

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 09/08/2025
NAME OF PROVIDER OR SUPPLIER Katherine Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow its Policy and Procedures regarding oxygen administration for two out of six sampled residents (Resident 43 and Resident 3) when:1. No oxygen (O2: a colorless, odorless and tasteless gas, essential for life) administration order for Resident 43;2. O2 humidifier(a device, often a bottle contains water that adds moisture to dry supplemental O2 use) not adequately replaced for Resident 43;3. No O2 administration order, unlabeled oxygen tubing, and no oxygen in use sign posted for Resident 3;4. No care plan for O2 administration for Resident 3. These failures had the potential to affect sampled residents medical condition, well-being, and safety. Findings: 1. Review of Resident 43's clinical record indicated she was admitted to the facility on [DATE] with a diagnoses of dementia (a disorder of the brain that causes a person to lose their memory), ischemic cardiomyopathy (enlarging of the heart due to lack of oxygen), and acute on chronic systolic congestive heart failure (a worsening of the pump function of the heart on top of existing disease). During an observation on 9/2/25 at 12:46 p , Resident 43 was seen sitting on the side of the bed, wearing a nasal cannula (a type of oxygen delivery device through the nostrils). The O2 delivery rate was set at 2 liters (L, amount of oxygen delivered from an oxygen delivery device per minute). During a second observation on 9/4/25 at 1:56 p.m., Resident 43 was seen sitting on the side of the bed, talking to her son, wearing the nasal cannula. The oxygen device rate was set to 2 L. Review of Resident 43's physician orders on 9/4/25 at 2:00 PM indicated there was no documented evidence of physician order for oxygen administration. During an interview with the director of staff development/infection preventionist (DSD/IP) on 9/4/25 at 2:12 p.m., the DSD/IP stated there needs to be a physician order for oxygen administration to residents. During a concurrent interview and record review with the director of nursing (DON) on 9/4/25 at 2:26 p.m., the DON stated there needs to be an order to administer oxygen and currently there was no order for oxygen for Resident 43. 2. During an observation on 9/2/25 at 12:46 p.m., Resident 43 was seen receiving O2 via nasal cannula. The nasal cannula tubing was connected to a humidifier bottle, which was also labeled 9/2/25. During a second observation on 9/5/25 at 11:27 a.m., the humidifier bottle was seen half full, still labeled 9/2/25. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DSD/IP on 9/5/25 at 12:31 p.m., the DSD/IP stated humidifier bottle was change whenever the bottle is empty. Review of facility policy and procedure (P&P) titled, Oxygen Administration, revised October 2010, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. Review of facility P&P, titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised 2011, the P&P indicated, Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours. 3. During an observation on 9/2/2025 at 11:44 a.m., noted Resident 3's bed side, unlabeled nasal cannula (NC) wrapped on humidifier, which was attached to room air concentrator (RAC: a medical device that filters room air to make pure O2) while Resident 3 was not in room, and RAC was turned off. NC progs (part of NC tubing goes into nose to deliver O2) was open to air. Oxygen in use sign was not posted for this room. Review of Resident 3's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 3 was admitted to facility on 8/8/2025. Review of Resident 3's FS indicated Resident 3 was admitted with diagnoses included chronic respiratory failure with hypoxia (a persistent inability to breath adequately, resulting in low levels of blood O2 levels), congestive heart failure (a chronic condition in which heart cannot pump blood efficiently, fluid buildup and difficult to breath), and end stage renal disease (loss of kidneys [pair of body organs, responsible to filter waste and excess fluids from blood to produce urine] function to remove excess fluid from blood). Review of Resident 3's minimum data set (MDS: clinical assessment tool) dated 8/14/2025 indicated Resident 3's brief interview for mental status (BIMS) score of 14 (score of 0-7: severe cognitive impairment, 8-12: moderate cognitive impairment, 13-15: intact cognition), intact cognition. Review of Resident 3's order summary report noted no documented evidence of an order to administration O2 for Resident 3. During an interview with Resident 3 on 9/3/2025 at 1:35 pm., Resident 3 stated using O2 on and off for shortness of breath while in facility. During an observation and interview with registered nurse A (RN A) on 9/3/2025 1:56 pm., RN A confirmed NC tubing not labeled, uncovered and no oxygen in use sign posted for Resident 3's room. RN A also stated Resident 3 uses O2 as needed. RN A also stated nursing staff should have labeled NC when changed on weekly basis and placed NC tubing in a cover when not in use for infection control. RN A further stated this room should have posted sign for oxygen in use. 4. Review of Resident 3's care plans indicated there was no documented evidence of care plan for O2 use. During a concurrent record review for O2 orders, care plan for O2 and interview with director of nursing on 9/5/2025 at 9:43 am., DON confirmed there was no documented evidence of an order and care plan for oxygen administration for Resident 3. DON stated license nursing staff should have (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received an order to administer oxygen and care planned for use of oxygen for Resident 3. Review of facility's P&P titled, Oxygen Administration, revised October 2010, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility's protocol for oxygen administration. Place an Oxygen in Use sign on the outside of the room entrance door. Review of facility's P&P titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised November 2011, the P&P indicated, Change the oxygen cannulae and tubing every seven (7) days, or as needed. Keep the oxygen cannula and tubing used PRN (pro re nata: as needed) in a plastic bag when not in use.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 3 out of 14 sampled residents (Resident 35, Resident 53, and Resident 3) were free from unnecessary medications when: 1. Resident 35 received calcium acetate (brand name: Phoslo; medication to treat high phosphate [phosphorous] in the blood, in patients with end-stage renal disease [ESRD, a condition when the kidneys no longer function well enough to meet the body's needs]) for a wrong indication and not given with mealtimes as in accordance with the manufacturer's specifications. This resulted in inadequate indication and ineffective use of the medication to treat/prevent high phosphorous level. 