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	04/30/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure resident's needs were accommodated for one of five sampled residents (Resident 17) when Resident 17's urinal (a container used to collect urine) was not within reach to use. This failure resulted in Resident 17 to not be able to reach his urinal. Findings: Review of Resident 17's Admission Record indicated, Resident 17 was admitted to the facility with diagnoses including urinary tract infection (UTI, an infection caused by a bacterium (germs) that get into the bladder or kidneys (a pair of organs that are found on either side of the spine, just below the rib cage in the back)), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hemiplegia (paralysis of one side of the body/a severe or complete loss of strength in the arm, leg, and sometimes face on one side of the body) affecting nondominant side (part of the body not used as much as, or does not have as much effect as) and cerebral infarction (commonly referred to as a stroke). Review of Resident 17's Admission/5 day scheduled minimum data set (MDS, an assessment tool) assessment dated [DATE], indicated Resident 17's brief interview for mental status (BIMS, cognition level) score was 14 (13-15 suggests the patient is cognitively intact). During an observation on 4/22/2024 at 11:51 a.m., in Resident 17's room, Resident 17 was lying in bed with bilateral (both sides) upper bed rails in upright position. Resident 17 was observed with left sided weakness and the left hand had a splint. A transfer pole with 2 curves was also observed located to Resident 17's right side of the bed wherein a urinal was hanging at the lower part of the transfer pole's curve. Resident 17 was observed trying to reach for the urinal with his right hand but unable to reach it. During a concurrent observation and interview on 4/23/2024 at 1:55 p.m., in Resident 17's room, Resident 17 was sitting on a wheelchair at the right side of the bed, the urinal was hanging at the transfer pole to his left side. Resident 17 complained of not being able to reach the urinal when it was needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with certified nurse assistant D (CNA D) on 4/23/2024 at 1:59 p.m., in Resident 17's doorway, CNA D confirmed Resident 17 had left sided weakness and was unable to use his left hand or left arm. CNA D confirmed the urinal's positioning at the transfer pole would be hard for Resident 17 to reach. CNA D stated the urinal should always be within Resident 17's reach to accommodate his needs. During a concurrent observation and interview with licensed vocational nurse A (LVN A) on 4/23/2024 at 2:06 p.m., in Resident 17's room, LVN A confirmed the above observation. LVN stated the location of Resident 17's urinal was not within Resident 17's reach for use. During a concurrent observation and interview with Resident 17 and CNA D on 4/24/2024 at 9:00 a.m., in Resident 17's room, Resident 17's urinal was still hanging at the lower part of the transfer poll's curve. Resident 17 still complained of being unable to reach the urinal. CNA D stated they tried to move the urinal around, but they ran out of options of where to placed it. Resident 17 stated, I've been independent for [AGE] years and I am trying to make use of what I have right now. I still want to be independent . During a follow up interview with LVN A on 4/24/2024 at 11:00 a.m., LVN A confirmed they tried to position the urinal within Resident 17's reach, but to no success. LVN A confirmed she placed the urinal back to the transfer pole. LVN A stated she would report it to the director of nursing (DON). During a follow up interview with DON on 4/26/2024 at 10:53 a.m., DON confirmed she was aware of Resident 17's problem about his urinal but she did not check with Resident 17 yet. DON stated Resident 17 was non-compliant with use of a urinal. DON further stated, Resident 17 would place the urinal on his bedside table, which they did not allow due to infection control reasons. DON confirmed Resident 17's urinal should be placed at the bed frame within Resident 17's reach. DON stated Resident 17's needs should be accommodated. Review of Resident 17's care plan titled, Resident is non-compliant, dated 4/19/2024, indicated Resident 17 was non-compliant with a urinal, and he continued to place it on his bedside table. Further review of the care plan did not indicate the possible contributing factors of Resident 17's non-compliance and there was no intervention on how to possibly resolve the problem. Review of the facility's policy and procedure titled, Accommodation of Needs, date revised 1/2020, indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning . The resident's individual needs and preferences will be accommodated to the extent possible . The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes . Staff will arrange toiletries and personal items so that they are easy reach of the resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46553 Based on interview and record review, the facility failed to implement their abuse policy for two of three residents (Resident 19 and 146) when Resident 19 had an allegation of verbal abuse, and Resident 146 had allegation of financial abuse, but the allegations were not reported to the Adult Protective Services (APS). This failure left APS unaware of these allegations of abuse. Findings: 1. Review of Resident 19's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Dysarthria (difficulty speaking) and Anarthria (complete loss of speech), Depression (a mood disorder) , Insomnia due to other mental disorder , Schizophrenia (a mental disorder characterized by disruptions in though processes , perceptions, emotional responsiveness). Review of SOC 341 (form used for reporting elder/dependent adult abuse) sent by the facility to the Department, dated 2/16/23, indicated Resident 19 alleged that a Certified Nurse Assistant (CNA) made a joke on stating that Resident 19 might have eaten too much, like a pig, and that's why he vomited. The SOC 341 did not indicate whether a telephone or written report was made to APS. Review of Resident 19's Interdisciplinary Team (IDT) notes, dated 2/16/24, indicated Medical Director, Responsible Party, Ombudsman, and Department of Health were notified regarding the incident. During an interview on 4/29/24 at 4:16 p.m., with the Administrator (ADM), she stated the incident was not reported to APS. 37409 2. Review of Resident 146's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 146's Social Service Note, dated 9/22/23, at 4 p.m., indicated Resident 146 reported to the social service director (SSD) that while he was at home prior to coming to the facility, his caregiver would take his bank card and would not give it back to him for a couple of days even though he would ask for it. Resident 146 also stated that the caregiver would spend his money without his consent. However, there was no indication that the facility reported Resident 146's allegation to the APS when he reported it to the facility. During an interview with the SSD on 4/29/24, at 3:40 p.m., she reviewed the facility's abuse policy and confirmed Resident 146's allegation should have been reported to the APS when he reported the allegation to the facility on [DATE]. Review of the facility's policy, Abuse Investigation and Reporting, dated 7/2017, indicated All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies . d. Adult Protective Services .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to follow their policy and procedure to obtain a hospice admission order for one of two sampled residents (Resident 41) when Resident 41's admission orders had no indication of a hospice order. This failure had the potential to affect Resident 41's well being and care. Findings: Review of Resident 41's Admission Record indicated, Resident 41 was admitted to the facility with admitting diagnosis of encounter for palliative care (a specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), atherosclerotic heart disease of native coronary artery (a plaque buildup [fat deposits] in the wall of the arteries that supply blood to the heart), hemiplegia (paralysis of one side of the body/a severe or complete loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body) following cerebral infarction (also called stroke) affecting non-dominant side (side of the body not used as much as the preferred side), and dysphagia (difficulty swallowing). During a concurrent interview and record review on 4/26/2024 at 9:54 a.m., minimum data set coordinator (MDSC, a licensed nurse in charge of assessments) reviewed Resident 41's Order Summary Report. MDSC confirmed Resident 41 did not have an admission order for hospice care. MDSC stated the order summary report should indicate an order, To admit to [name of hospice] and with the terminal diagnosis. MDSC further stated the importance of having the hospice admission order for staff to know Resident 41's level of care. During an interview with the director of nursing (DON) on 4/26/2024 at 11:03 a.m., DON confirmed Resident 41 should have an order for hospice care. Review of the facility's policy and procedure titled, Hospice Program, date revised July 2017, indicated, Our facility has designated [Name] [Title] to coordinate care provided to the resident by our facility staff and the hospice staff . He or she is responsible for the following . (7) Hospice physician and attending physician (if any) orders specific to each resident.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to complete and transmit the Minimum Data Set (MDS, an assessment tool) discharge assessment in a timely manner for one of three residents (Resident 12). This failure resulted in Resident 12's discharge assessment not being transmitted and received by the Center for Medicare and Medicaid System (CMS) within the time requirement. Findings: Review of Resident 12's Admission Record indicated, Resident 12 was admitted to the facility on [DATE] and was discharged on [DATE]. During a concurrent interview and record review on 4/26/2024 at 9:35 a.m., minimum data set coordinator (MDSC, a licensed nurse in charge of completing an assessment) reviewed Resident 12's list of MDS assessments. MDSC confirmed she completed and transmitted Resident 12's MDS discharge assessment on 4/22/2024. MDSC stated the director of nursing (DON) signed the completion of the discharge assessment on 4/22/2024. MDSC confirmed she was late in the completion and submission of Resident 12's MDS discharge assessment. MDSC stated the discharge assessment should be completed and submitted to CMS within 14 days of discharge date . During an interview with DON on 4/26/2024 at 10:59 a.m., DON confirmed Resident 12's MDSC was late in the completion and submission of Resident 12's MDS discharge assessment. DON stated the MDSC asked her to sign Resident 12's MDS discharge assessment on 4/22/2024. