

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055959	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Watsonville Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 525 Auto Center Drive Watsonville, CA 95076	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>44577</p> <p>Based on interview, and record review, the facility failed to develop and implement care plans (a plan that provides direction on the type of nursing care the individual may need) for two of 19 sampled residents (38 and 66):</p> <ol style="list-style-type: none"> 1. For Resident 38, there was no care plan that addressed the long term care of her gastrostomy tube (g-tube, a surgical opening into the stomach for administration of nutrition and medications), no care plan developed for the use of an anticoagulant (a medication that prevents or reduces blood from clotting); and, 2. For Resident 66, a care plan for diabetes was not developed. <p>These failures had the potential for the facility to overlook care issues and render person-centered care plans lacking measures to address identified needs.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 38's face sheet indicated Resident 38 was admitted to the facility for multiple diagnoses that included hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (one-sided weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, chronic atrial fibrillation (an irregular and often very rapid heart rhythm), and dysphagia (difficulty swallowing). <p>Review of Resident 38's SBAR (Situation, Background, Assessment, Recommendation) communication forms indicated Resident 38 was transferred to the emergency department on 12/20/23 at 12:00 p.m. due to the g-tube coming out, and redness at the site, on 12/23/23 at 12:00 p.m. due to blood-tinged drainage at the g-tube site, and on 2/29/24 at 9:00 p.m. due to a dislodged g-tube.</p> <p>During a concurrent interview and record review on 3/7/24 at 4:22 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 38's medical record and care plans were reviewed. The care plans indicated there was no care plan for the long-term care of a g-tube. MDSC indicated there should be a care plan for the long-term care of Resident 38's g-tube.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 38's physician orders, dated 1/6/23, indicated, Apixaban Tablet 5 milligrams (MG) (a unit of measurement) via G-tube, two times a day for CVA [cerebral vascular accident, an interruption in the flow of blood to cells in the brain] prophylaxis [prevention].</p> <p>Resident 38's medical record lacked a care plan for the anticoagulation medication Apixaban.</p> <p>During an interview and concurrent medical record reviewed with Licensed Vocational Nurse (LVN) B on 3/8/24 at 11:40 a.m., she stated there was no care plan for the care and/or monitoring of Resident 38 for Apixaban and there should be.</p> <p>36623</p> <p>2. Review of Resident 66's clinical record indicated she was admitted to the facility with diagnoses including diabetes (a condition which affects the way the body processes blood sugar) and hypertension (high blood pressure).</p> <p>Review of Resident 66's physician orders indicated she had two orders for insulin, one to be given at night and sliding scale insulin (set of instructions for administering insulin dosages based on specific blood glucose readings).</p> <p>Review of Resident 66's care plans indicated the resident had no care plan that addressed her diagnosis of diabetes or use of insulin.</p> <p>During an interview with the minimum data set coordinator (MDSC) on 3/8/24 at 9:32 a.m., the MDSC confirmed Resident 66 did not have a care plan for diabetes. The MDSC stated there should be a diabetes care plan for Resident 66 to monitor for signs and symptoms of hyperglycemia (high levels of sugar in the blood) and hypoglycemia (low levels of sugar in the blood).</p> <p>Review of the facility's policy, Comprehensive Person-Centered Care Plans, revised 3/2023, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>44577</p> <p>Based on observation, interview, and record review the facility failed to ensure one of 19 sampled residents (Resident 38), was provided the necessary care to maintain good grooming and personal hygiene.</p> <p>This failure resulted in Resident 38 not receiving fingernail care and had the potential for infection and to negatively impact Resident 38's overall health.</p> <p>Findings:</p> <p>Review of Resident 38's face sheet indicated Resident 38 was admitted to the facility for multiple diagnoses that included hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (one-sided weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, muscle weakness, and dysphagia (difficulty swallowing).</p> <p>A review of Resident 38's Minimum Data Set (MDS, an assessment and care screening tool), dated 2/7/23, indicated Resident 38's cognitive skills (related to thinking, reasoning, decision-making, and problem solving) were severely impaired. The MDS indicated the resident was fully dependent on staff for dressing, eating, personal hygiene, and toilet use.