

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: 055959	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Certified Nursing Assistant E (CNA E) wore gloves when providing toilet hygiene and bed bath to Resident 20 who was on enhanced barrier precautions (EBP, an infection control strategy for healthcare settings, especially nursing homes, to reduce the spread of multidrug-resistant organisms - MDROs, germs that are resistant to many antibiotics - by requiring healthcare personnel to wear gowns and gloves during all high-contact resident care activities); 2. Licensed vocational nurse B (LVN B) did not sanitize her hands when she went from Resident 58's room to Resident 31's room; 3. The oxygen filters of Resident 31's, Resident 49's, Resident 58's, and Resident 60's oxygen concentrators were dirty, and the filter boxes were not dated; 4. Registered nurse D (RN D) threw the used blood lancet (a pricking needle used to obtain drops of blood for testing) on top of the lid of the sharp container; 5. Registered nurse D (RN D) did not disinfect the glucometer (a portable medical device used to measure the sugar level in a small sample of blood) between checking blood sugar level for Resident 94 and Resident 6; 6. Registered nurse A (RN A) placed one cup of medications on top of the medications in the other cup to bring them to Resident 54. RN A also did not disinfect the blood pressure cup before taking Resident 54's blood pressure; 7. Licensed vocational nurse B (LVN B) did not cleanse her hands and change gloves before administering fluticasone nasal spray (used to relieve allergy symptoms in the nose) to Resident 32; and 8. Certified nursing assistant F (CNA F) left the lunch cart door open, the dessert food was not covered while she brought the lunch trays to Resident 11 and his two roommates. These failures had the potential to spread infection to residents and staff. Findings: 1. During an observation on 8/25/25, at 10 a.m., CNA E was helping Resident 20 who was on EBP in his room, and she only had gloves on. During a concurrent interview with CNA E, she confirmed that Resident 20 was on EBP. CNA E stated Resident 20 had bowel movement, so she cleansed him and gave him a bed bath. CNA E stated she should wear a gown and gloves when she cleaned Resident 20 and gave him a bed bath. During an interview with the infection preventionist (IP) on 8/29/25, at 11:01 a.m., she stated the CNAs should wear gowns and gloves when cleaning and giving the residents bed baths. Review of the facility's policy, Enhanced Barrier Precautions, dated 8/2022, indicated . 2. EBPs employ targeted gown and glove use during high contact resident care activities . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include a. Dressing . c. providing hygiene d. changing linens e. changing briefs or assisting with toileting. 2. During an observation on 8/25/25, at 10:30 a.m., LVN B checked the filter of Resident 58's oxygen concentrator, then she went to Resident 31's room to check the filter of his oxygen concentrator without sanitizing her hands. During a concurrent interview with LVN B, she stated she should sanitize her hands when she went from one resident's room to another. Review of the facility's policy, Handwashing/Hand Hygiene, dated 10/2023, indicated . 1. Hand hygiene is indicated: . e. after touching the resident's environment . 3. During an observation and interview with LVN B on 8/25/25, from 10:25 a.m. to 10:35 a.m., the filters of Resident 31's, Resident 49's, Resident 58's, and Resident 60's oxygen concentrators were dirty, and the filter boxes were not dated. LVN B confirmed that the filters of Resident 31's, Resident 49's, Resident 58's, and Resident 60's oxygen concentrators were dirty, and the filter boxes were not (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dated. During an interview with the director of staff development (DSD) on 8/25/25, at 10:52 a.m., she stated the filter boxes should be dated. During an interview with the IP on 8/29/25, at 11:09 a.m., she stated the staff should sanitize their hands when going out of the residents' rooms. The filter of the oxygen concentrator should be kept clean and should be cleansed every week. Review of the facility's Oxygen Concentrator Guide indicated that the recommended cleaning interval for filter door vents was 7 days. 4. During a medication pass observation with RN D on 8/25/25, at 11:47 a.m., after obtaining Resident 94's drops of blood with a lancet for checking his blood sugar level, RN D threw the lancet on top of the lid of the sharp container. During an interview with RN D on 8/25/25, at 11:55 a.m., she confirmed that she threw the lancet on top of the lid of the sharp container. RN D acknowledged that she should have throw the lancet inside the sharp container and not on top of its lid. Review of the facility's policy, Obtaining a Fingerstick Glucose Level, dated 10/2011, indicated . 