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI - a guide that facility staff use for coding and transmission) 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, Discharge Assessment-Return Not Anticipated . Must be completed within 14 days after the discharge date . Must be submitted within 14 days after the MDS completion date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview, and record review, the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool) for four of 13 sampled residents (Residents 34, 27, 17, and 7) when: 1. Resident 34's two different MDS assessments did not reflect the following: hospice care, facility acquired pressure injury (PI, damage to the skin caused by prolonged pressure), nutritional intervention, and the physician orders for life-sustaining treatment (POLST, a tool for end-of-life planning); 2. Resident 27's behavior of rejection of care was not reflected in the MDS assessment; 3. Resident 17's left sided weakness was not reflected in MDS assessment; and, 4. Resident 7's behavior of rejection of care was not reflected in MDS assessment. These failures resulted in inaccurate MDS assessments, which had the potential to affect the residents' care. Findings: 1. During a concurrent interview and record review on 4/25/2024 at 10:17 a.m., minimum data set coordinator (MDSC, licensed nurse in charge of the assessment) reviewed Resident 34's MDS Significant change in status assessment, dated 12/7/2023. MDSC confirmed Resident 34 was admitted to hospice and developed a pressure injury (PI) on 12/6/2023. MDSC confirmed Resident 34's MDS Significant change in status assessment did not reflect Resident 34's PI and the number of unhealed PI. MDSC further reviewed the MDS and confirmed the MDS section S (POLST section) was not coded accurately. Upon review of section S, it was coded Resident 34's POLST was not completed. However, a POLST in Resident 34's chart, dated 12/28/2022, indicated it was completed and signed by both Resident 34's physician and daughter. At 10:25 a.m., MDSC reviewed Resident 34's MDS Quarterly assessment dated [DATE]. MDSC confirmed she missed coding the following on Resident 34's Quarterly assessment: PI, the nutrition intervention to manage skin problems, and hospice care. 2. Review of Resident 27's medication administration record (MAR) for the month of January 2024, indicated Resident 27 refused 4 different routine medications on 1/12/2024 and 1/13/2024. During a concurrent interview and record review on 4/26/2024 at 9:50 a.m., MDSC reviewed Resident 27's MDS Admission/5-day assessment dated [DATE]. MDSC confirmed the rejection of care in MDS should have been coded 1 (behavior of this type occurred 1 to 3 days) and not 0 (behavior not exhibited). MDSC stated their social service director (SSD) was the one assigned to code the behavior section of the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with SSD on 4/29/2024 at 2:01 p.m., SSD confirmed she did Resident 27's Section B - Hearing, Speech, and Vision; Section C - Cognitive Patterns; Section D - Mood; Section E - Behavior; and Section Q - Participation in Assessment and Goal Setting. SSD stated she reviewed Resident 27's nurse's notes before she answered the Section E. SSD confirmed she did not review Resident 27's January 2024 MAR. 3. During an observation on 4/22/2024 at 11:51 a.m., in Resident 17's room, Resident 17 was in bed and was observed with left sided weakness. During a concurrent interview and record review on 4/29/2024 at 1:14 p.m., MDSC reviewed Resident 17's MDS Admission/5-day assessment dated [DATE]. MDSC confirmed she should have coded the limitation of Resident 17's upper (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). MDSC stated Resident 17's MDS did not reflect his impairment on one side of the body. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI - a guide that facility staff use for coding and transmission) 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 37409 4. Review of Resident 7's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including anemia (the blood produces a lower-than-normal amount of healthy red blood cells) and hypothyroidism (the thyroid gland doesn't make enough thyroid hormones to meet the body's needs). Review of Resident 7's 3/2024 Medication Administration Record (MAR) indicated from 3/16/24 to 3/22/24 Resident 7 refused vitamin D3 4000 international unit (IU) 4 days, cyanocobalamin (a manufactured version of vitamin B12) 1000 micrograms (ug, a metric unit of mass) 4 days, levothyroxine (used to treat an underactive thyroid gland, which is a gland located beneath the voice box) 75 ug 4 days, and ciprofloxacin ophthalmic solution (used to treat infections of the eye) 0.3% 2 drops in right eye 7 days. Resident 7's 3/22/24 Minimum Data Set (MDS) indicated that Resident 7 did not reject evaluation or care, such as taking medications. During an interview with the social service director (SSD) on 4/29/24 at 2:01 p.m., she stated for Resident 7's 3/22/24 MDS, the period for observing Resident 7's behavior was from 3/16/24 to 3/22/24. The SSD reviewed Resident 7's 3/2024 MAR and 3/22/24 MDS and confirmed that Resident 7's 3/22/24 MDS was not accurately coded. The SSD stated Resident 7's 3/22/24 MDS should indicated that Resident 7 rejected evaluation or care, such as taking medications every day. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Long-Term Care Facility Resident Assessment Instrument (RAI - a guide that facility staff use for coding and transmission) 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, It is important to note that information obtained should be validated for accuracy, what the resident's actual status was during the observation period.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to ensure a pre-admission screening and resident review (PASARR, 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) was accurately completed for two of 13 sampled residents (Residents 27 and 21). These failures had the potential for inaccurate care and services provided to residents with a mental disorder, intellectual disability, or related conditions. Findings: 1. Review of Resident 27's Admission Record indicated, Resident 27 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and other psychoactive substance abuse (a patterned use of a drug that affects thinking which the user consumes the substance in amounts or methods which are harmful to themselves or others). Review of Resident 27's PASARR, dated 1/9/2024, indicated the result of Level I Screening was negative (no mental illness) which was completed at the hospital. It also indicated for the question, 10. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? the answer, No was marked. Review of Resident 27's nurse's note dated 1/12/2024, indicated, Resident 27 had been refusing his routine medications. Review of Resident 27's nurse's note dated 1/17/2024, indicated, The resident noted inappropriate behavior verbally abusing staff, pointing fingers, yelling loudly as disturbing other residents and threatening to call the police. Resident was pulling curtains, throwing the basin, water pitcher and remote control. Patient roommate were being disturbed from his sleep. Patient states I'm going to fall as he drag his body to the floor . Patient continue to scream stating Put me in the floor . Review of Resident 27's nurse's note dated 3/16/2024, indicated, . He is exhibiting very disruptive behavior. Review of Resident 27's nurse's note, dated 3/22/2024, indicated, 0745 Resident is in the hallway, raising his voice and stating inappropriate language . Writer explained to resident that him cussing in the hallway is making some of the residents uncomfortable and that it is not ok to be yelling and cursing . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/2024 at 3:24 p.m., minimum data set coordinator (MDSC) reviewed Resident 27's Level 1 PASARR Screening. MDSC stated she should review the PASARR prior to coding it in resident's minimum data set (MDS, a tool for assessment). MDSC confirmed she did not review Resident 27's detailed Level I PASARR screen and she just reviewed the result. MDSC stated DON would be notified if the Level I PASARR screen was inaccurate. MDSC confirmed there should have been a new Level I PASARR screen completed for Resident 27 because he exhibited behaviors when he was admitted to the facility. During an interview with director of nursing (DON) on 4/26/2024 at 11:10 a.m., DON confirmed she had access to conduct a Level I PASARR screen, Resident 27's Level I PASARR screen was completed at the hospital, and she did not review the Level 1 PASARR screen for accuracy. DON further confirmed Resident 27 had diagnoses of bipolar disorder and depression. DON stated Resident 27 exhibited some behaviors at the facility. DON further stated, we talked about his behaviors .we have good brains here, but I don't know why we did not think of doing another Level I PASARR? DON confirmed there should have been another Level I PASARR Screen completed because the first one completed at the hospital did not reflect Resident 27's diagnoses of mental illness and Resident 27 had some behaviors exhibited at the facility. Review of the facility's undated policy and procedure titled, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR), indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process . Facility will complete Level I PASARR screen and notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in mental or physical condition of a resident who has MD or ID . 37409 2. Review of Resident 21's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including anxiety (persistent and excessive worry that interferes with daily activities), depression (feeling empty, sad, or worthless), and bipolar disorder (extreme mood swings that include emotional highs and lows). Review of Resident 21's PASRR Level 1 Screening Document, dated 4/20/22, indicated Resident 21 was not marked for having diagnosed mental disorder such as anxiety, depression, and/or bipolar disorder. During an interview and record review with the director of nursing (DON) on 4/26/24 at 1:24 p.m., she reviewed Resident 21's PASRR Level 1 Screening Document and stated Resident 21 should be marked for having diagnosed mental disorder because Resident 21 had anxiety, depression, and bipolar disorder diagnoses. Review of the facility's undated policy, Preadmission Screening and Resident Review (PASRR), indicated PASRR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the residents received the necessary care and services for six of 13 residents (1, 7, 9, 22, 27,145) when: 1. Licensed vocational nurse A (LVN A), who worked with Resident 1 for a year, did not know Resident 1 had a pacemaker (a small battery-operated device that helps the heart beat in a regular rhythm); the facility did not have information on Resident 1's cardiologist and pacemaker, and did not schedule for Resident 1's pacemaker to be checked; 2. Resident 7 refused vitamin D3 4000 international unit (IU), cyanocobalamin (a manufactured version of vitamin B12) 1000 micrograms (ug, a metric unit of mass), and levothyroxine (used to treat an underactive thyroid gland which is a gland located beneath the voice box) 75 ug multiple times, and her refusals were not reported to the physician; 3. LVN A did not follow the physician order for the treatment of Resident 9's suspected deep tissue injury (SDTI) on his second, third, and fourth left toes; 4. Resident 27 refused his routine medications and his refusals were not reported to the physician; and, 5. Cyclosporine 0.05% Eyedrops (a medication used to increase tear production) was administered to Resident 145 with a physician's order without indication for strength; 6. Blood pressure (BP, the pressure of blood on the walls of the arteries as the heart pumps blood) parameters for administration of Amlodipine (a medication to treat high blood pressure) was not followed according to the physician order for Resident 22. These failures had the potential to affect the residents' care and could jeopardize their health and well-being. Findings: 1. Review of Resident 1's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including atrial flutter (an abnormal heart rhythm which causes the upper chambers of the heart to beat too quickly) and presence of cardiac pacemaker. Review of Resident 1's clinical record indicated there was no information on Resident 1's cardiologist and pacemaker. There was no documentation to indicate Resident 1 was sent out for routine check-ups for his pacemaker. During an interview with the director of nursing (DON) on 4/30/24 at 12:25 p.m., she stated Resident 1 should be sent out for routine check-up on his pacemaker every 6 months or a year. The DON reviewed Resident 1's medical record and confirmed no information on Resident 1's cardiologist and pacemaker were found. The DON stated the information on Resident 1's cardiologist and pacemaker should be available in his medical record. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A on 4/30/24 at 1 p.m., she stated she worked with Resident 1 for a year, but she did not know Resident 1 had a pacemaker. LVN A stated she should monitor Resident 1's pacemaker functioning by checking Resident 1's heart rate, and that was all she knew. During an interview with the DON on 4/30/24 at 2:50 p.m., she stated she reviewed Resident 1's medical record and confirmed that the facility did not schedule routine check-ups for Resident 1's pacemaker. Review of the facility's policy, Pacemaker, Care of a Resident with a, dated 12/2015, indicated Monitor the resident for pacemaker failure by monitoring for signs and symptoms of abnormally slow heart rate which may include: fainting, shortness of breath, dizziness, fatigue, and/or confusion . For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: The name, address, and telephone number of the cardiologist; type of pacemaker; type of leads; manufacturer and model; serial number; date of implant, and paced rate. 2. Review of Resident 7's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including anemia (the blood produces a lower-than-normal amount of healthy red blood cells) and hypothyroidism (a condition where the thyroid gland does not make enough thyroid hormones to meet the body's needs). Review of Resident 7's Medication Administration Records (MAR) indicated, in 1/2024, Resident 7 refused vitamin D3 4000 IU 7 days, cyanocobalamin 1000 ug 11 days, and levothyroxine 75 ug 9 days; in 2/2024, Resident 7 refused cyanocobalamin 1000 ug 14 days and levothyroxine 75 ug 17 days; in 3/2024, Resident 7 refused vitamin D3 4000 IU 4 days, cyanocobalamin 1000 ug 4 days, and levothyroxine 75 ug 4 days; and in 4/2024, Resident 7 refused levothyroxine 75 ug 12 days. However, there were no documents that indicated the physician was notified about Resident 7's refusals of these medications. During an interview with the director of nursing (DON) on 4/26/24 at 2:40 p.m., she reviewed Resident 7's clinical record and confirmed that there were no documents that indicated the physician was notified about Resident 7's refusals of these medications. The DON stated the licensed nurses should have notified the physician about Resident 7's refusals of these medications. Review of the facility's policy, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 5/2017, indicated, Detailed information relating to the request, refusal, or discontinuation of care or treatment will be documented in the resident's medical record. Documentation pertaining to a resident's request, discontinuation, or refusal of treatment shall include at least the following . The date and time the practitioner was notified as well as the practitioner's response . The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. 3. Review of Resident 9's Admission Record indicated he was admitted to the facility on [DATE] with pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) diagnosis. Review of Resident 9's New Skin Incident Notes, dated 4/19/24, indicated he developed SDTI on his second, third, and fourth left toes. (continued on next page)

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	055311	A. Building B. Wing	04/30/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 9's physician order, dated 4/19/24, indicated he had an order for the licensed nurse to apply skin prep (used to form a protective film or barrier on the skin) to his second, third, and fourth left toes every day. During a treatment observation on 4/24/24 at 1:45 p.m., LVN A applied povidone iodine (used on the skin to decrease risk of infection) on Resident 9's second, third, and fourth left toes. During an interview with LVN A on 4/24/24 at 2:10 p.m., she acknowledged that she should follow the physician's order and apply skin prep on Resident 9's second, third, and fourth left toes. Review of the facility's job description, Licensed Vocational Nurse (LVN), dated 5/25/21, indicated Prepares and administers medications as ordered by the physician in accordance with government regulations and facility policies and procedures. 44583 4. Review of Resident 27's Admission Record indicated, Resident 27 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), chronic kidney disease, stage 5 (kidney failure also known as end-stage kidney disease or ESKD), (bipolar disorder, a mental disorder characterized by periods of elevated mood and depression, often with poor decision-making), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and other psychoactive substance abuse (a patterned use of a drug which the user consumes the substance in amounts or methods which are harmful to themselves or others). Review of Resident 27's medication administration record (MAR) for the month of January 2024, indicated Resident 27's refusal of his routine medications: 1) Calcitriol capsule (a supplement to treat low calcium levels): refused on 1/12, 1/13, 1/14, and 1/15/2024; 2) Melatonin (a supplement to help in treating sleep disorders): refused on 1/25 and 1/27/2024; 3) Prednisone (a class of medication called corticosteroids. It treats low levels of corticosteroids, in other cases, reduce swelling and redness by changing the way the immune system works), ordered to be taken for 10 days: refused on 1/12, 1/13, 1/14, 1/15 and 1/18; 4) Calcium Acetate (medication used to control high blood levels of phosphorus in people with kidney disease) ordered to be taken three times a day: refused twice on 1/12, 1/13, 1/14, 1/15, 1/21, 1/22, and once on 1/16, 1/18, 1/20,1/29 and 1/30/2024; 5) Sodium Bicarbonate (medication used to relieve heartburn, sour stomach, or acid indigestion by neutralizing excess stomach acid) ordered to be taken three times a day: refused twice on 1/12, 1/13, 1/14, 1/15, 1/21 and 1/22, and once on 1/16, 1/18, 1/20, 1/29 and 1/30/2024; and 6) Albuterol Sulfate inhalation (it works to relax the muscles around the airways so that they open up and patient can breathe more easily) ordered four times a day for shortness of breath (SOB): refused twice on 1/21/2024. During a concurrent interview and record review on 4/26/2024 at 9:50 a.m., minimum data set coordinator (MDSC) reviewed Resident 27's MAR and nurse's progress notes. MDSC confirmed nurses did not notify Resident 27's physician for the refusal of medications. MDSC stated nurses should have notified Resident 27's physician for the refusal of medications. During an interview with social service director (SSD) on 4/26/2024 at 10:37 a.m., SSD confirmed attending physicians should be notified whenever residents refused their medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with director of nursing (DON) on 4/26/2024 at 11:10 a.m., DON stated Resident 27's refusal of medications or treatments was one of resident's rights, but the physician should have been notified about it. Review of the facility's policy and procedure titled, Requesting, Refusing and/or Discontinuing Care or Treatment, date revised May 2017, indicated, Documentation pertaining to a resident's request, discontinuation or refusal of treatment shall include at least the following . g. The date and time the practitioner was notified as well as the practitioner's response . 49345 5. During a medication administration observation on 04/22/24 at 9:46 a.m., licensed vocational nurse (LVN) B administered Cyclosporine 0.05% eyedrops on both eyes for Resident 155. During a concurrent interview and record review on 4/22/24 at 12:43 p.m. with LVN B, she verified the physician order for Cyclosporine eyedrops for Resident 145 did not indicate the strength. LVN B stated the strength should have been clarified. Review of facility's policy and procedure (P&P) Medication Orders, dated 2014, indicated, . When recording orders for medication, specify the type, route, dosage, frequency and strength of medication ordered. 6. During a medication administration observation on 04/22/24 at 9:33 a.m., licensed vocational nurse (LVN) B administered Amlodipine 5 milligrams (mg, unit of measurement) oral tablet to Resident 22. During an interview with LVN B on 04/22/24 at 9:44 a.m., she stated that the blood pressure for Resident 22 was 115/55 mmhg (unit of measurement). A review of Resident 22's physician orders dated 9/15/22, indicated, Amlodipine 5 mg , give 1 tablet by mouth one time a day related to essential (primary) hypertension Hold for BP <110/70. During a concurrent interview and record review on 4/22/24 at 4:01 p.m. with the Director of Nursing (DON), the DON verified Amlodipine was not held 17 times during the month of April, when the blood pressure did not meet physician ordered parameters. Review of facility's P&P titled, Administering Medications, dated April 2019, indicated, Medications are administered in accordance with prescriber orders .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44583 Based on observation, interview and record review, the facility failed to ensure that proper care and treatment services for oxygen (O2, a colorless, odorless gas) use was provided for one of two sampled residents (Resident 15) when Resident 15's physician order for oxygen administration was not followed. This failure had the potential to result in complications related to improper treatment while receiving O2 therapy. Findings: Review of Resident 15's Admission Record indicated, Resident 15 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe), chronic respiratory failure (a condition when lungs cannot release oxygen to blood causing shortness of breath) with hypoxia (occurs when oxygen level in the body organs are low), chronic diastolic heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), and dependence on supplemental oxygen. Review of Resident 15's Order Summary Report, indicated Resident 15 had an order dated 11/3/2022, O2 at 3 LPM (liters [L-a metric unit of capacity] per minute) via (thru) nasal cannula (NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration) as needed for SOB (shortness of breath). During an observation on 4/22/2024 at 9:35 a.m., in Resident 15's room, Resident 15 was lying in bed, and had O2 at 2.5 LPM via NC, connected to the oxygen concentrator (a device which concentrates the oxygen from ambient air). During another observation on 4/23/2024 at 9:34 a.m., in Resident 15's room, Resident 15 was seated on her wheelchair and had O2 at 2 LPM via NC, connected to oxygen E-tank (a three-foot tall aluminum tank of oxygen and could be carried anywhere). During a concurrent interview and record review on 9/23/2024 at 9:50 a.m., registered nurse I (RN I) reviewed Resident 15's order summary report. RN I confirmed Resident 15 had an O2 order at 3 LPM. Resident 15 was not in her room at this time. RN I reviewed the picture of Resident 15's oxygen level of administration taken on 4/22/2024 at 9:39 a.m. RN I confirmed the oxygen was at 2.5 LPM. RN I reviewed Resident 15's oxygen level of administration taken on 9/23/2024 at 9:38 a.m. RN I confirmed it was at 2 LPM. RN I stated licensed nurses should follow the physician's order for oxygen level of administration. RN I confirmed Resident 15's O2 should have been at 3LPM as ordered. Review of the