</p> <p>During an observation in the resident dining/activities room on 3/4/24 at 10:35 a.m., Resident 38 sat in a wheelchair, Resident 38's fingers were noted to have brown/black substance under the nails of her right hand.</p> <p>During an observation in the resident dining/activities room on 3/6/24 at 2:04 p.m., Resident 38 sat in a wheelchair with a food tray. Resident 38's fingers were noted to have brown/black substance under the nails of her right hand.</p> <p>During an observation in Resident 38's room on 3/8/24 at 8:25 a.m., Resident 38 lay bed. Resident 38's fingers were noted to have a brown/black substance under the nails of her right hand.</p> <p>During an interview with Certified Nursing Assistant (CNA) D on 3/8/24 at 8:45 a.m., CNA D stated Resident 38's nails were dirty on the right hand. CNA D stated nails should be cleaned during every bath or shower.</p> <p>During an interview with Licensed Vocational Nurse (LVN) F on 3/8/24 at 9:38 a.m., LVN F stated nails should be nice and clean. Resident 38's shower days are Monday and Thursday during the evening (PM) shift and if the resident refused, the reason why should be documented.</p> <p>During an interview with the Nursing Supervisor (NS) on 3/8/24 at 10:08 a.m., the NS stated showers are documented in tasks including refusals and nail cleaning should be done during showers.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA G on 3/8/24 12:59 p.m., CNA G stated bed baths or partial baths, all include cleaning the hands and nails. CNA G stated Resident 38 is scheduled for PM shift; who do the total bath including the hair.</p> <p>During an interview in Resident 38's room with CNA D and CNA E on 3/8/24 at 2:34 p.m., CNA E stated, Resident 38's nails have been dirty all week and they should be cleaning the residents nails.</p> <p>During a review of the undated Resident shower schedule, the schedule indicated Resident 38 was scheduled for showers on PM shift on Mondays and Thursdays.</p> <p>During review of Resident 38's the task list, dated 3/2/24 thru 3/08/24, indicated Resident 38 received a bath/shower/bed bath 3/4/24 (Monday). There was no indication Resident 38 received a bath/shower/bed bath on 3/7/24 (Thursday) and there was no documented resident refusal.</p> <p>During a follow up interview with the NS on 3/8/24 at 2:56 p.m., the NS stated only scheduled days would be documented for showers. The NS confirmed Thursday 3/7/24 was a scheduled shower day that indicated NA, which meant a shower or bed bath was not given; and that, it should be documented if the resident refused.</p> <p>Review of the facility's policy and procedure titled, Care of Fingernails/Toenails, dated February 2023, indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . Nail care includes regular cleaning and regular trimming. Gently, remove the dirt from around and under each nail.</p> <p>Review of the facility's policy and procedure titled, Bathing/Showers, dated February 2023, indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin . Documentation . If the resident refused the shower.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44577</p> <p>Based on observation, interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for three of 19 sampled residents (Residents 38, 47, and 61) when:</p> <ol style="list-style-type: none"> 1. For Resident 38, levothyroxine (a medicine used to treat an underactive thyroid gland) was not administered per the manufacturer's specification; 2. For Resident 47, Lorazepam (a prescription medication used to manage anxiety) was signed out of the resident's Controlled Drug Record (CDR, or an inventory sheet that keeps record of the usage of controlled medications) when he did not have a physician order for Lorazepam. 3. Resident 61 did not have a smoking assessment completed. <p>These failures had the potential to compromise the residents' health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 38's face sheet indicated Resident 38 was admitted to the facility for multiple diagnoses that included hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (one-sided weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, chronic atrial fibrillation (an irregular and often very rapid heart rhythm), and dysphagia (difficulty swallowing). <p>Review of Resident 38's physician orders, dated 1/5/23, indicated Levothyroxine Sodium tablet, Give 12.5 mcg (micrograms, a unit of measure) via G-tube (gastrostomy tube is a tube inserted through the belly that brings nutrition /medications directly to the stomach) one time a day for hypothyroidism (condition in which the thyroid gland cannot make enough thyroid hormone to keep the body running normally) Give 12.5 mcg every day.</p> <p>Review of Resident 38's physician orders, dated 4/21/23, indicated External Feed Order in the afternoon for cyclic feed (an alternative to continuous tube feeding given at the same time each day for the same amount of time) Peptamen (a feeding formula) 1.5 at 60 ml (milliliters, unit of measure) x16 hours. Provides 960 mL (milliliters, a unit of measure)/1440 kcals (kilocalories, calories and kcal are units of measure for energy) 65 g (grams, unit of measure) of protein (a nutrient your body needs to grow and repair cells, and to work properly) Initiate at 5 p.m.