16. Dispose of the lancet in the sharp disposal container. 5. During a medication pass observation with RN D on 8/25/25, at 11:47 a.m., after obtaining Resident 94's blood sugar level with the glucometer, RN D did not disinfect the glucometer. During a medication pass observation with RN D on 8/25/25, at 12:06 p.m., RN D used the same glucometer to obtain Resident 6's blood sugar level without disinfecting it before use. During an interview with RN D on 8/25/25, at 12:12 p.m., RN D acknowledged that she should have disinfect the glucometer between use on different residents. Review of the facility's policy, Obtaining a Fingerstick Glucose Level, dated 10/2011, indicated . 18. Clean and disinfect reusable equipment between uses . 6. During a medication pass observation on 8/26/25, at 4:02 p.m., RN A placed Resident 54's two tablets of lanthanum carbonate (used to treat too much phosphate in the blood) in one medicine cup and 6 tablets of Resident 54's other medications in another medicine cup. Then RN A placed the cup with two tablets of lanthanum carbonate on top of the 6 tablets of other medications in the other cup to bring the two cups to Resident 54 to take. During a concurrent medication pass observation, RN A needed to obtain Resident 54's blood pressure before administering carvedilol (used to treat high blood pressure) 25 milligrams (mg, a metric unit of mass) one tablet to her. RN A went to look for a blood pressure machine, brought it to Resident 54's room, and applied the blood pressure cup on Resident 54's arm took her blood pressure without disinfecting the cup. During an interview with RN A on 8/26/25, at 4:38 p.m., RN A confirmed that she placed the cup with two tablets of lanthanum carbonate on top of the 6 tablets of other medications in the other cup to bring the two cups to Resident 54 to take, and she did not disinfect the blood pressure cup before applying it on Resident 54's arm. RN A stated she should not place one cup of medications on top of the other cup because the bottom of the cup might not be clean, and she should disinfect the blood pressure cup before taking the residents' blood pressure. Review of the facility's policy, Cleaning and Disinfecting, dated 5/2023, indicated . 4. Non-disposable medical equipment used for that resident is cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident. 7. During a medication pass observation on 8/27/25, at 9:54 a.m., LVN B put on gloves, took Resident 32's blood pressure, applied lidocaine (used to relieve pain) 4% one patch to Resident 32's left thigh, then without cleansing her hands and changing gloves, LVN B administered one spray of fluticasone 50 micrograms (mcg, a metric unit of mass)/actuation (act, a single puff or spray) to each of Resident 32's nostrils. During an interview with LVN B on 8/27/25, at 10:15 a.m., she acknowledged that she should have cleanse her hands and change gloves before administering fluticasone nasal spray to Resident 32's nostrils. During an interview with the IP on 8/29/25, at 11:14 a.m., she stated the licensed nurse should have place the lancet inside the sharp container not on top of its lid and disinfect glucometer between residents. The licensed nurse should not stack one cup of medicine on top of the medications in the other cup because the bottom of the cup might not be clean. The licensed nurse should have disinfect the blood pressure cup before taking the residents' blood pressure and should have cleanse hands and change gloves before administering the nasal spray to the residents. Review of the facility's policy, Administering Medications, dated 4/2023, indicated . 19. Staff follows established facility infection control procedures for the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administration of medications, as applicable. 