2. Resident 53 had an as-needed order for milk of magnesia (product containing magnesium, to treat constipation), a medication to avoid in residents that have ESRD. This had the potential for adverse effects (such as high magnesium level in the blood) for the resident 53. Findings: 1. During a medication administration observation with Registered Nurse (RN) A on 9/2/25 at 10:25 a.m., RN A was observed administering 17 medications to Resident 35 including 2 tablets of calcium acetate (Phoslo) 667 milligrams (mg, unit of measurement). During an interview post medication administration, on 9/2/25 at 10:26 a.m., when asked when Resident 35 had his breakfast, RN A stated, I am not sure. A review of the Prescribing Information (PI; detailed information about a medication and its use) for calcium acetate, dated 3/2011, indicated it is a phosphate binder for the reduction of serum phosphorus in patients with ESRD. The PI indicated to take calcium acetate with each meal, as it combines with dietary phosphate to form an insoluble calcium phosphate complex, which is excreted in the feces, resulting in decreased serum phosphorus concentration. During an interview with Resident 35 on 9/2/25 at 12:02 p.m., Resident 35 stated he ate breakfast around 7 a.m. (about 3 hours before receiving the calcium acetate). During an interview with Certified Nursing Assistant B (CNA B) on 9/2/25 at 2:54 p.m., she stated Resident 35 had his breakfast around 7:40 a.m., but she has not had a chance to document in the computer system yet. A review of Resident 35's clinical record indicated he was admitted to the facility with diagnoses including ESRD and kidney dialysis (medical procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so). Resident 35 had a physician's order, dated 2/13/25, for Calcium Acetate (Phosphate Binder), Give 2 tablet[s] by mouth two times a day for Supplement. It was scheduled to be administered daily at 9 a.m. and 7 p.m. A review of the facility's meal schedule indicated breakfast is scheduled daily at 7:10 a.m., and dinner at 5:10 p.m. During an interview with RN A and the Director of Nursing (DON) on 9/3/25 at 10:30 a.m., the DON stated the calcium acetate should be written for ESRD, not supplement; and should be given with meals. RN A confirmed he administered the medication to Resident 35 around 10 a.m. yesterday and not with a meal. RN A and the DON reviewed Resident 35's clinical record and confirmed it was (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled daily at 9 a.m. and 7 p.m., not at or around mealtimes. They confirmed the medication has the wrong indication and wrong time of administration. On 9/3/25 at 10:50 a.m., a review of the 10-day administration history for Resident 35's calcium acetate, from 8/24/25 to 9/2/25, with the DON and RN A indicated was administered at the following days and times. They confirmed it was not given with meals. - 8/24/25 at 9:41 a.m. and 6:09 p.m. - 8/25/25 at 9:46 a.m. and 8:28 p.m. - 8/26/25 at 8:22 a.m. and 6:45 p.m. - 8/27/25 at 9:33 a.m. and 6:18 p.m. - 8/28/25 at 9:08 a.m. and 7:22 p.m. - 8/29/25 at 9:03 a.m. and 6:22 p.m. - 8/30/25 at 9:41 a.m. and 6:42 p.m. - 8/31/25 at 9:11 a.m. and 8:03 p.m. - 9/1/25 at 10:27 a.m. and 6:05 p.m. - 9/2/25 at 10:20 a.m. and 7:01 p.m. During a telephone interview with the Consultant Pharmacist (CP) on 9/3/25 at 12:16 p.m., he stated calcium acetate works by binding to phosphate in the food, it will not work to its capacity if not with meals. When questioned about the indication, the CP stated, Certainly for chronic kidney disease. Definitely not a supplement. The CP also stated medication administration with meals should be scheduled 7:30 a.m. for breakfast, and 5:30 p.m. for dinner. On 9/3/25, the facility provided Resident 35's laboratory report from the dialysis center. It indicated the following phosphorous levels and dates: Date Level 7/15/25 7.3 (normal level: 2.5 &ndash; 4.5) 7/29/25 7.2 8/02/25 8.9 8/26/25 6.8 A review of the facility's policy and procedures (P&P) titled Medication Therapy, revised 4/2007, indicated: (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions. All decisions related to medications shall include appropriate elements of the care process.Consideration of the clinical relevance of symptoms.conditions Upon or shortly after admission, and periodically thereafter, the staff and partitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen, to identify whether: a. There is a clear indication for treating that individual with the medication. A review of the facility's P&P titled Administering Medications, dated 4/2019, indicated, Medication administration times are determined by resident need and benefit. Enhancing optimal therapeutic effect of the medication. 2. Review of Resident 53's clinical record indicated that Resident 53 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, failure of the kidneys to filter out toxins from the bloodstream and create urine), acute respiratory failure with hypoxia (difficulty with breathing caused by lack of oxygen), type 2 diabetes mellitus (a disease that causes elevated blood sugar levels), and unspecified dementia (a disorder of the brain that causes people to lose their memory). Review of Resident 53's physician orders indicated an order for aluminium and magnesium hydroxide-simethicone suspension 40 milligrams (mg, measuring amount) in 5 milliliters (mL, measuring liquid), give 10 mL, every 4 hours as needed for indigestion, heartburn, gas, nausea, dated 9/1/25. During an interview with the consulting pharmacist (CP) on 9/4/25 at 2:29 p.m., the CP stated Milk of Magnesium is not recommended for residents who are diagnosed with ESRD, and that on the next review he does for the facility, he would provide recommendation to discontinue. During an interview with the director of staff development/infection preventionist (DSD/IP) on 9/4/25 at 2:52 p.m., the DSD/IP stated there should not be an order for Milk of Magnesium for residents who receive dialysis, and that the order for Resident 53 would be discontinued.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that infection control practices were implemented when: 1. Unlabeled personal care items; 2. Uncovered BiPAP (bilevel positive airway pressure, a machine used to help breathe by providing two different levels of air pressure through a mask) face mask; 3. No appropriate receptacle (a container to hold or store things) in room with contact precautions (CP: infection control measures used to prevent the spread of germs between residents) to discard used personal protective equipment (PPE: equipment worn to minimize exposure to infections and illnesses); 4. Cloudy urine in foley catheter (F/C: a thin, flexible tube inserted into the bladder [a body organ that stores urine] to drain urine) drain tube for Resident 8; 5. Appropriate hand hygiene between task while feeding residents was not followed. These above failures could result in the spread of infection and cross-contamination that could affect 43 residents who currently reside in the facility. Findings: 1. During room rounds on 9/2/2025 at 10:58 a.m., noted unlabeled gray color plastic wash basin (small plastic container used to provide personal hygiene for residents) in bathroom [ROOM NUMBER]. During room rounds on 9/2/2025 at 11:15 a.m., observed unlabeled small gray color plastic kidney shape basin with toothbrush and toothpaste inside in bathroom [ROOM NUMBER]. During an interview with certified nursing assistant D (CNA D) on 9/2/2025 at 11:30 a.m., CNA D confirmed above findings. CNA D stated above care items been in use and both bathrooms been shared between multiple residents. CNA D also stated resident's care items should have labeled, without label, these items would potentially use by unassigned residents and risk infection control. During an interview with facility's director of staff development/infection preventionist (DSD/IP) on 9/4/2025 at 2:07 pm., DSD/IP stated care items should be labeled to prevent use by unassigned residents for infection control practices. 2. During room observation rounds on 9/2/2025 at 11:37 a.m., noted uncovered BiPAP face mask, left on tray table when not in use in room [ROOM NUMBER] and no smoking sign posted. During an interview with registered nurse A (RN A) on 9/3/2025 at 1:56 a.m., RN A confirmed uncovered BiPAP face mask in room [ROOM NUMBER] and no smoking sign posted for this room. RN A stated mask should have been in a bag when not in use. During an interview with DSD/IP on 9/4/2025 at 2:07 pm., DSD/IP stated BiPAP face mask should have been in a bag when not in use. During an interview with facility's director of nursing (DON) on 9/5/2025 at 1:53 p.m., DON stated smoking sign should have been posted when using BiPAP machine for room [ROOM NUMBER], and BiPAP mask should be covered when not in use. 3. During room observation on 9/2/2025 at 10:40 a.m., noted CP sign posted outside on wall for room [ROOM NUMBER]. There was no closed lid receptacle available inside the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During room rounds on 9/3/2025 at 1:25 pm., noted CP sign posted outside on wall for room [ROOM NUMBER]. There was no closed lid receptacle available inside the room. During an observation and interview with RN A on 9/3/2025 at 1:56 pm., RN A observed room [ROOM NUMBER] and 3 and confirmed there were no close lid receptacles available in both rooms. RN A stated should have placed closed lid receptacle to discard used PPE before coming out of these rooms. During an interview with facility's DSD/IP on 9/4/2025 at 2:07 p.m., IP stated rooms with CP to follow should have assigned receptacle to discard used PPE before coming out of the room for infection control. 