- 9 a.m.</p> <p>Review of Resident 38's Medication Administration Record (MAR, a report detailing the drugs administered to a patient by a healthcare professional at a treatment facility) indicated Resident 38 received Levothyroxine at 9 a.m. everyday.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and concurrent record review on 3/8/24 at 11:50 a.m. with Licensed Vocational Nurse (LVN) B, LVN B stated Resident 38's Levothyroxine tablets were given at 9 a.m. immediately after the g-tube feeding was stopped. Concurrent review of [NAME].com (an online evidence-based referential drug information) indicated, Administer consistently in the morning on an empty stomach, at least 30 to 60 minutes before food. Do not administer within 4 hours of calcium or iron-containing products.</p> <p>Review of Resident 38's tube feeding Peptamen nutritional facts indicated the nutrient composition included calcium and iron.</p> <p>Review of the facility's policy and procedure, Administering Medications, dated April 2023 indicated, Medications are administered in a safe and timely manner, and as prescribed . Medication administration times are determined by resident need and benefit.</p> <p>46553</p> <p>2. The Controlled Drug Records (CDRs) for six random residents receiving PRN (as needed) controlled medications were requested for review during the survey.</p> <p>Review of Resident 47's CDR for Lorazepam 0.5 milligrams (mg, unit of measurement) indicated nursing staff signed out one tablet on 2/19/24, 2/20/24, and 2/24/24.</p> <p>Review of Resident 47's physician's orders indicated he had a previous physician's order for Lorazepam 0.5 milligrams to be administered every twelve hours as needed for anxiety with an end date of 2/14/24. It also indicated he had a current physician order for Lorazepam 0.5 milligrams to be administered every twelve hours as needed for anxiety with a start date of 2/26/24.</p> <p>During an interview with registered nurse H (RN H) on 3/6/24 at 3:21 p.m., RN H confirmed Resident 47 did not have a physician order for Lorazepam from 2/15/24 to 2/25/24.</p> <p>During an interview with the Nurse Supervisor (NS), on 3/7/24 09:47 a.m., the NS confirmed there was no active order during the time the three doses of Lorazepam were given. The NS further stated the nurse failed to verify to check the active orders of the Medical Administration Record (MAR).</p> <p>Review of the facility's policy and procedure (P&P), titled, Administering Medications, revised 4/23, it indicated Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>36623</p> <p>3. Review of Resident 61's clinical record indicated he was admitted to the facility with diagnoses including diabetes (a condition which affects the way the body processes blood sugar) and depression.</p> <p>During an interview with Resident 61 on 3/4/24 at 1:11 p.m., he stated he was a smoker.</p> <p>Review of a list of smokers provided by the facility indicated Resident 61 was a smoker.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 61's Admission/Readmission Data Tool, dated 1/31/24, indicated for the question, Does resident smoke? the answer was No. The following questions regarding smoking were left blank: What time of day does resident like to smoke? Can resident safely light and extinguish own cigarette? Select any adaptive equipment needed for the resident (smoking apron, cigarette holder, supervision, 1:1 assistance, other); Has a plan of care been developed for safe smoking?</p> <p>Resident 61 did not have a smoking assessment completed.</p> <p>Review of Resident 61's smoking care plan, dated 3/4/24, indicated he was at risk for injury related to smoking.</p> <p>During an interview with the minimum data set coordinator (MDSC) on 3/8/24 at 9:36 a.m., the MDSC confirmed Resident 61 did not have a smoking assessment; and that, he should have one.</p> <p>Review of the facility's policy, Smoking Policy - Residents, dated 1/2024, indicated, Resident smoking status is evaluated upon admission. If a smoker, evaluation includes:</p> <ul style="list-style-type: none"> a. Current level of smoking frequency. b. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. Desire to quit smoking; and d. Ability to smoke safely with or without supervision.

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623</p> <p>Based on interview and record review, the facility failed to implement fall-related interventions for one of two residents (Resident 32) when staff did not document Resident 32's skid mat (non-slip material) was in place on 6/17/23, when staff did not ensure Resident 32's sensor pad alarm (device that emits an audible alarm when pressure is removed from the sensor pad to alert the caregivers; such as, when the user gets out of a bed or wheelchair) orders were transcribed in the administration records for nurses to document pad placement and functioning, and when the facility failed to provide evidence of periodic staff training on the operation of the sensor pad alarm and daily device testing of the sensor pad alarm per manufacturer's recommendations. These failures in fall-related interventions led up to Resident 32's fall on 6/17/23, from which Resident 32 suffered a fractured clavicle (broken collar bone).