facility's policy and procedure titled, Oxygen Administration, date revised October 2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure the proper use of bed or side rails (adjustable rigid bars attached to the side of a bed) for five (Residents 26, 145, 194, 17, and 4) of five sampled residents (residents who used bed or side rails) when: 1. There was no documentation that indicated the facility followed the manufacturers' recommendations and specifications for installation and maintenance of the facility's beds and side rails for five of five sampled residents (Residents 26, 145, 194, 17, and 4); 2. There was no documentation that indicated alternatives were offered and/or attempted prior to the use of bed or side rails for three of five sampled residents (Residents 194, 17, and 4); 3. There was no documentation that indicated an entrapment risk assessment was completed prior to the use of bed or side rails for two of five residents (Residents 17, and 4); 4. There was no updated bed or side rail assessment form completed for one of five residents (Resident 4); and, 5. There was no physician's order that indicated the use of bed or side rails for one of five residents (Resident 4). These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During a concurrent observation and interview on 4/22/2024 at 9:47 a.m., in Resident 26's room, Resident 26 had the bilateral (both sides) upper bed rails in upright position. Resident 26 stated she used her bed rails to transfer out of bed. During an observation on 4/22/2024 at 10:11 a.m., in Resident 145's room, Resident 145 had the left upper bed rail in upright position. During an observation on 4/22/2024 at 10:16 a.m., in Resident 194's room, Resident 194 was asleep on his bed and the right upper bed rail was observed in upright position. During an observation on 4/22/2024 at 11:51 a.m., in Resident 17's room, Resident 17 was in bed and had the bilateral upper bed rails in upright position. During an observation on 4/22/2024 at 2:54 p.m., in Resident 4's room, Resident 4 had the left upper bed rail in upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with licensed vocational nurse A (LVN A) on 4/24/2024 at 11:05 a.m., in Resident 26's room, Resident 26 had the bilateral upper bed rails in upright position. LVN A confirmed the observation. During a concurrent observation and interview with LVN A on 4/24/2024 at 11:07 a.m., in Resident 194's room, Resident 194 had the right upper bed rail in upright position. LVN A confirmed the observation. During a concurrent observation and interview with LVN A on 4/24/2024 at 11:10 a.m., in Resident 17's room, Resident 17 had the bilateral upper bed rails in upright position. LVN A confirmed the observation. During an interview with maintenance supervisor (MS) on 4/24/2024 at 3:40 p.m., MS confirmed there should be no bed rails installed in bed for newly admitted residents (Resident 194). MS stated the nurses would call him when they needed him to install the bed rails on resident's bed. MS confirmed he would install the bed rails as instructed by nurses without following the manufacturers' specifications for bed installation. MS stated he did not have any documentation indicated that he followed the manufacturer's recommendations for safe use of bed rails. During an interview with director of nursing (DON) on 4/24/2024 at 4:14 p.m., DON confirmed their beds were old and they did not have the manufacturer's handbook anymore. Review of the facility's policy and procedure titled, Proper Use of Side Rails, date revised 12/2016, indicated, Manufacturer instructions for the operation of side rails will be adhered to. The resident will be checked periodically for safety relative to side rail use. 2. During a concurrent interview and record review with minimum data set coordinator (MDSC, a licensed nurse in charge of resident assessment) on 4/24/2024 at 12:30 p.m., MDSC reviewed Resident 17's Device Assessment Tool for bed rail use dated 3/7/2024. MDS confirmed there was no documentation that indicated alternatives were offered or attempted prior to Resident 17's used of bilateral upper bed rails. During a concurrent interview and record review with DON on 4/24/2024 at 12:43 p.m., DON reviewed Resident 4's, Device Assessment Tool for bed rail use dated 8/19/2023. DON confirmed there was no documentation that indicated alternatives were offered or attempted prior to Resident 4's used of left upper bed rail. During a concurrent interview and record review with DON on 4/24/2024 at 12:49 p.m., DON reviewed Resident 194's Bed Rail Observation/Assessment (INITIAL), dated 4/22/2024. DON confirmed she completed Resident 194's assessment on 4/22/2024 at 11:37 a.m. DON was informed about the surveyor's above observation on 4/22/2024 at 10:16 a.m. when Resident 194 had the right upper bedrail already installed in his bed before the DON did the assessment and before they tried to attempt an alternative. DON confirmed there was no alternatives offered or attempted prior to Resident 194's used of right upper bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with MS on 4/24/2024 at 3:40 p.m., MS stated Resident 194 was admitted to the facility on [DATE]. MS further stated the nurse called him on 4/21/2024 to install Resident 194's right bed rail. MS confirmed he came to the facility on [DATE] and installed Resident 194's right bed rail as instructed. Review of the facility's policy and procedure titled, Proper Use of Side Rails, date revised 12/2016, indicated, Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 3. During a concurrent interview and record review with DON on 4/24/2024 at 12:35 p.m., DON reviewed Resident 17's Device Assessment Tool for bed rail use dated 3/7/2024. DON confirmed Resident 17 had no entrapment risk assessment completed prior to bed rail used. During a concurrent interview and record review with DON on 4/24/2024 at 12:43 p.m., DON reviewed Resident 4's Device Assessment Tool for bed rail use dated 8/19/2023. DON confirmed Resident 4 had no entrapment risk assessment completed prior to bed rail used. Review of the facility's policy and procedure titled, Proper Use of Side Rails, date revised 12/2016, indicated, An assessment will be made to determine the resident's symptoms, risk of entrapment . 4. During an interview with DON on 4/24/2024 at 12:35 p.m., DON confirmed bed rail assessment should be completed upon admission, quarterly, and during significant change in resident's condition. DON stated the assessment should collaborate with minimum data set (MDS, an assessment tool) assessments (admission, quarterly, annual, and significant change in status assessment). During a concurrent interview and record review with DON on 4/24/2024 at 12:43 p.m., DON reviewed Resident 4's Device Assessment Tool for bed rail use dated 8/19/2023. DON confirmed although an initial Device Assessment Tool done on 8/19/2023 for Resident 4's bed rail use, it was not updated quarterly. Review of Resident 4's assessment form title, Device Assessment Tool V1.1 - V2 (version 1.1 - version 2), dated 8/19/2023, indicated licensed nurses should complete each section of the assessment and it should be done initially, quarterly, annually, and during significant change. 5. During a concurrent observation and interview with DON on 4/29/2024 at 9:52 a.m., in Resident 4's room, Resident 4 had the left upper bed rail in upright position. DON confirmed the observation and stated nurses should obtain a physician's order for bed rail use prior to installation of bed rails. Review of Resident 4's Order Summary Report, dated 4/3/2024, indicated Resident 4 did not have a physician's order for the bed rail used. 37409 46553

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44583 Based on interview, and document review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis on weekends based on, Census and Direct Care Service Hours Per Patient Day (DHPPD, a form containing daily staffing information). This failure had the potential to affect resident's care, health, and psychosocial wellbeing. Findings: Review of a document titled, DHPPD, from January through March 2024, indicated the following dates with Actual Certified Nursing Assistant (CNA) DHPPD were below 2.4: 1/6: 2.28 and 1/7: 2.39. Further review revealed on 2/17/2024 the actual DHPPD was 3.35 (3.5 required staffing) and the actual CNA DHPPD was 2. 35. During an interview with the director of staff development (DSD) on 4/29/2024 at 9:13 a.m., DSD confirmed she did the DHPPD calculation. DSD stated their director of nursing (DON) did the licensed nurses schedule and CNA J did the CNA schedule. DSD further stated, CNA J did the staffing on weekends as well. DSD confirmed the actual DHPPD should be 3.5 and the actual CNA DHPPD should be 2.4. During a concurrent interview and document review on 4/29/2024 at 10:17 a.m., DSD reviewed the DHPPD dated 1/6, 1/7 and 2/17/2024. DSD confirmed the actual CNA DHPPD on 1/6 and 1/7 were below 2.4. DSD stated there were CNA's who called off on those dates and were never replaced. Further review, DSD confirmed the actual DHPPD and the actual CNA DHPPD on 2/17/2024 were below the staffing requirement. DSD stated one CNA who was scheduled to work 12 hours got sick. CNA J did not find a replacement which resulted to short staffing. Review of the All Facilities Letter (AFL) 21-11, dated March 17, 2021, indicated, The 3.5 DHPPD staffing requirement, of which 2.4 hours per patient day must be performed by CNAs, is a minimum requirement for SNFs [Skilled Nursing Facility]. SNFs shall employ and schedule additional staff and anticipate individual patient needs for the activities of each shift, to ensure patients receive nursing care based on their needs.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 44583 Based on observation, interview, and record review, the facility failed to ensure the daily staffing information posted was the current date. This failure had the potential to result in nurse staffing misinformation to residents, families, and visitors. Findings: During facility rounds on 4/22/2024 at 11:42 a.m., the Census and Direct Care Service Hours Per Patient Day (DHPPD-a form containing daily staffing information) form was posted in front of the nurse station located in the facility's first floor, dated 4/5/2024 (17 days past). During facility rounds on 4/22/2024 at 11:45, on facility's second floor, the DHPPD form was posted at the hallway beside the charting room, dated 4/2/2024 (20 days past). During an interview with director of staff development (DSD) on 4/24/2024 at 8:40 a.m., DSD stated she was the one in charged to initiate, post, and update the DHPPD postings. DSD further stated DHPPD posting should have the current date. DSD confirmed the DHPPD posted on 4/22/2024 was outdated. DSD stated she was on vacation, and nobody updated the DHPPD posting. During an interview with administrator (ADM) on 4/24/2024 at 8:49 a.m., ADM confirmed the DHPPD posted on 4/22/2024 was outdated. ADM stated DSD was off and ADM missed to post a daily updated DHPPD. ADM stated the DHPPD posted should reflect the current date. Review of the facility's policy and procedure titled, Posting Direct Care Daily Staffing Numbers, dated 7/2016, Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Review of the Centers for Medicare and Medicaid Services Compliance Group document titled, Posted Nurse Staffing Information, dated 4/30/2021, indicated, The required information that needs to be posted includes: Facility name, current date . The facility needs to post nurse staffing information in a prominent place where it is accessible to residents and visitors. The data should be clear, readable, up to date and current.