4. During an observation on 9/5/2025 at 10:50 a.m., noted F/C urine collection drain tube with cloudy urine for Resident 8. Review of Resident 8's face sheet (FS: a document that provides resident's information at a quick glance) indicated Resident 8 was admitted to facility on 7/2/2022. Review of Resident 8's FS indicated Resident 8's diagnosis included obstructive and reflux uropathy (a condition in which the flow of urine blocked and flows backward). Review of Resident 8's order summary report indicated, Foley catheter 16 fr (fr: french, size of the F/C external diameter measurement) /10ml (ml: milliliter, a measure of volume equal to one thousandth of a liter) for., dated 8/9/2022. During an observation and interview with RN A on 9/5/2025 at 10:59 a.m., RN A confirmed F/C drain tube with cloudy urine for Resident 8. RN A stated urine should have been clear and amber color, not cloudy. RN A also stated will follow up with medical doctor. During an interview with DSD/IP on 9/5/2025 at 1:49 pm., DSD/IP stated urine draining from F/C should be clear and amber color, charge nurse will follow up with medical doctor today for cloudy urine for Resident 8. 5. During a lunch meal observation on 9/2/2025, at 12:12 p.m., on the second floor of dining room, there were two tables; Residents 19 and 36 sat down by a table facing each other and Resident 39 sat alone by the other table. At 12:25 p.m., Resident 39 was taken back to her room by a restorative nursing assistant C (RNA C). At 12:36 p.m. RNA C was back to dining room without performing hand hygiene, RNA C mixed food in plate for Resident 19 to scoop easy while eating. During a follow-up interview on 9/2/2025, at 12:45 p.m., with RNA C, RNA C confirmed that she should have performed hand hygiene before handling resident's food. During another lunch observation on 9/3/2025, at 12:36 p.m., on the second floor dining room, CNA F did not perform hand hygiene before to use Resident 18's spoon twice to encourage eating meal. During a follow-up interview on 9/3/2025, at 12:40 p.m., with CNA F, CNA F confirmed he should have performed hand hygiene before touching Resident 18's utensil to scoop food from the plate. Review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated August (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2019, Before and after eating or handling food. Review f facility's policy and procedure (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, revised June 2011, the P&P indicated, Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge. Review of facility's P&P titled, CPAP (continuous positive airway pressure)/BiPAP Support, revised March 2015, the P&P indicated No SMOKING sign for the resident's room. Review of facility's P&P titled, Personal Protective Equipment- Using Gowns, revised September 2010, the P&P indicated, If the gown is disposable, discard it into the waste receptacle inside the room. Use gowns only once and then discard into an appropriate receptacle. After completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room. If mask was used during the procedure(s) or service, remove it at this time and discard it into waste receptacle inside the room. Review of facility's P&P titled, Oxygen Administration, revised October 2010, the P&P indicated, Discard personal protective equipment in designated receptacles. Review of facility's P&P titled, Catheter Care, Urinary, revised September 2014, the P&P indicated, Check the urine for unusual appearance (i.e., color, blood, etc.). Observe for other signs and symptoms of urinary tract infection or urinary retention (difficulty urinating and emptying). Report findings to the physician or supervisor immediately.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain equipment and environment in safe operating and sanitary condition when; 1. Unsteady bed side commode (a portable toilet, chair like structure to accommodate different user heights) with missing floor grip pads and broken chest of drawers in room for Resident 40; 2. Penetrating holes in room [ROOM NUMBER] and bathroom [ROOM NUMBER]; 3. Red to dark brown color metal plumbing pipes and missing on and off button for light switch in bathroom [ROOM NUMBER]. Above failures had the potential to adversely affect the health and safety of residents in facility. Findings: 1. During an initial room rounds on 9/2/2025 at 11:25 a.m., Resident 40 stated bedside commode was unsteady, missing floor grip pads for both legs on back, chest of drawers in the room, doors were not opening and closing appropriately, and both bottom drawers falling on floor when opened. Review of Resident 40's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 40 was admitted to facility on 8/20/2025. Review of Resident 40's minimum data set (MDS: clinical assessment tool) dated 8/26/2025 indicated Resident 3's brief interview for mental status (BIMS) score of 13 (score of 0-7: severe cognitive impairment, 8-12: moderate cognitive impairment, 13-15: intact cognition), intact cognition. During a concurrent observation and interview with facility's maintenance supervisor (MS) on 9/5/2025 at 8:41 a.m., MS confirmed Resident 40's bedside commode was unsteady due to missing floor grip pads on back legs and chest of drawers was broken. MS stated the bedside commode and chest of drawers were not safe to use for Resident 40. MS also stated he will replace both today. 2. During initial room rounds on 9/2/2025 at 10:55 a.m., observed penetrating hole approximately 6 inches long on one side and 3 inches long on another side of light switch plate on the wall in bathroom [ROOM NUMBER]. During room rounds in room [ROOM NUMBER] on 9/2/2025 at 11:37 a.m., noted small penetrating holes x5 on the wall at the head of bed (HOB), and penetrating hole on the wall behind metal cover for heater near room door. During a concurrent observation and interview with facility's MS on 9/5/2025 at 8:41 a.m., MS confirmed penetrating hole on the wall around light switch plate in bathroom [ROOM NUMBER], penetrating holes x5 at HOB on the wall and one penetrating hole on wall behind metal heater cover in room [ROOM NUMBER]. MS stated these concerns would have been potential for safety for residents. MS also stated all above concerns should have been fixed as soon as possible. 3. During room rounds in bathroom [ROOM NUMBER] on 9/2/2025 at 11:50 a.m., observed 3 metal plumbing pipes x3 with red to dark brown in color near the sink in bathroom [ROOM NUMBER] and missing on and off button for light switch on the wall in bathroom [ROOM NUMBER]. During concurrent observation and interview with facility's MS on 9/5/2025 at 8:41 a.m., MS confirmed metal plumbing pipes x 3 with red to dark brown in color and missing on and off button for light switch in bathroom [ROOM NUMBER]. MS stated these metal pipes got rusted badly due to water use in the bathroom and on and off button broken for light switch. MS also stated he should not have rusted plumbing pipes in resident's bathroom. MS further stated he would remove rust and paint all these pipes, if unable to remove rust, will replace with new pipes and replace on and off button for light switch. Review of facility's policy and procedure (P&P) titled, Maintenance Service, revised December 2009, the P&P indicated, The maintenance Department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Maintaining the building in good repair and free from hazards.		