</p> <p>Findings:</p> <p>Review of Resident 32's Post-Fall Review, dated 6/17/23, indicated the following: Resident 32 was self-ambulating [moving about] in a wheelchair in the hallway and had an unwitnessed fall on 6/17/23 at 4:23 p.m. Resident was observed lying on his right side in the hallway across from room [ROOM NUMBER]. Resident was several feet away from wheelchair. Resident's knees were bent towards chest and arms were in front, but bent at elbows . IDT [interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents] met to review Res [Resident 32's] recent falls which resulted in Fx [fracture] to R [right] clavicle . Resident was more alert . and self propelling throughout the facility more than usual. Res was noted with discoloration to right shoulder the following morning, MD [Doctor of Medicine] advised to transfer to ER [emergency room] where non-displaced [bone cracks or breaks and maintains proper alignment] clavicle Fx was noted . Upon further investigation it was determined that the pad alarm was in place, but did not sound. Facility staff to be provided in-service regarding proper placement/use of pad alarms.</p> <p>Review of Resident 32's Imaging Report, dated 6/18/23 indicated, 4 views of the right shoulder were performed . There is a nondisplaced fracture of the distal clavicle (a break in the collar bone on a side away from a person's midline).</p> <p>Review of Resident 32's Admission Record, printed 3/6/24, indicated the resident was admitted to the facility with diagnoses including dementia (a group of conditions affecting thinking and social abilities that interferes with daily functioning) and chronic obstructive pulmonary disease (a condition that affects airflow in the lungs and makes it difficult to breathe).</p> <p>Review of Resident 32's Post-Fall Reviews for 2022 indicated the resident had 11 fall incidents in 2022.</p> <p>Review of Resident 32's Post-Fall Reviews for 2023 indicated the resident had 12 fall incidents in 2023.</p> <p>Review of Resident 32's Post-Fall Reviews for 2024 indicated the resident had two fall incidents in 2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 32's minimum data set (MDS, an assessment tool), dated 6/13/23, indicated he required extensive assistance with one person for bed mobility and transfers.</p> <p>Review of Resident 32's Quarterly Risk Data Collection Tool/Fall Risk Assessment, dated 6/14/23, indicated Resident 32 was at risk for falls.</p> <p>Review of Resident 32's physician orders indicated, Pad alarm in wheelchair at all times for fall precautions, dated 2/14/22, Bed alarm [type of sensor pad alarm] when in bed at all times for fall precautions, dated 2/14/22, and [brand name of a skid mat product] to wheelchair cushion at all times, dated 8/24/22.</p> <p>Review of Resident 32's Treatment Administration Record (TAR, record of treatments given) for June 2023, indicated a physician order for, [brand name of a skid mat product] to wheelchair cushion at all times every shift, that was not signed by a nurse on 6/17/23 evening shift (3 to 11 p.m.) to indicate whether the order was carried out.</p> <p>Review of Resident 32's Medication Administration Record (MAR, record of medications given) for June 2023 and TAR for June 2023, yielded a lack of documentation to indicate Resident 32's pad alarms were on his wheelchair and bed at all times and whether they functioned.</p> <p>During an interview and record review with the nurse supervisor (NS) on 3/8/24 at 12:26 p.m., he stated it is the licensed nurse (LN) and certified nursing assistants' (CNA) responsibility to check that fall interventions are in place. The NS stated it is also the LN's and CNA's responsibility to check if safety devices, like pad alarms are functioning. The NS stated Resident 32's fall interventions, including the [brand name of a skid mat product], floor mat, and concave mattress (type of mattress with raised sides) are to be signed by nurses in the MAR or TAR when carried out; however, the physicians' orders for pad alarms were not transcribed in Resident 32's MAR; and that, they should have been in order for documentation of their positioning and functioning. The NS confirmed that Resident 32's Post-Fall Review, dated 6/17/23, indicated the IDT determined Resident 32's pad alarm did not sound. He stated he did not remember the reason Resident 32's pad alarm failed to sound.</p> <p>During an interview on 3/8/24 at 2:29 p.m., the NS confirmed Resident 32's [brand name of a skid mat product] placement was not signed in the TAR for the evening shift of 6/17/23. The NS stated he could not confirm whether the [brand name of a skid mat product] was checked.</p> <p>During an interview on 3/8/24 at 10:15 a.m. with the administrator-in-training (AIT), in-service training on the operation of the pad alarms was requested.</p> <p>During an interview with the director of staff development (DSD) on 3/08/24 at 10:21 a.m., in-service training on the operation of the pad alarms was requested. The DSD did not provide any in-service training on the operation of the pad alarms, even though it was requested of her again on 3/08/24 at 3:05 p.m.