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	04/30/2024

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview and record review, the facility failed to ensure hazardous medications (medications that known to cause harm) were handled correctly and the safe and effective use of medications for two out of five (Resident 145 and 10) sampled residents when: 1. Two out of two licensed nurses were not knowledgeable on handling hazardous medications. This failure had the potential of harmful exposure for the staff through skin absorption. 2. Resident 145 received ferrous sulfate (iron, for prevention/treatment of iron deficiency anemia) tablet and magnesium oxide (medication used to relieve heartburn) tablet at the same time every day, when the co-administration could lead to decreased absorption of iron. This failure had the potential for the resident to not receive the amount of prescribed iron supplement as needed. 3. Resident 10 received ferrous sulfate and Calcium-Vitamin D (a medication used to prevent or treat low blood calcium levels) at the same time. This failure had the potential for the resident to not receive the amount of prescribed iron supplement as needed. Findings: 1. During a medication administration observation on 04/22/24 9:45 a.m., licensed vocational nurse (LVN) B prepared Depakote ER (medication used to treat seizure disorder) tablet without gloves. During a concurrent observation and interview on 4/22/24 at 9:54 a.m. with LVN B, Depakote ER medication bubble pack (a card that packages dosages of medication with a clear plastic bubble or blister) had a red label that indicated Hazardous Drug. LVN B stated she was unsure how to handle Depakote ER. During a medication administration observation on 04/22/24 10:02 a.m., licensed vocational nurse (LVN) C prepared Finasteride (medication to treat enlarged prostate) tablet without gloves. During a concurrent observation and interview on 4/22/24 at 10:15 a.m. with LVN C, Finasteride medication bubble pack (a card that packages dosages of medication with a clear plastic bubble or blister) had a red label that indicated Hazardous Drug with instructions to wear gloves. LVN C stated she should have worn gloves. Review of facility's policy and procedure (P&P) titled Hazardous Drugs, dated April 2019, indicated, Any staff members who come in contact with hazardous drugs are trained and exhibit competency in handling these drugs according to current safety and practice standards. 2. During a medication administration observation on 04/22/24 9:45 a.m., licensed vocational nurse (LVN) B administered ferrous sulfate tablet and magnesium oxide tablet at the same time to Resident 145. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 04/22/24 12:43 p.m., with LVN B, she confirmed that magnesium oxide tablet and ferrous sulfate tablet were both scheduled to be given at 9.am. According to Lexi-comp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of magnesium oxide and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of the DDI was the absorption of ferrous sulfate has been shown to be reduced by 37% to 49% with the combination of aluminum hydroxide, magnesium hydroxide, and magnesium carbonate. Lexi-comp also indicated to consider separating doses of oral iron and antacids in patients who require chronic use of both agents and monitor for reduced iron efficacy. Review of facility's policy and procedure (P&P) titled Administering Medications, dated April 2019, indicated, Medication administration times are determined by resident need and benefit . factors that are considered include . Preventing potential medication or food interactions . 37409 3. Review of Resident 10's Admission Record indicated she was admitted to the facility on [DATE] with anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells) diagnosis. Review of Resident 10's clinical record indicated, she had physician orders for ferrous sulfate 325 milligrams (mg, a metric unit of mass) every odd day for anemia at 9 a.m., started on 7/29/23, and for Calcium-Vitamin D 600-200 mg-unit every day at 9 a.m., started on 12/13/23. Thus, since 12/13/23, ferrous sulfate and Calcium-Vitamin D were given at the same time at 9 a.m. on odd days. During an interview with the director of nursing (DON) on 4/26/24 at 1:25 p.m., she reviewed Resident 10's clinical record and confirmed ferrous sulfate and Calcium-Vitamin D were given to Resident 10 at the same time at 9 a.m. on odd days since 12/13/23. The DON stated she would change the administration time so that ferrous sulfate and Calcium-Vitamin D would be given apart to Resident 10. According to Lexicomp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of calcium and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of the DDI was that the calcium may decrease the absorption of oral preparations of iron salts. It indicated the iron absorption was decreased an average of 60% when given as ferrous sulfate and co-administered with calcium. Lexicomp also indicated to separate the administrations of these medications so it may minimize the potential for significant interaction. Review of facility's policy, Administering Medications, dated 4/2019, indicated, Medication administration times are determined by resident need and benefit . factors that are considered include . Preventing potential medication or food interactions .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on interview and record review, the facility failed to ensure drug regimen review were done and acted on for three out of five residents (Resident 11, 15, and 31) when 1. Interim Medication Regimen Review (iMRR, a medication regimen review done when a resident had significant changes prior to the monthly drug regimen review) was not done for Resident 11 after multiple episodes of falls; 2. Consultant Pharmacist (CP) failed to identify and report irregularities related to a lack of monitoring of the blood pressures (BP, the pressure of blood on the walls of the arteries as the heart pumps blood) and heart rates of Resident 11 and Resident 15; and, 3. The facility did not act on the pharmacist's recommendation to administer Coreg (used to treat high blood pressure and a condition in which the heart cannot pump enough blood to all parts of the body) 3.125 milligrams (mg, a metric unit of mass) with food for Resident 31. These failures had the potential for residents experiencing possible adverse effects and for medications not being optimized for the best possible health outcome. Findings: 1. A review of Resident 11's chart indicated Resident 11 fell on [DATE], 12/18/23, 12/31/23, 2/7/24, 3/4/24 and 3/21/24. During a concurrent interview and record review with the Director of Nursing (DON) on 4/25/24 at 1:54 p.m., she verified an Interim Medication Regimen Review (iMRR, a medication regimen review done when a resident had significant changes prior to the monthly drug regimen review) was not done for Resident 11. The DON stated she was supposed to do iMRR after of the Resident 11's falls. During a concurrent phone interview and record review with the Consultant Pharmacist (CP) on 4/25/24 at 3:09 p.m., the CP verified there was nothing in Resident 11's clinical record to indicate an iMRR was ever done for Resident 11. The CP stated iMRR should have been done after Resident 11's falls, and were not done. Review of the facility's policy and procedure (P&P) titled Medication Regimen Reviews, dated May 2019, indicated, The Medication Regimen Review involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example . f. potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences. 2. A review of Resident 11's physician order, dated 4/3/24, indicated, Amiodarone (a medication used to treat life-threatening heart rhythm problems) 200 mg tablet one time a day was started on 12/14/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's medical record, indicated a diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm). It also indicated heart rate was monitored seven times in March, five times in February and five times in January. During a concurrent interview and record review with licensed vocational nurse (LVN) B on 4/25/24 at 10:30 a.m., LVN B verified the heart rate was last monitored on 3/25/24. LVN B stated the heart rate should be monitored every shift. During a concurrent interview and record review with Director of Nursing (DON) on 4/25/24 at 10:43 a.m., the DON reviewed Resident 11's medical record and verified the heart rate was not consistently monitored and agreed it should have been monitored consistently. During a concurrent phone interview and record review with Consultant Pharmacist (CP) on 4/25/24 at 3:09 p. m., CP verified heart rate was not consistently monitored for Resident 11. Review of the facility's policy and procedure (P&P) titled Medication Regimen Reviews, dated May 2019, indicated, 9. An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring . 37409 3. Review of Resident 31's Admission Record indicated he was admitted to the facility on [DATE] with ischemic cardiomyopathy (ICM, a term that refers to the heart's decreased ability to pump blood properly) diagnosis. Review of Resident 31's clinical record indicated he had received Coreg 3.125 mg two times a day related to ICM at 9 a.m. and 5:30 p.m., started on 6/22/23. Review of Resident 31's Consultant Pharmacist's Medication Regimen Review (MRR), dated 8/22/23, indicated the pharmacist recommended to administer Coreg with food to Resident 31 to minimize the risk of orthostatic hypotension (a drop in blood pressure that occurs when moving from a laying down position to a standing position) because the current administration time is 9 a.m. but the breakfast time is 7:30 a.m. However, the facility did not act on the pharmacist's recommendation. During an interview with the director of nursing (DON) on 4/26/24 at 2:14 p.m., she reviewed Resident 31's clinical record and confirmed that Resident 31's Consultant Pharmacist's MRR was not acted on. The DON stated she would change the administration time of Coreg from 9 a.m. to 7:30 a.m. for Resident 31. Review of the facility's policy, Medication Regimen Reviews, dated 5/2019, indicated The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.