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 09/08/2025
NAME OF PROVIDER OR SUPPLIER Katherine Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Alameda Avenue Salinas, CA 93901	
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure to follow their policy and procedure (P&P) for physician orders for life-sustaining treatment (POLST: a document that specifies the medical treatments the resident wants to receive during serious illness) for two of five sampled residents (Resident 3 and 8). These failures could lead to the delivery of unnecessary or inappropriate medical services against sampled resident's goals and wishes. Findings: Review of Resident 3's face sheet (a document that gives a resident's information at a quick glance) indicated Resident 3 was admitted to facility on 8/8/2025. Review of Resident 3's POLST form date prepared 8/8/2025 indicated, section D for advance directive was not completed and available all three options were left blank. Review of Resident 8's face sheet indicated, Resident 8 was admitted to facility on 7/2/2022. Review of Resident 8's POLST form date prepared 8/1/2022 indicated, section C for artificially administered nutrition was not completed and available all three options were left blank. During a concurrent record review of POLST form for Residents 3 and 8 and interview with facility's director of nursing (DON) on 9/4/2025 at 12:12 p.m., DON confirmed POLST form section D for Resident 3 and section C for Resident 8 were not completed and left blank. DON stated nursing staff responsible to review and complete all sections of POLST upon resident's admission to facility. DON also stated nursing staff should have completed all sections of POLST form for both Resident 3 and Resident 8. DON further stated interdisciplinary team (IDT: a group of healthcare professionals from different specialties who collaborate to provide comprehensive care to residents) reviews and completes POLST form as needed during care plan meeting for each resident. Review of facility's P&P titled, Physician Orders For Life-Sustaining Treatment (Or POLST), updated 4/8/2022, the P&P indicated, A qualified healthcare provider, preferably a registered nurse or social worker will review the POLST form for completeness. The POLST will be reviewed by the facility interdisciplinary team:		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure free from unnecessary psychotropic medication (medications capable of affecting the minds, emotions, and behaviors) for one of four sampled resident (Resident 56) when: There was no documented evidence of non-pharmacological (treatments and strategies that manage health conditions without using medications) approaches attempted before administered psychotropic medication quetiapine (used to treat mental health condition); 2. There was no documented evidence for episodes of appropriate behavior monitored for quetiapine; 3. There was no documented evidence for side effects monitored for quetiapine. These above failures had the potential to place sampled resident at risk to receive unnecessary psychotropic medication. Findings: Review of Resident 56's face sheet (FS: a document that gives a resident's information at a glance) indicated Resident 56 was admitted to facility on 8/1/2025 and discharged from facility on 8/3/2025. Review of Resident 56's diagnoses included mood disorder (type of a mental illness affects emotional state). Review of Resident 56's order summary report indicated Quetiapine Fumarate 25 MG (mg: milligram, a unit of weight, equal to one thousandth of a gram) every 12 hours as needed for Mood Disorder for 14 days, dated 8/1/2025. Review of Resident 56's electronic medication administration record (EMAR, a digital system used in healthcare setting to track and document the administration of medications to residents) for August/2025 indicated Resident 56 received quetiapine one dose on 8/2/2025 at 7:11 p.m. 1. Review of Resident 56's electronic clinical documentation indicated there was no documented evidence of non-pharmacological approaches attempted before administered quetiapine on 8/2/2025. 2. Review of Resident 56's electronic clinical documentation indicated there was no documented evidence of indicated episodes of appropriate behavior monitored for use of quetiapine. 3. Review of Resident 56's electronic clinical documentation indicated there was no documented evidence for side effects monitored for quetiapine use. During a concurrent record review and interview with director of nursing (DON) on 9/8/2025 at 11:08 a.m., DON reviewed physician orders, EMAR, and clinical documentation for Resident 56. DON confirmed there was no documentation for attempted of non-drug approaches before administered antipsychotic medication to Resident 56 on 8/2/2025. DON also confirmed there was no contraindication for above resident to attempt non-drug approaches. DON also confirmed there was no documented evidence of behavior and side effects monitored for use of quetiapine for Resident 56. DON stated license nursing staff should have provided non-drug interventions before administered, monitored, documented for episodes of behavior and side effects for use of quetiapine for Resident 56 to minimize the need for antipsychotic medication for this resident. Review of facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated 4/8/2022, the P&P indicated, Psychoactive can only be prescribed if there is an appropriate indication: diagnosis and behavior. Behavior must be individualized and specific to the patient. If a psychoactive is being prescribed after admission Non-pharmacological interventions must be attempted first and clearly documented. Side effect monitoring should be mentioned/documented .		

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NAME OF PROVIDER OR SUPPLIER Katherine Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Alameda Avenue Salinas, CA 93901	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately code the minimum date set (MDS: an assessment tool) assessment for one of three sample resident (Resident 3) when Resident 3's MDS assessment did not reflect status of the resident. This failure had the potential to affect inappropriate care and interventions. Findings:Review of Resident 3's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 3 was admitted to facility on 8/8/2025.Review of Resident 3's diagnoses included diabetes type 1(a chronic condition in with high level of sugar in the blood).Review of Resident 3's order summary report indicated insulin (a hormone that helps to regulate blood sugar levels) glargine (a type of long acting insulin used to trat treat diabetes) 100 Unit (unit: specific volume of fluid) /ML (ml: milliliter, a unit of volume, equal to one-thousandth of a liter) inject 5 units subcutaneously (SQ: a method of administering medication by injecting into the layer just below the skin) at bed time for diabetes 1, dated 8/9/2025.Review of 3's order summary report also indicated insulin lispro (a type of short acting insulin used to treat diabetes) 100Unit per milliliter as per sliding scale (dose chart that uses to correct high blood sugar based on sugar levels in blood) SQ at bed time dated 8/9/2025 and before meals dated 8/8/2025.Review of Resident 3's electronic medication administration record (EMAR: digital system for documenting medication administration) for August/2025 and September 2025 indicated Resident 3 received insulin every day.Review of Resident 3's MDS assessment dated [DATE], section N, N0415 for high-risk drug classes: used and indication indicated No for Hypoglycemic (including insulin). During concurrent record review of Resident 3's EMAR for August and September/2025, MDS assessment dated [DATE], section N, and interview with facility's MDS coordinator (MDSC) on 9/5/2025 at 1:18 p.m., MDSC confirmed Resident 3 received insulin every day after admitted to facility. MDSC also confirmed MDS assessment, section N for hypoglycemic medication not coded accurately. MDSC stated hypoglycemic medication should be coded Yes for Resident 3. MDSC also stated she would modify MDS assessment to correct above concern.Review of facility's policy and procedures (P&P) titled, Resident Assessments revised November 2019, the P&P indicated, The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team (IDT: a group of healthcare professionals from different specialties who collaborate to provide comprehensive care to residents) conducts timely and appropriate resident assessment and reviews .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure to implement comprehensive person-centered care plan for two of 14 sampled residents (Resident 4 and 29) when: Bilateral (both) heel boots were not applied while in bed for Resident 4; Floor mat (padded mat to reduce the risk of serious injury from fall) was not placed while Resident 29 was in bed. Above these failures had potentially affect Resident 4 and 29 's quality of care for prevention of pressure ulcer and injury in the facility. Findings: 1. During a review of Resident 4's physician order dated 4/29/25, it indicated, Keep weight off heels: use heel boot on right foot while in bed and check placement every shift (QS). During a review of Resident 4 's care plan for the potential impairment to skin integrity, revised on 8/6/25, care plan indicated, Boots to heels when in bed for preventative measure. During an observation on 09/02/2025, at 10:19 a.m., Resident was in bed and there were bilateral boot left on the bedside table. No pillow under her feet for offloading pressure for both feet. During an interview on 09/02/2025, at 2:40 p.m., with certified nursing assistant D (CNA D), CNA D confirmed she did not apply boots for Resident 4's legs until afternoon. 