</p> <p>During an interview and concurrent record review with the NS on 3/8/24 at 3:04 p.m., he searched through an in-service binder for in-service training regarding the operation of pad alarms. The NS provided a copy of an in-service on pad alarms, dated 10/12/22, and stated it was for checking placement of the pad alarms only, and otherwise excluded instructions on the usage/operation of pad alarms. The NS stated he did not think there was an in-service on the usage/operation of pad alarms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the NS on 03/08/24 at 3:13 p.m., he stated he would look in a different binder for in-service training regarding the usage/operation of pad alarms; however, no evidence of such in-service training was provided.</p> <p>Review of the facility's policy, Falls and Fall Risk, Managing, revised 2/7/24, indicated, In conjunction with the attending physician, licensed staff will identify and implement relevant interventions to try to minimize serious consequences of falling.</p> <p>Review of an undated sensor pad(s) manufacturer's Installation and Use Instructions indicated, We recommend that all caregivers receive periodic training in the operation of these systems and that the devices are tested daily.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055959	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Watsonville Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 525 Auto Center Drive Watsonville, CA 95076	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>44577</p> <p>Based on interview and record review, the facility failed to monitor the side effects related to the use of Apixaban (an anticoagulant [blood thinner] medication that interrupts the formation of blood clots) for one of 19 sampled residents (Residents 38). This failure had the potential to affect the residents' physical well-being while in the facility.</p> <p>Findings:</p> <p>During a review of Resident 38's Medical Record (MR), the MR indicated Resident 38 was admitted to the facility for multiple diagnoses that included hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (one-sided weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, and chronic atrial fibrillation (an irregular and often very rapid heart rhythm).</p> <p>During a review of Resident 38's medical record, the physician orders, dated 1/6/23, indicated, Apixaban Tablet 5 milligrams (mg, a unit of measurement) via G-tube (a gastrostomy tube is a tube inserted through the belly that brings nutrition directly to the stomach) two times a day for CVA (cerebral vascular accident, or a brain attack, is an interruption in the flow of blood to cells in the brain) prophylaxis (prevention).</p> <p>During an interview and concurrent record review with Licensed Vocational Nurse (LVN) B on 3/8/24 at 11:20 a.m., LVN B stated for Resident 38's Apixaban, We should be monitoring for signs and symptoms of bleeding. Reviewing Resident 38's medical record indicated there was no documentation that monitoring for bleeding was documented. LVN B stated, No, it is not being done.</p> <p>Review of facility's policy titled Anticoagulation (Anticoagulants are sometimes referred to as blood thinners, and are drugs that prevent blood from clotting or prevent existing clots from getting larger) Clinical Protocol, dated November 2023, indicated, Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. a. Assess for evidence of effects related to the subtherapeutic (lower than that usually prescribed to treat a disease effectively) or greater than therapeutic drug level related to that drug if applicable. The staff and physician will monitor for possible complications in individuals who are being anticoagulated (a substance that hinders the clotting of blood) and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in the urine) hemoptysis (coughing up blood) or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46553</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when:</p> <ol style="list-style-type: none"> 1. An open box of tuberculin (use for skin test to determine exposure to tuberculosis) vial found in the medication refrigerator did not have an open date on the vial; 2. Medications were not properly labeled and stored in one of two inspected medication storage rooms; and, 3. Multiple loose tablets were observed in the two drawers of one medication cart. <p>These failures had the potential for residents to receive medications with reduced efficacy, inadequately monitored medications, and unlabeled medications, which could compromise residents' health and safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a medication room observation on 3/5/24 at 1:11 p.m., with Licensed Vocational Nurse (LVN) C, there was an open box of tuberculin vial in the medication refrigerator without an expiration date or open date written on the vial. <p>During a concurrent observation and interview with LVN C on 3/6/24 at 9:50 a.m., LVN C confirmed there was no open date on the tuberculin vial. LVN C stated it should be thrown out since she did not know when the medication vial was opened.