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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** 49345 Based on observation, interview and record review, the facility failed to ensure two out of five residents (Resident 11 and Resident 15) were free from unnecessary medications when: 1. An order for Carvedilol (a medication to treat high blood pressure and heart failure) did not include hold parameters (a fixed limit on when a medication should be given or held) relevant to blood pressure (bp, the pressure of blood on the walls of the blood vessels as the heart pumps blood) and heart rate for Resident 15. 2. An order for gabapentin (a medication to treat seizures) had an incorrect indication for Resident 11. 3. An order for amiodarone (a medication used to treat life-threatening heart rhythm problems) did not include heart rate monitoring for Resident 11. These failures had the potential for inadequate care and side effects of these medications to go undetected or recognized for timely intervention. Findings: 1. A review of Resident 15's physician order dated 4/25/24, indicated, Carvedilol 6.25 mg tablet Give 1 tablet by mouth two times a day related to CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE. Administer with food, which was started on 9/14/22. During a concurrent interview and record review on 4/25/24 at 12:09 p.m. with Director of Nursing (DON), the DON reviewed Resident 15's medical record and verified the physician order for Carvedilol did not include blood pressure and heart rate hold parameters. The DON verified the blood pressure and heart rate were last monitored on 3/25/24. The DON confirmed blood pressure and heart rate should be monitored. During a concurrent phone interview and record review with the Consultant Pharmacist (CP) on 4/25/24 at 3:09 p.m., the CP verified Resident 15's physician order for Carvedilol did not include hold parameters. CP verified blood pressure and heart rate were not consistently monitored. CP stated there must be consistent blood pressure and heart rate monitoring. Review of Lexi-comp (www.[NAME].com), a nationally recognized drug information resource, drug information for carvedilol indicated, Concerns related to adverse effects: Bradycardia (slow heart rate): may occur; Hypotension (low blood pressure) . Review of facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, The following information is checked/verified for each resident prior to administering medications: b. Vital signs, if necessary. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy and procedure (P&P) titled, Pharmacy Services- Role of the Provider Pharmacy, dated April 2019, the P&P indicated, The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including (but not limited to), the following: g. Screen new medication orders for key parameters 2. Review of Resident 11's physician order, dated 4/25/24, indicated, Gabapentin Oral Capsule 100 MG give 1 capsule by mouth at bedtime related to PARKINSONISM, which was started on 12/14/23. During a concurrent interview and record review with Director of Nursing (DON) on 4/25/24 at 10:43 a.m., the DON reviewed Resident 11's medical record and verified the physician order for gabapentin had parkinsonism as an indication, which was incorrect. Review of Lexi-comp (www.[NAME].com), a nationally recognized drug information resource, indicated gabapentin is used for treatment of seizures (uncontrolled body movements). Review of facility's policy and procedure (P&P) titled, Pharmacy Services- Role of the Provider Pharmacy, dated April 2019, it indicated, The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including (but not limited to), the following . g. Screen new medication orders for key parameters, including appropriate indications 3. Review of Resident 11's physician order, dated 4/25/24, indicated, Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 1 tablet by mouth one time a day related to UNSPECIFIED ATRIAL FIBRILLATION, which was started on 12/15/23. During a concurrent interview and record review with Director of Nursing (DON) on 4/25/24 at 10:43 a.m., the DON reviewed Resident 11's medical record and verified the physician order for amiodarone did not include heart rate monitoring. The DON verified the heart rate was last monitored on 3/25/24. The DON stated heart rate should be monitored. During a concurrent phone interview and record review with the Consultant Pharmacist (CP)on 4/25/24 at 3:09 p.m., the CP verified Resident 11's physician order for amiodarone had no hold parameters. The CP verified that heart rate was not consistently monitored. The CP stated the heart rate should be monitored consistently. Review of Lexi-comp (www.[NAME].com), a nationally recognized drug information resource, indicated, A variety of longer-term changes in conduction/heart rate are associated with amiodarone use, most commonly bradycardia (slow heart rate) . Review of facility's policy and procedure (P&P) titled, Pharmacy Services- Role of the Provider Pharmacy, dated April 2019, indicated, The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including (but not limited to), the following . g. Screen new medication orders for key parameters .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 11) was free from unnecessary psychotropic medications (medications that cause changes in mood, feelings, or behavior) when: 1. Evaluation or Gradual Dose Reduction (GDR, tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose) of psychotropic medications was not considered after multiple falls. 2. There was no baseline Abnormal Involuntary Movement Scale (AIMS, a rating scale designed to measure involuntary movements which are side effects of long-term treatment of antipsychotic medications) for the use of aripiprazole (a medication used to treat mental/mood disorders). 3. Care plan for bipolar disorder (a mental health condition that causes extreme mood swings) did not include specific target symptoms, interventions, and potential adverse effects. These failures had the potential for increased risks associated with the use of psychotropic medications that include, but are not limited to: sedation, respiratory depression, falls, constipation, anxiety, agitation, and memory loss. Findings: 1. Review of Resident 11's medical records, dated 4/25/24, indicated the diagnoses of insomnia (a sleep disorder with trouble falling or staying asleep), bipolar disorder, anxiety disorder (persistent and excessive worry that interferes with daily activities), and major depressive disorder (a mental health condition that causes persistently low or depressed mood). Review of Resident 11's physician order, dated 4/25/24, indicated orders for psychotropic medications such as paroxetine (a medication for management of anxiety and depression) 37.5 mg tablet every 12 hours started on 2/26/24, trazodone (a medication to treat insomnia) 50 mg tablet at bedtime started on 12/14/23, and aripiprazole 2 mg tablet once a day started on 12/15/23. Review of Resident 11's chart, it indicated that Resident 11 fell on [DATE], 12/18/23, 12/31/23, 2/7/24, 3/4/24 and 3/21/24. During a concurrent interview and record review with the Director of Nursing (DON) on 4/25/24 at 10:43 a.m., the DON verified there was no GDR attempted after the multiple falls. She astated GDR should have been attempted. Review of facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated December 2016, indicated, The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks of suspected or confirmed adverse consequences. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 11's physician order dated 4/25/24, it indicated an order for aripiprazole (a medication used to treat mental/mood disorders) 2 mg tablet once a day, started on 12/15/23. Review of Medication Regimen Review (MRR, a thorough evaluation of medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication), dated 12/18/23, the Consultant Pharmacist (CP) indicated an incomplete Abnormal Involuntary Movement Scale (AIMS, a rating scale designed to measure involuntary movements which are side effects of long-term treatment of antipsychotic medications) for the use of aripiprazole (a medication used to treat mental/mood disorders). During a concurrent interview and record review with Director of Nursing (DON) and Social Services Director (SSD) on 4/25/24 at 10:45 a.m., the DON and SSD verified there was no AIMS done for Resident 11. Review of facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated December 2016, indicated, Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician . D. Neurologic (having to do with nerves): akathisia (sensations of inner restlessness), dystonia (a movement disorder that cause muscles to contract involuntarily), extrapyramidal side effects (uncontrollable involuntary movements) . 3. Review of Resident 11's medical records, dated 4/25/24, indicated the diagnoses of bipolar disorder (a mental health condition that causes extreme mood swings). Review of Resident 11's physician order dated 4/25/24, it indicated an order for aripiprazole (a medication used to treat mental/mood disorders) 2 mg tablet once a day, started on 12/15/23. During a concurrent interview and record review with Director of Nursing (DON) and Social Services Director (SSD) on 4/25/24 at 10:45 a.m., the SSD verified the care plan for bipolar disorder lacked specific target behaviors, interventions, and potential side effects. Review of facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 4/8/22, indicated, Any psychoactive medication prescribed must have an individualized care plan which includes the monitoring of side effects of the medication, target behavior .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49345 Based on observation, interview, and record review, the facility had an 11.11% medication error rate when three medication errors out of 27 opportunities were observed during a medication pass for two out of five sampled residents (Residents 145 and 38) when: 1. Carvedilol (a medication to treat high blood pressure) tablet was not administered with food for Resident 145. Magnesium oxide (a medication used to treat heartburn) tablet and ferrous sulfate (an iron supplement) tablet were given at the same time for Resident 145. 2. Metformin (a medication used to treat high blood sugar) tablet was not administered with food for Resident 38. These deficient practices resulted in medications not given in accordance to manufacturer's specifications, which may result in unsafe and/or less than optimal therapeutic effect of the medications. Findings: 1. During a medication pass observation with Licensed Vocational Nurse (LVN) B on 4/22/24 at 9:46 a.m., LVN B was prepared 12 medications for Resident 145, which included Carvedilol 25 milligrams (mg, unit of measurement) tablet, magnesium oxide 400 mg tablet, and ferrous sulfate 325 mg tablet. At 9:50 a.m., LVN B administered these medications to Resident 145 with a glass of water. There was no breakfast tray or food observed on the resident's bedside table. During a concurrent interview and record review on 4/22/24 at 12:43 p.m. with LVN B, LVN B stated that breakfast usually starts at 7:15 am and it was charted that Resident 145 had breakfast at 8:08 a.m. LVN B verified the medication bubble pack for carvedilol indicated, Take with food. LVN B stated magnesium oxide tablet and ferrous sulfate tablet were scheduled at 9 a.m. During an interview with Certified Nursing Assistant (CNA) E on 4/22/24 at 12:53 p.m., CNA E stated Resident 145 had breakfast at around 7:15 a.m. During a concurrent phone interview and record review on 4/23/24 at 2:25 p.m. with the Consultant Pharmacist (CP), the CP stated magnesium oxide tablet affects the absorption of ferrous sulfate tablet if given at the same time. During a concurrent interview and record review on 4/24/24 at 2:56 p.m. with the Director of Nursing (DON), the DON verified that magnesium oxide 400 mg tablet and ferrous sulfate 325 mg tablet were scheduled and given at the same time. DON stated she will change the timing of the medications. Review of Lexi-comp, a nationally recognized drug information resource, indicated for Carvedilol to Administer with food to minimize the risk of orthostatic hypotension (low blood pressure experienced during changing positions, especially relevant to standing up from a sitting position). (continued on next page)