2. During a review of Resident 29's physician orders dated 2/14/23, it indicated, Floor mat left side of bed to decrease risk for injury. During a review of Resident 29's care plan for a floor mat to left side of bed o decrease risk for injury, dated 4/10/23, it was indicated the goal for Resident 29 was free from injury from device usage. During an observation on 09/02/2025, at 10:45 a.m., Resident 29 was in bed watching a television. Her bed was against the wall to the right side of bed and there was no floor mat on left side of her bed. During an interview on 9/3/25, at 12:45 p.m., with CNA D, CNA D confirmed there was no floor mat on Resident 29's left side of the bed. CNA D stated that Resident 29's floor mat should have been placed to her left side of bed to prevent injury. During an interview on 9/5/25 at around 9 a.m., with director of nursing (DON) and director of staff development (DSD), DON and DSD both confirmed above findings and stated nursing staff should have followed orders and implemented care plans for Resident 4 and 29. Review Of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to provide a restorative nurse assistant (RNA, a nursing program to increase and/or to prevent decrease in range of motion [ROM, the extent or limit to which a part of the body can be moved around a joint or a fixed point] exercise) program for one of 14 sample resident (Resident 4). Above this failure had the potential to result in further decline of ROM for sample Resident 4. Findings: 1. During a review of Resident 4's clinical record indicated she had diagnoses including Parkinson disease (a brain disorder that causes problems with movement, such as tremors (shaking), stiffness, and slow movement) and muscle weakness (a lack of muscle strength). Review of Resident 4's minimum data set (MDS, an assessment tool) assessment dated [DATE], she was totally dependent on her activities of daily living (ADL, such as eating, grooming, dressing, walking, transferring, and toileting). Resident 4 had impaired ROM on both sides of upper and lower extremities (hands and legs). During a review of Resident 4's order summary record indicated , RNA program: active assisted range of motion (AAROM, ability of a joint to move without external assistance) to passive range of motion (PRROM, unable to move a joint without assistance) of bilateral lower extremities (BLE) 10 reps (repeat) x3sets, 3x/week (3 times per week) to maintain mobility of BLE, dated 10/29/2024. During a review of Resident 4's order summary record indicated, RNA program: Right upper extremity resting hand splint (a medical device to support and limit movement of the hand and wrist) and left upper extremity hand roll 5x/ week for 4 to 6 hours to prevent further wrist/digits contracture (joints stiffen and shorten), dated 4/11/2025. During a review of Resident 4's RNA monthly summary (treatment progress and resident's response) dated 7/31/25, it was indicated Resident was provided ROM on BLE to maintain strength and mobility. There is no improvement, both hands and legs are stiff. She screamed when I attempted to put on the handroll and the splint. During a review of Resident 4's RNA weekly summary from 5/2025 to 8/5/25 (total of 16 weeks) indicated there were no documented evidence of weekly summary for the week of 5/2/25, 5/9/25, 5/16/25 , 7/18/25, 7/25/25 and 8/1/25 (total 6 weeks). During an observation on 9/2/25, at 10:19 a.m., Resident was lying in bed and her bilateral hand noted with contractures. During an interview with RNA C on 9/8/25, at 10:22 a.m., RNA C stated Resident 4's bilateral extremities were stiff than before. RNA C further stated she was on vacation during the weeks of 5/2/25, 5/9/25, 5/16/25 , 7/18/25, 7/25/25 and 8/1/25 and the RNA services should have been covered by the certified nursing assistants (CNAs) while she was gone for vacation. RNA C confirmed there should have been RNA services provided to Resident 4 and there were no written documents in place when RNA services were provided during those weeks of 5/2/25, 5/9/25, 5/16/25 , 7/18/25, 7/25/25 and 8/1/25. Review Of the facility's policy and procedures (P&P) titled, Restorative Nursing Services, revised July 2017, the P&P indicated, Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical [a healthcare profession that focuses on improving and restoring physical function], occupational [a healthcare profession that helps to improve ability to perform daily activities] or speech [focuses on assessing and treating disorders related to speech and swallow difficulties] therapies).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of 18 sampled resident (Resident 5) was appropriately treated for a urinary tract infection (UTI, an infection of the bladder [body organ that collects urine] which causes burning while urinating, abdominal pain and blood in the urine) with an appropriate medication as ordered by the physician. This failure had the potential for further progress of UTI and affect Resident 5's overall health condition. Findings: Review of Resident 5's clinical record indicated he was admitted on [DATE] with diagnoses including acute kidney failure (failure of the kidneys [pair of organs that produces urine], due to an outside cause such as other diseases or infection), hepatorenal syndrome (a complication of advanced liver [a large organ in the digestive system] disease that affects the kidneys), spontaneous bacterial peritonitis (an infection in the abdominal area due to bacteria) and Unspecified Cirrhosis (destruction of healthy liver tissue). Review of Resident 5's clinical record further indicated he was sent to an acute care hospital (AH, a healthcare facility that provides short-term intensive medical treatment) emergency department (ED, a specialized hospital unit that provides unscheduled medical care for acute and severe illnesses) on 8/9/25, diagnosed with a UTI and returned back to the facility on the same day, with a medication order for cephalexin (a type of antibiotic medication used to treat UTI) 500 milligram (mg, unit of measurement) every six hours for seven days. It was then ordered in the facility and given to the resident from 8/10/25 until 8/16/25. Review of Resident 5's document from AH's ER (emergency room/ED) Report dated 8/11/2025 indicated, the ED physician documented an addendum: I saw this patient 2 days ago in the emergency department. He (Resident 5) had some abdominal discomfort and UA (urinalysis, a test that examine a urine sample to detect and analyze various substances) was concerning for UTI. He was placed on Keflex [cephalexin]. Unfortunately his UA is growing out an ESBL (extended spectrum beta lactamase, a group of enzymes [help for the chemical reactions in our body] produced by certain bacteria that make them resistant [medication becomes less effective or completely ineffective] to wide range of antibiotic medications) E coli (a type of bacteria that normally harmless) Resistant to cephalosporins. However, there was sensitivity [easily able to be treated with another antibiotic medication] to Macrobid (an antibiotic medication used to treat UTI). I sent the new Macrobid to the pharmacy. Attempted to contact his nursing facility however there has been no answer. The AH physician documented giving an order for macrobid 100 mg every 12 hours for seven days. During a concurrent interview and record review with the director of staff development/infection preventionist (DSD/IP) on 9/5/25 at 9:04 a.m., the DSD/IP reviewed Resident 5's physician orders, and confirmed there was no documented evidence for an order of Macrobid, or administration of Macrobid for Resident 5. During a concurrent interview and record review with the DSD/IP on 9/5/25 at 11:00 AM, the DSD/IP verified she had asked the AH to send the ED documentation for Resident 5 on 8/11/25, two days after the resident returned from the AH ED, and confirmed she received the AH ED documentation on 8/18/25. The DSD/IP also stated she did not follow up on Macrobid physician order from the AH ED physician and Resident 5 did not receive Macrobid as ordered by the physician. Review of facility policy and procedure (P&P) titled, Medication and Treatment Orders, revised 2016, indicated, Drugs and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Review of facility P&P titled, Antibiotic Stewardship, revised 2016, indicated, When a resident was admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receiving dialysis (medical treatment that filters blood to remove waste and excessive fluids from body to sustain life) treatment received care consistent with professional standards for two of three sampled residents (Resident 3 and 35) when: 1. Inadequate communication from dialysis center (a place which provides dialysis treatment) to nursing facility for Resident 3; 2. Order for milk of magnesia (MOM: medication used to treat constipation [problem with passing stool]) for Resident 3 with dialysis status; 3. Antibiotic (medication used to treat infection) order was not discontinued as ordered for Resident 3; 4. No documented evidence for side effects (S/E, unwanted or unexpected effects that occur when taking medication) monitoring for use of antibiotic medications x2 for Resident 3; 5. Dialysis emergency kit (to prepare for emergency where regular dialysis treatments may be unavailable to manage condition) not available and fluid intake (amount of fluids taken) and output (amount of