</p> <p>During an interview with the Nurse Supervisor (NS) on 3/7/24 at 9:32 a.m., the NS confirmed the tuberculin vial had no open date.</p> <p>During a phone interview with the Pharmacy Consultant (PC) on 3/7/24 at 4:05 p.m., the PC stated the best practice is to put the open date on the vial once its opened.</p> <p>During a review of facility's policy and procedure (P&P), titled, Medication Labeling and Storage, revised 2/23, the P&P indicated, Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter date for the open vials.</p> <ol style="list-style-type: none"> 2. During an inspection of Medication Storage Station #3 with LVN B on 3/4/24 at 10:56 a.m., there was one bottle of Magnesium Oxide 400 mg tablet supplement, one bottle of Fish oil 500 mg soft gel dietary supplement, and one bottle of Folic acid 400 mcg tablet with no open dates to each of them. LVN B verified the medications were open with no labels of open date. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LVN B on 3/4/24 at 11:02 a.m., she stated once a medication is opened, the nurse should label it with an open date.</p> <p>During an interview with the NS on 3/7/24 at 9:27 a.m., the NS stated an opened medication should be discarded if it is found inside the storage room without a label to indicate the open date.</p> <p>Review of facility's policy and procedure (P&P), Administering Medications, revised 4/23, indicated, the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.</p> <p>3. During an inspection of the Station B medication cart B with LVN A on 3/6/24 at 11:02 a.m., there were multiple loose tablets observed in the middle section of the two drawers, which contained bubble packs of medications. These findings were verified by LVN A. She further stated these loose medicines should be in the drug buster (medication disposal system that deactivates non-hazardous medications).</p> <p>During an interview with the Director of Nursing (DON) on 3/7/24 at 9:37 a.m., she stated the assigned nurse should clean the medication cart and throw the loose meds in the drug buster.</p> <p>Review of facility's policy and procedure (P&P), Medication Labeling and Storage, revised 2/23, indicated, the nursing staff is responsible for maintaining medication storage preparation areas in a clean, safe, and sanitary manner.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44577</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired food items were not stored in the residents' refrigerator readily available for use when two boxes of Jevity (a calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition) was found unlabeled and expired in the residents' refrigerator.</p> <p>This failure had the potential to result in contaminated food and foodborne illnesses to an already vulnerable facility population.</p> <p>Findings:</p> <p>During a concurrent observation in the nurses' station and interview with the Director of Staff Development (DSD) on [DATE] at 9:31 a.m., two boxes of Jevity were observed in the residents' refrigerator. Both boxes had an expiration date of [DATE] printed on the box. The DSD stated she did not think they were for anyone; the expiration dates should be checked.</p> <p>Review of the facility's policy and procedure titled, Resident Food Refrigerator, dated [DATE], indicated, Foods that are in their original containers and have not been opened will be kept per the manufacturer's expiration date. Licensed nurses are responsible for ensuring food items in refrigerators, and freezers are not past the expiration dates.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46553</p> <p>Based on observation, interview, and facility record review, the facility failed to ensure infection control practices were followed for one of three residents (Resident 293) when licensed vocational nurse A (LVN A) did not perform hand hygiene during medication administration. This failure had the potential for transmission of infectious agents to residents.</p> <p>Findings:</p> <p>During a medication pass observation with LVN A on 3/5/24 at 8:22 a.m., LVN A took the blood pressure of Resident 293 and sanitized the blood pressure cuff. LVN A proceeded to prepare Resident 293's medications. LVN A administered the medications to Resident 293 without performing hand hygiene.</p> <p>During an interview with LVN A on 3/5/24 at 8:37 a.m., she stated she should have sanitized her hands after taking the resident's blood pressure and before popping out the medicine. LVN A confirmed she did not perform hand hygiene.</p> <p>During an interview with the Nurse Supervisor (NS) on 3/7/24 at 9:43 a.m., the NS stated when a nurse is giving medication, they need to do hand hygiene between each task.</p> <p>Review of facility's policy and procedure (P&P) titled, Handwashing /Hand Hygiene , revised 10/23, the P&P indicated, Personnel are trained and on the importance of hand hygiene . Indication for Hand Hygiene 1.a. immediately before touching resident . c. after contact with blood, body fluids, or contaminated surfaces.</p>