing (DON). RN A stated the replacement medication was received on 12/2/25. RN A confirmed Resident 1 missed two doses of the medication Lorazepam tablet 0.5 mg give 1 tablet on 11/30/25 and 12/1/25 at 9 a.m.Review of Resident 1's physician's order, dated 9/24/25, indicated lorazepam oral tablet 0.5 mg give 1 tablet by mouth (taken orally) one time a day for anxiety (feeling of fear, worry or uneasiness) as evidenced by repetitive questions/verbalizations.Review of Resident 1's Medication Administration Record (MAR, a record of prescribed medications) indicated lorazepam was documented as not administered on 11/30/25 and 12/1/25.During a concurrent interview and record review with the DON, on 12/2/25 at 12:50 p.m., the DON confirmed Resident 1's Lorazepam medication was missing during RN B's night shift on 11/29/25. The DON confirmed that Resident 1 missed the dose of the medication on 11/30/25 and 12/1/25 at 9 a.m.During a concurrent observation and interview with the DON on 12/2/25 at 3:05 p.m., the DON confirmed there were no lorazepam in the five E-kits (Emergency Kits, a kit/box containing medications and supplies for immediate use during a medical emergency).Review of the facility's policy and procedure (P&P), titled Controlled Substances, dated 4/19, indicated The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.