fluids left the body) not monitored for Resident 35. These above deficient practices had the potential for sampled residents to be inadequately assessed and be at risk for complications for medical health and well-being. Findings: 1. Review of Resident 3's dialysis communication record (DCR), dated 8/9/2025 and 8/23/2025 indicated, dialysis center did not complete Resident 3's dialysis visit/treatment information, this section of the form was left blank on both dates. Review of DCR dated 8/14/2025 indicated partially completed with Resident 3's dialysis visit/treatment by dialysis center. Review of Resident 3's face sheet (FS: a document that provides resident's information at a quick glance) indicated Resident 3 was admitted to facility on 8/8/2025. Review of Resident 3's FS also indicated Resident 3 admitted with diagnoses included end stage renal disease (ESRD, a condition where the kidneys [a pair of bean-shaped body organs that filter waste and excess fluid from blood to produce urine] permanently failed, lost the function), dependence on renal dialysis, and cellulitis (bacterial infection of skin and the tissues beneath the skin) of left lower limb (leg). Review of Resident 3's order summary report indicated, Dialysis: Dialysis Center. On Tuesday, Thursday, Saturday. Chair time: 9:00 AM pick up at 8:00 AM. During record review of dialysis communication record for Resident 3 and interview with registered nurse A (RN A) on 9/5/2025 at 10:32 a.m., RN A confirmed above DCA were not completed by dialysis center for scheduled dialysis treatment visits for Resident 3. RN A stated dialysis center should have complete required information to communicate and coordinate care with facility for Resident 3. RN A also stated facility will reach out to dialysis center for incomplete DCR. 2. Review of Resident 3's order summary report indicated Milk of Magnesia Suspension 2400 MG (milligram, unit of mass, equal to one thousandth of a gram)/30 ML (milliliter, unit of volume, equal to one thousandth of a liter) Give 30 ml for constipation if no bowel movement in 2 days, dated 8/8/2025. During an interview over the telephone with facility's consultant pharmacist (CP) on 9/4/2025 at 2:29 p.m., CP stated it would not recommend medication MOM for residents who depended on dialysis due to risk for increase magnesium levels and impaired kidneys were not able to remove excess (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	magnesium from body. PC also stated will discuss with facility for MOM order for residents with dialysis status during his next visit. During an interview with director of nursing (DON) on 9/4/2025 at 2:52 p.m., DON confirmed a physician order for MOM for Resident 3. DON stated MOM contraindicated for residents with impaired kidney function and dialysis status. Resident 3 should not have an ordered MOM due risk of increased magnesium levels if taken. 3. Review of Resident 3's order summary report indicated Cefazolin (antibiotic medication used to treat bacterial infections) medication order was not discontinued on 8/26/2025 as ordered. Review of Resident 3's order summary report indicated, Cefazolin 1gm (gm: gram, a unit of weight, equal to one thousandth of kilogram) IV (intravenous, a needle inserted into a vein to administer fluids and medications into blood stream) will be given at dialysis center during dialysis days, dated 8/13/2025. Review of Resident 3's discharge summary from acute hospital (a healthcare facility that provides short-term intensive medical treatment with sudden and severe illnesses or injuries) dated 8/8/2025 indicated, Continue IV Ancef (brand name for cefazolin) x 6 weeks (stop date August 26,2025). During an interview with facility's director of staff development/infection preventionist (DSD/IP) on 9/4/2025 at 1:49 p.m., DSD/IP confirmed Resident 3's medication Cefazolin order was not discontinued on 8/26/2025 as stop order received from acute hospital. DSD/IP stated should not have continued cefazolin order to receive at dialysis center after 8/26/2025. 4. Review of Resident 3's clinical record indicated there was no documented evidence of facility monitored S/E for use of two different antibiotic medications. Review of Resident3's order summary report indicated, Cefazolin 1 gm IV will be given at dialysis center during dialysis days, dated 8/13/2025, and Cephalexin 500 MG give by mouth two times a day for cellulitis to LLE (left lower extremity), dated 8/8/2025. During an interview with facility's DSD/IP on 9/4/2025 at 1:49 pm., DSD/IP confirmed there was no documented evidence for facility monitored S/E when received two different antibiotic medications for Resident 3. DSD/IP stated nursing staff should have monitored and documented S/E every shift for Resident 3. During a telephone interview with CP on 9/4/2025 at 2:29 pm., CP stated facility should have monitored S/E for antibiotic medications for Resident 3. CP also stated she would recommend monitoring for S/E for Resident 3 due to impaired kidney function and dialysis status to identify drug toxicity (adverse effects that occur when too much of medication in system) and interactions. CP further stated would have missed to identify and recommend above concern to facility. During an interview with facility's DON on 9/4/2025 at 2:52 p.m., DON stated should have S/E monitoring for Cefazolin and Cephalexin medications for Resident 3. DON also stated nursing staff should have monitored and documented for S/E for both antibiotic medications for Resident 3. Review of facility's policy and procedures (P&P) titled, Coordination of Care of Residents on Dialysis, undated, the P&P indicated, The Dialysis Center communicates changes in medication or lab (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 09/08/2025
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abnormalities in the same form. Review of facility's P&P titled, End-Stage Renal Disease, Care of a Resident with, P&P revised September 2010, the P&P indicated, Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. The type of assessment data that is to be gathered about resident's condition on a daily or per shift basis; How information will be exchanged between the facilities; Review of facility's P&P titled, Antibiotic Stewardship, revised December 2016, the P&P indicated, when a resident is admitted from an emergency department (a specialized unit in acute hospital that provides immediate medical care for urgent or life threatening conditions), acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. Review of facility's P&P titled, Antibiotic Stewardship-review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, the P&P indicated, All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: Outcome; and Adverse events. 5.During review of Resident 35's clinical record indicated Resident 35 was admitted to the facility on [DATE] and had diagnoses including end stag of renal disease and dependence on renal dialysis. He was scheduled for dialysis every Tuesday, Thursday, and Saturday. During an observation on 9/3/2025, at 8:35 a.m., Resident 35 had a permacath (long, flexible tube inserted into a vein most commonly in the neck and into the heart to allow dialysis to occur) covering with clean dry dressing to his right chest. During a review of Resident 35's physician orders, dated 7/8/2025, indicated he had a hemodialysis catheter for dialysis via right chest permacath and was scheduled to go to a dialysis center three times a week. During a review of Resident 35's care plans indicated he had two care plans to address dialysis; the first care plan for dialysis with revision date of 3/18/25 had interventions including monitoring intake (total amount of fluids taken) and output(total amount of fluids out from body) and fluid restrictions (limit of fluids) 1400 milliliters (ml, unit of measurement for amounts) per day (24 hours), and the second care plan of dialysis dated 9/3/25 with intervention for emergency kit at bedside including gauze dressing, wrap bandage and tape. During an interview on 9/03/2025 at 9:17 a.m. and 9/5/2025 at 8:40 a.m., with registered nurse A (RN A), RN A stated he did not receive training to deal with emergency situation of hemodialysis residents, and he was not familiar with where the emergency kit was stored at the beginning of interview on 9/3/2025 and during an interview on 9/5/25 he was able to explain the emergency kit was stored in medication cart (mobile cart used to store, organize and transport medications for residents). RN A further stated if Resident 35 had bleeding at dialysis access site, he would just call 911(a phone number used to contact the emergency services). During a concurrent interview and record on 9/5/25, at 10:11 a.m. and 12:55p.m.,with minimum data set (MDS, clinical assessment tool) coordinator (MDSC), she reviewed Resident 35's care plans for dialysis, stated facility did not monitor Resident 35's intake and output as a intervention for resident (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with dialysis status. During a review of the facility's P&P titled, End of Stage Renal Disease (ESRD), Care of a Resident With, revised 9/2010, the P&P indicated, Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. How to recognize and manage equipment failure or complications (according to the type of equipment used in the facility);. How the care plan will be developed and implemented. Review of facility's P&P, titled, Coordination of Care of Residents on Dialysis, undated, the P&P indicated, Ensure Dialysis Emergency Kit is available at bedside at all times.		