8. During an observation on 8/25/25, at 12:25 p.m., CNA F pushed the lunch cart to the front of Resident 11's room. CNA F opened the door of the lunch cart and left it open the whole time that she brought the lunch trays to Resident 11 and his two roommates, Resident 12 and Resident 3, prepared the lunch for them, and talked to them in their room. The dessert cups on resident lunch trays in the lunch cart had no lid and were not covered, and there were no other staff around the lunch cart. During a concurrent interview with CNA F, she confirmed that she left the door of the lunch cart open; the dessert cups on resident lunch trays in the lunch cart had no lid and were not covered, and there were no other staff around the lunch cart. CNA F acknowledged she should close the door of the lunch cart while she was in the resident's room. During an interview with the IP on 8/29/25, at 11:11 a.m., she stated the staff should have close the door of the lunch cart while they were in the resident's room.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that meet professional standards for two of 20 residents (2 and 54) when:1. Registered nurse A (RN A) left two tablets of lanthanum carbonate (used to treat too much phosphate in the blood) with Resident 54 and did not observe Resident 54 taking the medication during meds administration; and 2. RN A did not verify the placement of Resident 2's jejunostomy tube (J-tube, a medical device that is surgically placed through the abdominal wall directly into the middle part of the small intestine to deliver liquid nutrition, fluids, and medications directly to the small intestine) before administering Resident 2's medications through his J-tube, and RN A did not flush Resident 2's J-tube with 30 milliliters (ml, and metric unit of volume) of water before and after administering his medications as ordered by the physician.This failure had the potential to result in the residents not taking medications as prescribed by the physician and being at risk of aspiration. Findings:1. Review of Resident 54's admission Record indicated she was admitted to the facility on [DATE].During a medication pass observation on 8/26/25, at 4:02 p.m., RN A placed Resident 54's two tablets of lanthanum carbonate in one medicine cup and 6 tablets of Resident 54's other medications in another medicine cup.RN A handed the two medicine cups to Resident 54. Resident 54 finished taking the 6 tablets in one medicine cup, but she had not taken the two tablets of lanthanum carbonate yet. RN A started obtaining Resident 54's blood sugar. RN A left the two tablets of lanthanum carbonate there with Resident 54 and went back to her medication cart to chart the blood sugar and draw the insulin lispro (used to treat high blood sugar levels). When RN A went back to Resident 54 to administer insulin lispro to her, the two tablets of lanthanum carbonate were no longer there.During an interview with RN A on 8/26/25, at 4:38 p.m., she acknowledged that she should not leave the two tablets of lanthanum carbonate with Resident 54 and she should have stay and observe Resident 54 taking them. 2. Review of Resident 2's admission Record indicated he was admitted to the facility on [DATE].Review of Resident 2's physician order, dated 3/21/25, indicated he had a physician order for the licensed nurse to flush his J-tube with 30 ml of water before and after medication.During a medication pass observation on 8/26/25, at 4:43 p.m., RN A did not verify the placement of Resident 2's J-tube before administering Resident 2's medications through his J-tub. RN A flushed Resident 2's J-tube with 20 ml of water before medication and two times of 40 ml, total 80 ml of water after medication.During an interview with RN A on 8/26/25, at 5:12 p.m., RN A reviewed Resident 2's physician orders and acknowledged that she should have verify the placement of Resident 2's J-tube before administering Resident 2's medications and flush his J-tube with 30 ml of water before and after medication as ordered by the physician.Review of the facility's policy, Administering Medication through an Enteral Tube, dated 11/2018, indicated . Steps in the Procedure: . 6. Verify placement of feeding tube . 7. Stop feeding and flush tubing with at least 15 ml of water (or prescribed amount) . 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of water (or prescribed amount).