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Lexi-comp indicated, Interaction of Magnesium Oxide and Ferrous Sulfate: Risk Rating D: Consider therapy modification; Antacids may decrease the absorption of Iron Preparations. Review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, indicated, Medication administration times are determined by resident need, and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions . 2. During a medication pass observation with Licensed Vocational Nurse (LVN) F on 4/22/24 at 4:23 p.m., LVN F prepared Metformin (a medication used to treat high blood sugar) 500 milligram (mg, unit of measurement), two tablets for Resident 38. LVN F crushed the pills and mixed it with apple sauce. LVN F administered the medication to Resident 38 with water. There was no food tray or snack observed on the resident's bedside table. During concurrent interview and record review with LVN F on 4/22/24 at 4:30 p.m., she verified that metformin was scheduled at 4 p.m. and dinner was at 5 p.m. LVN F also stated that Resident 38 had no snack prior to medication administration. During an observation on 4/22/24 at 5:10 p.m. in Resident 38's room, there was no dinner tray on Resident 38's bedside table. During a concurrent phone interview and record review with Consultant Pharmacist (CP) on 4/23/24 at 2:25 p. m., CP agreed to change the schedule of Metformin to be given with a meal. CP also stated he created a time administration chart for Metformin and that it was discussed with the facility. Review of Resident 38's Medication Administration Record, dated 4/23/24, indicated Metformin was scheduled and given at 7:30 a.m. and 4:00 p.m. daily. Review of the facility's Nursing Drug Handbook, dated 2024, indicated to administer Metformin with a meal to decrease gastrointestinal (relating to stomach and intestines) upset. Review of the facility's policy and procedure (P&P) titled Administering Medications dated April 2019, indicated, Medication administration times are determined by resident need, and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when: 1. An opened multi-dose insulin (a medication used to control high blood sugar) vial and an insulin pre-filled pen were found without labelling for their open dates. 2. An expired insulin pen and four expired over-the-counter medications were found. These failures had the potential for residents to receive medications with reduced efficacy. Findings: 1. During concurrent observation and interview regarding a Station 2 medication cart with licensed vocational nurse (LVN) C on [DATE] at 1:49 p.m., an opened multi dose vial of insulin was found without open date label. LVN C verified the manufacturing label indicated Discard unused portion 31 days after first opening. During concurrent observation and interview regarding a Station 1 medication cart with licensed vocational nurse (LVN) B on [DATE] at 3:10 p.m., a pre-filled insulin pen was found without an open date label. LVN B verified the manufacturing label indicated Discard pen 56 days after first use. 2. During concurrent observation and interview on the second floor with licensed vocational nurse (LVN) B on [DATE] at 3:20 p.m., the following were identified and confirmed with LVN B: a. A pre-filled insulin pen had an open date label that indicated, [DATE]. Upon the review of drug information by LVN B, she acknowledged it was good for 28 days after opening, and that it expired on [DATE]; b. A bottle of Calcium + D3 (a medication used to treat low calcium levels) tablets had an expiration date of , d+[DATE],and had expired; c. A bottle of [Brand name of a vitamin and mineral supplement] tablets had an expiration date of ,d+[DATE], and had expired; d. A bottle of [Brand name of a medication to treat allergies] tablets had an expiration date of ,d+[DATE], and had expired; and, e. A bottle of CoQ10 (a medication for heart-related conditions) softgels had an expiration date of ,d+[DATE], and had expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy and procedure (P&P) titled Storage of Medications, dated [DATE], indicated Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37409 Based on observation and interview, the facility failed to maintain hygiene in the kitchen and to ensure food was stored in accordance with professional standards for food safety when: 1. Past use-by date food, rotten bananas, and dented cans were found in the freezer and on the shelves in the kitchen; 2. Cook K's (CK K) and dietary aid L's (DA L) hair were out of their hair nets; the maintenance director (MD) did not wash his hands when he entered the kitchen and opened the ice machine; the dietary director (DD) did not sanitize the thermometers before checking the food temperatures; and, 3. The screw in the ice storage bin was rusty with rusty water that dripped down onto the ice, and the ice machine did not have an air gap. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illnesses and cross-contaminated food for residents eating at the facility. Findings: 1. On 4/22/24 at 9:25 a.m., during an observation of the ice cream freezer, walk-in freezer, and the storage shelves in the kitchen, with the Dietary Director (DD), the followings were observed: a. One third of a 5-gallons container of Blue Bunny sherbet had a use by date of 4/5/24 b. Half of a 20-pound container of frozen cookie dough had a use by date of 3/22/24 c. Two 7-pound cans of lemon pudding were dented d. Seven bananas had black spots During a concurrent interview with the DD, he stated he would discard these food items. Review of the facility's policy, Washing and Handling Produce, dated 1/2015, indicated . Produce that looks rotten is discarded . Review of the facility's policy, Dented Cans, dated 2/2011, indicated, Employees inspect cans for dents when putting them away after delivery . Set aside in separate box, bin, or container; labeled Dented Cans . 2. During an observation in the kitchen on 4/22/24 at 9:25 a.m., half bottom of cook K's (CK K) hair was out of his hair net at the backside, and half of the front of dietary aid L's (DA L) hair was out of her hair net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview, CK K and DA L acknowledged that their hair were out of their hair nets. CK K and DA L stated their hair should be covered with their hair nets. During an observation in the kitchen on 4/22/24 at 12:50 p.m., the maintenance director (MD) came in the kitchen, put on gloves, and started to open the ice machine. During a concurrent interview, the MD acknowledged that he should have washed his hands when he came into the kitchen. During an observation of the tray line on 4/24/24 at 12:05 p.m., the dietary director (DD) removed the caps of three thermometers and checked the temperature of rice, yellow squash, and chicken without sanitizing the thermometers. During a concurrent interview with the DD, he acknowledged he should have sanitized the thermometers before checking the food temperatures. Review of the facility's policy, Personal Hygiene Standards, dated 8/2018, indicated Hair restraining devices (e.g., hair nets), covering all hair, are worn while on duty . Hands are washed after each trip to the restroom, washrooms, after touching the hair, mouth, or nose, when leaving and reentering the kitchen . Review of the facility's policy, Cleaning and Sanitizing a Thermometer, dated 7/2009, indicated When taking temperatures during meal service, the thermometer is re-sanitized before taking the next temperature. 3. During an observation with the maintenance director (MD) on 4/22/24 at 12:50 p.m., a interior screw of the ice storage bin that anchored a white panel above the ice was rusty with a line of rusty water that dripped down to the ice of the storage bin. The ice machine lacked an air gap, since the drainage pipe led from the ice machine into a bigger drainage pipe on the floor. During a concurrent interview, the MD confirmed the ice in the ice storage bin was contaminated, and that the ice machine did not have an air gap. The MD stated he would throw out all of the ice, change out the rusty screw, and that he would lift the ice machine drainage pipe to create an air gap. Review of the 2017 Food and Drug Administration (FDA) Food Code, Section 5-402.11, indicated, Backflow Prevention, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview, and record review, the facility failed to maintain accurate and systematically organized documentation in accordance with accepted professional standards and practices for one of five sampled residents (Resident 41) when Resident 41's pronouncement of death was not properly documented. This failure resulted to an inaccurate documentation of Resident 41's death. Findings: Review of Resident 41's Admission Record indicated, Resident 41 was admitted to the facility on [DATE] with diagnoses including encounter for palliative care (a specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), atherosclerotic heart disease of native coronary artery (a plaque buildup [fat deposits] in the wall of the arteries that supply blood to the heart), hemiplegia (paralysis of one side of the body/a severe or complete loss of strength in the arm, leg, and sometimes face on one side of the body), and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body) following cerebral infarction (also called stroke) affecting the non-dominant side (side of the body not used as much as much), and dysphagia (difficulty in swallowing). Further review indicated, Resident 41 had a discharge date on [DATE]. Review of Resident 41's progress notes titled, Nurse's Note, dated [DATE] at 7:15 a.m., indicated, Received report from NOC [short for nocturnal - night shift] nurse that resident passed away @ [at] 0540 (military time for 5:40 a.m.) . Detailed documentation about Resident 41's death and resident's status before 5:40 a.m. was lacking. Review of Resident 41's progress notes titled, Orders -Administration Note, dated [DATE] at 8:45 a.m., indicated, deceased . Review of Resident 41's progress notes titled, Nurse's Note, dated [DATE] at 11:28 a.m., indicated, Mortician is here to pick up the body. Documents are signed. Further review of Resident 41's progress notes titled, Nurse's Note, dated [DATE] at 3:30 a.m., indicated a registered nurse note, Patient Declining Condition and deceased . Patient at start of shift was resting in bed with eyes closed. She is non-verbal, in no apparent distress . CNA alerted this writer that pt. [patient] appeared to have passed at 0540. This writer went in to assess pt and there were no spontaneous respirations, and no pulse auscultated . During a concurrent interview, and record review on [DATE] at 9:54 a.m., minimum data set coordinator (MDSC) reviewed Resident 41's progress notes. MDSC confirmed there was no pronouncement of death by the registered nurse (RN) that worked night shift on [DATE]. MDSC stated RN should document a detailed assessment, date, time, and the nurse who did the pronouncement of death. During a concurrent interview and record review on [DATE] at 11:03 a.m., director of nursing (DON) reviewed Resident 41's progress notes. DON confirmed the nurse's documentations were confusing and the sequencing was not organized. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Death of a Resident, Documenting, dated ,d+[DATE], indicated, Appropriate documentation shall be made in the clinical record concerning the death of a resident . All information pertaining to a resident's death (i.e. date, time of death, the name and title of the individual pronouncing the resident dead, etc.) must be recorded on the nurse's notes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. Licensed vocational nurse A (LVN A) picked up clean gauges and Silver Alginate (a sterile dressing for wounds with moderate to heavy exudate that helps prevent infection of wounds while providing optimum environment to facilitate healing) with her contaminated gloved hands for the treatment of Resident 9's wound; 2. Certified nursing assistant H (CNA H) did not sanitize her hands before serving a lunch tray to Resident 35; 3. LVN A went to Resident 17's room wearing the same gloves that she wore to give insulin to Resident 195, and then walked out of Resident 17's room with the same gloves on; 4. Restorative nurse assistant (RNA) did not perform hand hygiene in between residents during meal assistance; 5. Licensed vocational nurse C (LVN C) touched the privacy curtain with dirty gloves, did not change gloves afterwards, and continued to used her contaminated gloves for wound treatment; and, 6. The facility lacked a water management program (usually with a team consisting of an infection preventionist [IP], administrator [ADM], medical director [MD], and maintenance supervisor [MS]) to prevent water-borne contaminants (bacteria, viruses, protozoa and toxins, and exposure to them through ingestion, inhalation, or direct contact that can cause water-related illness) such as Legionella (a bacteria that grows in water).) These failures had the potential to spread infection in the facility. Findings: 1. Review of Resident 9's Admission Record indicated he was admitted to the facility on [DATE] with a pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) diagnosis. Review of Resident 9's physician order, dated 2/27/24, indicated he had an order for the licensed nurse to clean his sacrococcygeal (pertaining to body region at lowest two sections of the spine) wound with normal saline (NS, 0.90% of salt that has been dissolved in sterile water) and pack wound bed with Silver Alginate every day and evening shift. During a treatment observation on 4/24/24 at 1:45 p.m., licensed vocational nurse A (LVN A) started the treatment procedure by preparing the treatment supplies. LVN A washed her hands, put on gloves, picked up a ring of keys, opened the treatment cart, opened the drawers of the treatment cart looking for supplies, then picked up clean gauzes, picked up the Silver Alginate dressing, and cut it with scissors for Resident 9's sacrococcygeal wound treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with LVN A on 4/24/24 at 2:10 p.m., she acknowledged that after touching the ring of keys and the treatment cart, her gloved hands had already been contaminated. LVN A stated she should pick up the Silver Alginate and clean gauzes with clean hands. During an interview with infection preventionist G (IP G) on 4/29/24 at 10:29 a.m., she stated licensed nurses should not touch clean gauzes and dressings after touching objects. Licensed nurses should prepare clean gauzes and dressings with clean hands and/or clean gloves. Review of the facility's policy, Handwashing/Hand Hygiene, dated 8/2019, indicated, Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations . g. Before handling clean or soiled dressings, gauze pads . k. After contact with objects . 2. Review of Resident 35's Admission Record indicated he was admitted to the facility on [DATE]. During a dining observation on 4/22/24 at 12:20 p.m., certified nursing assistant H (CNA H) pushed the drink cart over; then, she went to the meal cart and carried the lunch tray to Resident 35 without sanitizing her hands. During a concurrent interview with CNA H, she stated she should have sanitized her hands before carrying the lunch tray to Resident 35. During an interview with IP G on 4/26/24 at 1:34 p.m., she stated CNAs should sanitize their hands before carrying meal trays to residents. Review of the facility's policy, Handwashing/Hand Hygiene, dated 8/2019, indicated Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations . p. Before and after assisting a resident with meals . 3. During an observation on 4/30/24 at 1:30 p.m., licensed vocational nurse A (LVN A) walked out of Resident 17's room with gloves on. She held an insulin (medication used to lower the level of sugar in the blood) syringe in her gloved right hand and a used alcohol swab in her gloved left hand. During a concurrent interview with LVN A, she stated she gave insulin to Resident 195 in his room. She heard Resident 17 called for assistance, so she went to Resident 17's room to see what he needed; then, she walked out of Resident 17's room with the same gloves that she wore to give insulin to Resident 195. LVN A stated she should not have worn the same gloves while going from one room to another; and that, she should have removed and discarded her used gloves and the used alcohol swab before she walked out of a resident's room. Review of the facility's undated policy, Sequence for Removing Personal Protective Equipment (PPE), indicated, Except for respirator, remove PPE at doorway or in anteroom . Discard gloves in waste container. 44583 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During a dining observation on 4/22/2024 at 12:30 p.m., in the facility's second floor assisted dining room, four residents (Residents 2, 38, 1, and 30) were observed seated around a square dining table and an RNA was assisting them. The RNA stood up, touched Resident 38's wheelchair to moved it closer to the table, and then touched Resident 1's chair to moved it closer to the table as well. The RNA did not perform hand hygiene and continued to served lunch to Resident 2. The RNA sliced Resident 2's chicken using Resident 2's fork and knife. The RNA stepped out of the assisted dining room to grab a cup of water without performing hand hygiene. At 12:35 p.m., The RNA went back to the assistance dining room and provided a cup of water to Resident 2. No hand hygiene was observed. The RNA sat down in between Resident 2 and Resident 38. The RNA started feeding Resident 2. The RNA stood up and went beside Resident 30 to turn his plate towards him. The RNA did not perform hand hygiene and continued to pick up Resident 2's tortilla with her bare right hand, and fed it to Resident 2. At 12:39, The RNA stood up again, went beside Resident 30, used his utensils to gather his food in one spot on his plate for easy access. The RNA sat down beside Resident 2 again without hand hygiene and wiped Resident 38's mouth using a towel without hand hygiene, and continued to hold Resident 2's tortilla to assist with her food. The RNA wiped Resident 38's mouth again without performing hand hygiene. During a follow up interview with the RNA on 4/22/2024 at 12:47 p.m., the RNA confirmed the above observations. The RNA stated she should have performed hand hygiene in between assisting residents with their meals. During an interview with infection preventionist G (IP G) on 4/29/2024 at 10:23 a.m., IP G confirmed staff should perform hand hygiene in between meal trays and in between assisting residents with meals to prevent the spread of infection. Review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated 8/2019, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap and water for the following situations . Before and after assisting a resident with meals . 5. During a wound treatment observation in Resident 34's room with LVN C on 4/25/2024 at 1:06 p.m., LVN C was wearing a pair of gloves and wiped Resident 34's right heel wound with a skin barrier pad. LVN C reached for the other skin barrier pad in a tray on top of a drawer behind her. LVN C struggled reaching for the skin barrier pad, touched the privacy curtain, and then took the skin barrier pad. LVN C opened the skin barrier pad and continued to wipe Resident 34's right heel wound without changing gloves and without hand hygiene. During an interview with LVN C on 4/25/2024 at 1:14 p.m., LVN C confirmed the above observations and stated she should have changed her gloves after touching the privacy curtain. LVN C further confirmed she should not have touched the privacy curtain with her dirty gloves. During an interview with IP G on 4/29/2024 at 10:23 a.m., IP G confirmed staff should change their gloves once they touched a contaminated area; and that, staff should not touch anything if their gloves were dirty. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated 8/2019, indicated, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap and water for the following situations: .After contact with objects in the immediate vicinity of the resident; After removing gloves . 6. During an interview with maintenance supervisor (MS) on 4/29/2024 at 10:37 a.m., MS stated he was not aware on how to prevent the spread of water borne contaminants such as Legionella. MS stated the facility had an outside water contractor that checks their boiler once a month. MS further stated he was not sure if the outside contractor did the water testing for Legionella. During a concurrent interview and document review with MS on 4/29/2024 at 2:38 p.m., MS reviewed the Legionella Risk Assessment he completed on 12/4/2023. MS confirmed he did not do another Legionella Risk Assessment for this year, 2024 because he got busy. MS confirmed the Legionella Risk assessment dated [DATE] indicated his YES answer to questions 1 through 3. Further review of the assessment indicated, If you answer YES to any of questions 1 through 4, you should have a water management program for the building's hot and cold water distribution system. During a concurrent interview with both IP G and MS on 4/30/2024 at 9:06 a.m., IP G confirmed the facility did not have a water management program to control any water borne contaminants. MS confirmed he did not know what a water management program was. MS stated, an outside water contractor visited the facility monthly, and he was not aware of what they were testing. During a phone interview with service technician (ST) of the outside water contractor on 4/30/2024 at 9:20 a.m., ST confirmed he visited the facility monthly to check their water boiler's conductivity. ST stated, he checked how dirty the water was in the boiler. ST further stated he tested the boiler's water for sulfite, and alkalinity to prevent corrosion, and calcium and magnesium build up. ST confirmed he never checked the potable water (also known as drinking water) for its chlorine level, nor did he test the water for Legionella. ST stated those tests mentioned were not a part of his job. Review of the facility's policy and procedure titled, LEGIONELLA WATER MANAGEMENT PROGRAM, updated 8/31/2022, indicated, The facility shall establish an infection control program that will prevent, detect and control water-borne contaminants, including Legionella which is overseen by the water management team. The water management program will identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaires disease using the Centers for Disease Control and Prevention and ASHRAE (American Society of Heating, Refrigerating and Air Conditioning Engineers) [guidelines].

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	04/30/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to ensure two of six residents (Residents 10 and 35) were offered and/or received pneumococcal (common bacteria that can affect different parts of the body) vaccinations. This failure increased the potential for residents to have inadequate immunity to pneumococcal infections (also known as pneumonia, an infection of one or both lungs). Findings: During a concurrent interview and record review on 4/29/2024 at 11:28 a.m., infection preventionist G (IP G) reviewed Resident 10's admission and immunization records. IP G confirmed Resident 10 was admitted on [DATE] and that she had a history of getting the pneumococcal polysaccharide vaccine (PPSV23, a vaccine that can prevent pneumococcal disease) on 6/26/2022. IP G confirmed she missed offering the pneumococcal conjugate vaccine 20 (PCV20, one of the three pneumococcal conjugate that helps protect against bacteria that cause pneumococcal disease) to Resident 10 when she reviewed Resident 10's immunization record. During a concurrent interview and record review on 4/29/2024 at 3:52 p.m., IP G reviewed Resident 35's admission and immunization records. IP G confirmed Resident 35 was admitted to the facility on [DATE] and only had a history of pneumococcal 23 (another name for PPSV23) on 3/19/2019. IP G confirmed she did not offer the PCV20 to Resident 35. Review of the facility's policy and procedure titled, Pneumococcal Vaccine, date revised October 2019, indicated, All residents will be offered pneumococcal vaccines to aide in preventing pneumonia/pneumococcal infections . 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission . 7. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. During a review of CDC's recommendations titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate, dated reviewed 2/13/2023, indicated, For adults [AGE] years or older who have only received PPSV23, CDC recommends you either: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV 20 dose should be administered at least 1 year after the most recent PPSV23 vaccination.

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	04/30/2024

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

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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 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. 46553 Based on observation and interview, the following multi-resident rooms provided less than 80 square feet per resident, which had the potential to compromise the residents' care. Findings: Room numbers and measurements per resident were as follows: Room No. No. of beds Sq. foot per Res. 3 2 74.25 10 2 78.48 23 2 76.30 None of the rooms were observed to inhibit the staff to provide care to the residents. The staff and the residents moved freely in the rooms. The residents received adequate care. The square footage of the rooms was not a concern to residents and the staff. Recommend the waiver remain in effect.