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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** Based on interview and record review, the facility failed to ensure accurate accountability of controlled substances (that can be easily abused and are under strict government control) when controlled medications were signed out of the controlled drug record (CDR, an accountability sheet of controlled medications) but not documented on the medication administration record (MAR) to show they were administered for 2 out of 4 residents (Residents 54 and 55). This resulted in facility not having accurate accountability and the potential for abuse/loss of controlled medications. Findings: During the survey, the CDRs for 4 residents receiving as-needed medications were requested for review. During a concurrent interview and record review with the Director of Nursing (DON) and Registered Nurse (RN) A on 9/3/25 at 10:37 a.m., the DON stated whenever an as needed controlled medication is requested by a resident, the nursing staff needs to assess the resident, remove the medication from the medication cart, sign it out of the book (the CDR), and document the administration on the MAR. a. A review of Resident 54's clinical record indicated she had a physician's order, dated 6/28/25, for hydrocodone/acetaminophen (brand name: Norco, a narcotic for pain) 5/325 milligrams (mg, unit of measurement), 1 tablet by mouth every 4 hours as needed for severe pain. On 9/03/25 at 10:40 a.m., a review of Resident 54's CDR for Norco 5/325 mg and July 2025 MAR with the DON and RN A indicated a nursing staff signed out 1 tablet of Norco 5/325 mg but did not document the administration on the MAR on 7/16/25 at 10:30 p.m. Both staff verified this finding. b. A review of Resident 55's clinical record indicated she had a physician's order, dated 6/24/25, for hydrocodone/acetaminophen 5/325 mg, 1 tablet by mouth every 4 hours as needed for moderate to severe pain. During a concurrent interview and record review with the DON and RN A on 9/03/25 at 10:44 a.m., a review of Resident 55's CDR for Norco 5/325 mg and July 2025 MAR indicated the nursing staff signed out the Norco but did not document the administration on the [DATE] occasions: on 7/1/25 at 11:06 p.m.; 7/5/25 at 2:18 a.m., and on 7/6/25 at 0:13 a.m. RN A reviewed these documents and confirmed they were not documented on the MAR. Both the DON and RN A stated they should have been documented on the MAR to account for the medications. A review of the facility's policy and procedures titled Administering Medications dated 4/2019, indicated: The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered .		

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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. Based on observation, interview, and record review, the facility had a medication error rate of 7.89% when three medication errors occurred out of 38 opportunities during the medication administration for three out of six residents (Residents 3, 27, and 35). Resident 35 did not receive calcium acetate (brand name: Phoslo; medication to treat high phosphate in the blood, in patients with end stage kidney disease) as in accordance with the manufacturer's specifications; Resident 27 received an insulin (medication to lower blood sugar) injection not in accordance with the manufacturer's specifications; and Resident 3 did not receive his metoprolol (medication to treat high blood pressure [BP]) as ordered. The failures resulted in the residents not receiving medications as prescribed or per manufacturer's specifications, which had the potential for complications of their medical conditions (such as high phosphate level, high blood sugar, or high BP). Findings: 1. During a medication administration observation with Registered Nurse (RN) A on 9/2/25 at 10:25 a.m., RN A was observed administering 17 medications to Resident 35 including 2 tablets of calcium acetate (Phoslo) 667 milligrams (mg, unit of measurement). During an interview post medication administration, on 9/2/25 at 10:26 a.m., when asked when Resident 35 had his breakfast, RN A stated, I am not sure. During an interview with Resident 35 on 9/2/25 at 12:02 p.m., Resident 35 stated he ate breakfast around 7 a.m. (about 3 hours before receiving the calcium acetate). During an interview with Certified Nursing Assistant B (CNA B) on 9/2/25 at 2:54 p.m., she stated Resident 35 had his breakfast around 7:40 a.m. but she has not had a chance to document in the computer system yet. A review of Resident 35's clinical record indicated he was admitted with diagnoses including end-stage kidney disease (when the kidneys no longer function well enough to meet the body's needs); and a physician's order, dated 2/13/25, for Calcium Acetate (Phosphate Binder), Give 2 tablet by mouth two times a day for Supplement. A review of the Prescribing Information (PI; detailed information about a medication and its use) for calcium acetate, dated 3/2011, indicated to take calcium acetate with each meal. The PI indicated, Calcium acetate (PhosLo(R)), when taken with meals, combines with dietary phosphate to form an insoluble calcium phosphate complex, which is excreted in the feces, resulting in decreased serum phosphorus concentration. During an interview with RN A and the Director of Nursing (DON) on 9/3/25 at 10:30 a.m., the DON stated the calcium acetate should be written for end-stage kidney failure and should be given with meals. RN A confirmed he administered the medication around 10 a.m. yesterday and not with a meal. 2. During a medication administration observation with Licensed Vocational Nurse (LVN) E on 9/2/25 at 4:24 p.m., she was observed drawing up into a syringe 3 units of insulin lispro (a short-acting insulin) for Resident 27. On 9/2/25 at 4:25 p.m., at Resident 27's bedside, LVN E injected the insulin into the resident's right lower abdomen. On 9/2/25 at 4:28 p.m., when asked when dinner is served, LVN E stated the resident gets dinner a little after 5 p.m. A review of Resident 27's clinical record indicated an order, dated 8/25/25, for insulin lispro injection solution 100 units/ milliliter, to inject as per sliding scale (set of instructions for administering insulin dosages based on specific blood sugar readings) before meals and at bedtime. The afternoon dose was scheduled daily at 4:30 p.m. During a concurrent interview and record review with LVN E on 9/2/25 at 5:10 p.m., LVN E stated Resident 27 typically gets her insulin dose around 4 p.m. because it is scheduled daily at 4:30 p.m.; and with insulin, she would typically give it about 30 minutes before or after due time. A review of the online Prescribing Information for insulin lispro, revised 9/2023, with LVN E indicated, Administer Insulin Lispro by subcutaneous injection into the abdominal wall. within 15 minutes before a meal or immediately after a meal. LVN E verified that it has been 45 minutes since she administered the insulin to Resident 27, and the resident has not received her dinner yet. On 9/2/25 at 5:17 p.m., the dinner cart was observed being brought in the hallway where Resident 27's room was located. By 5:20 p.m. (almost an hour after the insulin administration), no dinner tray was brought into Resident 27's room yet. During a telephone interview with the Consultant Pharmacist (CP) on 9/3/25 at 12:16 p.m., he stated sliding scale insulin lispro should be given within 15 minutes of a (continued on next page)		