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 22.22% when 6 medication errors occurred out of 27 opportunities during medication administrations for four out of 8 residents (2, 3, 6, and 54). This failure resulted in medications not given in accordance with the prescriber's orders which resulted in residents not receiving the therapeutic effects of the medications. Findings: 1. During a medication pass observation on 8/25/25, at 11:32 a.m. with registered nurse D (RN D), RN D obtained Resident 3's blood sugar, and it was 229. RN D set 4 units on Resident 3's insulin pen (look like writing pen except it contains insulin instead of ink, and it uses a needle instead of a pen tip) of insulin lispro (used to treat high blood sugar) 100 units/milliliters (ml, a metric unit of volume) and administered them to Resident 3 without priming the insulin pen (the process of removing any air bubbles from the needle and insulin cartridge before an injection; this is a critical safety step that ensures the correct dose is delivered and that the pen is functioning properly). During a concurrent interview with RN D, she confirmed that she did not prime Resident 3's lispro insulin pen before administering 4 units of insulin lispro to him. RN D stated she should have prime Resident 3's lispro insulin pen with 2 units of insulin lispro before administering 4 units of insulin lispro to him, otherwise it would have been a wrong dose. Review of the facility's Instruction for Use, BD AutoShield Duo, indicated . 1.3 Check if the pen needle is attached correctly - dial 2 units, point the pen up and press the thumb button. 2. During a medication pass observation on 8/25/25, at 12:06 p.m. with RN D, RN D obtained Resident 6's blood sugar, and it was 78. RN D told Resident 6 no insulin and did not administer any unit of insulin to Resident 6. Review of Resident 6's physician order, dated 8/8/25, indicated Resident 6 was to receive 10 units of insulin lispro one time a day for lunch time if his blood sugar was less than 120. During an interview with RN D on 8/26/25, at 12:10 p.m., RN D reviewed Resident 6's physician orders and acknowledged that she should have administer 10 units of insulin lispro to Resident 6 when his blood sugar was 78. Review of the facility's policy, Administering Medications, dated 4/2023, indicated . 4. Medications are administered in accordance with prescriber orders . 3. During a medication pass observation with registered nurse A (RN A) on 8/26/25, at 4:02 p.m., RN A obtained Resident 54's blood sugar, and it was 161. RN A stated per the insulin sliding scale (a regimen that adjusts the dose of insulin based on a resident's current blood sugar level), Resident 54 was to receive 1 unit of insulin lispro. RN A stated per physician order, Resident 54 was also to receive 5 units of insulin lispro in conjunction with the sliding scale. So, she would administer a total of 6 units of insulin lispro to Resident 54. RN A set 6 units on Resident 54's insulin pen of insulin lispro 100 units/ml and administered them to Resident 54 without priming the insulin pen. During an interview with RN A on 8/26/25, at 4:38 p.m., she confirmed that she did not prime Resident 54's lispro insulin pen before administering 6 units of insulin lispro to her. RN A stated she should have prime Resident 54's lispro insulin pen with 2 units of insulin lispro before administering 6 units of insulin lispro to her, otherwise it would be a wrong dose. Review of the facility's Instruction for Use, BD Auto Shield Duo, indicated . 1.3 Check if the pen needle is attached correctly - dial 2 units, point the pen up and press the thumb button. 4. During a medication pass observation with RN A on 8/26/25, at 4:43 p.m., RN A stated she did not have glycopyrrolate (used to treat open sores in the digestive tract) 1 milligram (mg, a metric unit of mass)/5 milliliters (ml, a metric unit of volume) on hand to give to Resident 2. During a concurrent medication pass observation, RN A crushed midodrine (used to treat low blood pressure) one 10 mg tablet, mixed it with 10 ml of sucralfate (used to treat open sores in the digestive tract) 1 gram (gm, a metric unit of mass)/10 ml, then mixed them with water, and administered them to Resident 2 through his jejunostomy tube (J-tube, a medical device that is surgically placed through the abdominal wall directly into the middle part of the small intestine to deliver liquid nutrition, fluids, and medications directly to the small intestine). During an interview with RN A on 8/26/25, at 5:12 p.m., she acknowledged that she should have administer midodrine and sucralfate to Resident 2 separately through his J-tube. Review of (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's physician order, dated 8/18/25, indicated he was to receive 5 ml of glycopyrrolate 1 mg/5 ml three times a day for excessive secretion. Review of the facility's job description, Registered Nurse Supervisor, indicated . Essential Duties and Responsibilities: . Maintaining medicine supply room well stocked. Review of the facility's policy, Administering Medication through an Enteral Tube, dated 11/2018, indicated . General Guidelines: . 3. Administer each medication separately and flush between medications.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food serving items were air-dried prior to stacking them, when serving trays and plate covers were observed to be wet while stacked. This failure had the potential of causing food-borne illnesses in the resident population of those who ate food from the kitchen. Findings: During the initial kitchen tour on 8/25/2025 @ 9:49 a.m., serving trays and plate covers were stacked on the counter by the steam table, some of them still remained wet. During a subsequent interview with the dietary manager (DM), and the registered dietician (RD) standing there, the DM acknowledged the wet trays and wet plate covers. DM stated they should have been air-dried, if they are still wet they would have been dried with blue cloth Wiper towels by vendor ? During a subsequent interview with the dietary aide (DA), she stated the trays and plate covers are usually air-dried, but if they don't dry completely, it was okay to use the blue Wiper towels by vendor ? to dry them. During a review of the facility's policy and procedure (P&P) titled Dishwashing Machine Use, revised 03/2010, the P&P indicated 1. The following guidelines will be followed when dishwashing: . After running items through entire cycle, allow to air-dry.		

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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 interview and record review, the facility failed to ensure one of two residents (7) receive care and services for the provision of dialysis (procedure to remove waste or toxins from the blood and adjust fluid and electrolyte imbalances) consistent with professional standards of quality when licensed vocational nurse B (LVN B) did not check Resident 7's bruit (an audible vascular sound associated with turbulent blood flow usually heard with the stethoscope). These failures had the potential for delayed detection, reporting, and management of complications from the dialysis shunt for the residents. Findings: Review of Resident 7's admission Record indicated he was admitted to the facility on [DATE] with dependence on renal dialysis diagnosis. Review of Resident 7's physician orders, dated 1/2/25, indicated he had orders for the licensed nurse to monitor bruit and thrill (a vibration that is felt on the skin overlying a dialysis shunt) of dialysis shunt every shift and monitor dialysis shunt to left forearm for tenderness, redness, or bleeding every shift. During an interview with LVN B on 8/28/25, at 12:30 p.m., she stated Resident 7 was a dialysis resident. She checked the thrill at his dialysis shunt, but she did not check the bruit. LVN B stated she did not know how to check the bruit. Review of the facility's policy, Renal Dialysis, Care of Residents, dated 12/2013, indicated . Standard: 1. Access site care will be provided by a licensed nurse, with physician's order. 2. Access site care is checked for condition and patency every shift . Routine Access Site Care Guidelines: . 3. Routine access checks for bruit once per shift.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored appropriately when overused-by date insulin was found in Station 3 medication cart. This failure resulted in the overused-by date insulin being administered to Resident 32. Findings: On 8/25/25, at 12:55 p.m., during an observation of Station 3 medication cart with licensed vocational nurse B (LVN B), one insulin Lantus (used to control high blood sugar levels) 100 units/milliliters (ml, a metric unit of volume) pen for Resident 32 dated to be discarded on 8/23/25. During a concurrent observation, interview, and review record with LVN B, she observed Resident 32's insulin Lantus pen and she confirmed that it should have been discarded on 8/23/25. LVN B also confirmed that Resident 32 received 10 units of insulin Lantus from this insulin pen on 8/24/25. Resident 32 had no other insulin Lantus pen in Station 3 medication cart. Review of the facility's policy, Medication Labeling and Storage, dated 2/2023, indicated . 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		