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Centers for Medicare & Medicaid Services

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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 09/08/2025
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal.3. During a medication administration observation on 9/3/25 at 8:34 a.m., RN A was observed assessing Resident 3's BP. The BP reading was 179/98 (high; normal BP for adults is typically defines as less than 120/80).On 9/3/25 at 8:45 a.m., RN A was observed administering 7 medications to Resident 3. The medications did not include metoprolol.A review of Resident 3's clinical record indicated a physician's order, dated 8/13/25, for metoprolol succinate extended release (ER) 100 mg, 1 capsule by mouth one time a day for hypertension (high BP). It was scheduled daily at 9 a.m.A review of Resident 3's September 2025 MAR indicated RN A placed a code 9 (meaning Other/See Progress Notes) in the entry for metoprolol administration on 9/3/25 at 9 a.m. A review of the corresponding progress notes, written by RN A at 9/3/25 at 8:41 a.m., indicated, Waiting for pharmacy to deliver. Will follow up. MD will be notified.During an interview with RN A on 9/3/25 at 10:28 a.m., he stated Resident 3' metoprolol ER was not available for administration. He said, I just realized it was out this morning.A review of the facility's policy and procedures titled Administering Medications, dated 4/2019, indicated, Medications are administered in accordance with prescriber orders including any required time frame. Medication administration times are determined by resident need and benefit. Enhancing optimal therapeutic effect of the medication. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure to conserve nutritional food value and palatability for one of 42 sampled resident (Resident 47), when:1. Resident 47 stated vegetables were soft, mushy and overcooked;2. A test tray for cooked vegetable was soft.This failure had the potential to compromise nutritional quality and palatability of meals for sampled resident 47.Findings: 1.During an initial room rounds on 9/2/2025 at 11:10 a.m., Resident 47 stated food in facility horrible, bland, no taste, veggies served soft, mushy and overcooked. Review of Resident 47's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 47 was admitted to facility on 7/14/2024. Review of Resident 47's minimum data set (MDS: clinical assessment tool) assessment dated [DATE] indicated Resident 47's brief interview for mental status (BIMS) score of 13 (score of 0-7: severe cognitive impairment, 8-12: moderate cognitive impairment, 13-15: intact cognition), intact cognition. Review of Resident 47's order summary record indicated NAS (no added salt) diet regular texture, thin liquids consistency, chopped meats, dated 11/18/2024. Review of facility menu for lunch on 9/3/25 indicated the meal included cheesy broccoli rice as the vegetable dish. During a concurrent test tray observation and interview done with the certified dietary manager (CDM) on 9/3/25 at 12:40 PM, the cheesy broccoli rice was noted to be soft, close to mushy. The CDM stated the broccoli was soft, but not mushy. CDM also stated broccoli cooked with rice, made broccoli softer. During an interview with facility's registered dietitian (RD) on 9/4/2025 at 3:39 p.m., RD stated vegetables should have cooked and served not hard and not soft for residents with regular consistency diet order. RD also stated vegetables should have been cooked and served between al [NAME] (cooked until tender but still firm to bite than being soft or mushy) and soft. 2. Review of lunch meal menu for 9/3/25 indicated the meal included cheesy broccoli rice as the vegetable dish. During a concurrent observation and interview with [NAME] H on 9/3/25 at 11:25 a.m., [NAME] H was seen preparing the lunch meal for the day, with broccoli in a pot of boiling water. [NAME] H says he makes the broccoli softer, for residents who have a bite size diet order (a therapeutic diet order that calls for food to be cut into small pieces so that it is easy to chew). During a concurrent test tray observation and interview done with CDM on 9/3/25 at 12:40 p.m., the cheesy broccoli rice was noted to be soft, close to mushy. The CDM stated the broccoli was soft, but not mushy. Review of facility's policy and procedure (P&P) titled, Food and Nutrition Services, revised October (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2017, the P&P indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the following multi-resident rooms were less than 80 square feet per resident. Findings:Room Beds Square Feet/Room Square Feet/Resident 3 2 148.5 74.25 10 2 156.96 78.48 23 2 152.6 76.30 During an observation of room [ROOM NUMBER] on 9/3/2025 at 1:43 p.m., noted there were no care or privacy issues identified with lack of space regarding the size of resident room.During an observation of room [ROOM NUMBER] on 9/3/2025 at 2:36 pm., noted there were no care or privacy issues identified with lack of space regarding the size of resident room.During an interview with certified nursing assistant D (CNA D) on 9/3/2025 at 2:50 p.m., CNA D stated no concerns with care and safety for taking care of both residents in room [ROOM NUMBER] and 23 regarding the size of both rooms.During an interview with registered nurse A (RN A) on 9/3/2025 at 2:45 pm., RN A stated no concerns with providing care to both residents in rooms [ROOM NUMBERS] regarding to the space and size of both rooms.During an observation of room [ROOM NUMBER] on 9/3/2025 at 2:50 pm., noted there were no care or privacy issues identified with lack of space regarding the size of room.During an interview with CNA B on 9/3/2025 at 2:54 pm., CNA B stated there were no concerns with providing care for two residents in room [ROOM NUMBER] regarding the size and space of this room.During an interview with RN G on 9/3/2025 at 2:56 pm., RN G stated no issues with providing care for two residents in room [ROOM NUMBER] related to size of the room.During an interview with facility's maintenance supervisor (MS) on 9/5/2025 at 9:12 a.m., MS confirmed size of above three rooms less than 80 square feet for each resident and each room shared by two residents.The residents were observed in their rooms throughout the survey. The nursing care and services were not impacted by the shortage of space for residents' rooms. The closet and storage spaces were sufficient to accommodate the needs of the residents.Review of facility's policy and procedure titled, Bedrooms, revised May 2017, the P&P indicated, Bedrooms measure at least 80 square feet of space per resident . Review of the facility's room variance reports recommend the waiver		