

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Carmel Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23795 W. R. Holman Highway Monterey, CA 93940	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>28193</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure licensed staff locked 1 of 4 medication carts when the cart was not within the sight of the nurse during medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2019, revealed, 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.</p> <p>During medication administration observation on 12/17/2024 at 8:24 AM, a medication cart was found unlocked, and Licensed Vocational Nurse (LVN) #1 was in a resident room, behind a privacy curtain and the medication cart was out of her line of sight. Three minutes later, LVN #1 returned to the medication cart. At 8:38 AM, 8:42 AM, and 8:56 AM, LVN #1 left the medication unlocked and out of her sight when she administered medication to Residents #9, #10, and #61.</p> <p>During an interview on 12/17/2024 at 9:13 AM, LVN #1 stated she should have locked the medication cart when she walked away from the medication cart. LVN #1 acknowledged she left the medication cart unlocked for the entirety of the medication pass that began at 8:24 AM. Per LVN #1, it was the policy of the facility to lock the medication cart every time the nurse walked away from it to keep residents and staff from having access to the medications inside the cart.</p> <p>During an interview on 12/18/2024 at 12:03 PM, the Director of Nursing (DON) stated LVN #1 made her aware that she left the medication cart unlocked when she administered medications to multiple residents. The DON stated she expected the nurses to lock the medication cart when they walked away from the medication cart every time. Per the DON, the medication carts should always be locked when the medication cart was not within the nurses' line of sight.</p> <p>During an interview on 12/19/2024 at 8:23 AM, the Administrator stated he expected the medication cart to be locked when it was unattended.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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** 39438</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure food was thawed per the facility policy, there was not a crack in the kitchen floor, utensils were stored per the facility policy, the food drains were cleaned daily, there was not a build-up around the ice machine dispenser, and expired food items were discarded after their expiration date. These deficient practices had the potential to affect all residents who received food from the kitchen.</p> <p>Findings included:</p> <p>A facility policy titled, Handling Clean Equipment and Utensils, with a copyright date of 2017, revealed 4. Stored utensils should be covered or inverted whenever possible.</p> <p>A facility policy titled, General Food Preparation and Handling, with a copyright date of 2017, revealed, 3. Food Preparation a. Meats, fish and poultry will be defrosted using safe thawing practices: In the refrigerator in a drip proof container, and in a manner that prevents cross contamination. In the microwave if foods are cooked and served immediately after defrosting. In the sink, submerging the item under cold water that is running fast enough to agitate and float off loose ice particles.</p> <p>A facility policy titled, Floor Safety, with a copyright date of 2017, revealed, Floors will be maintained to maximize safety.</p> <p>A facility policy titled, Ice Machine Cleaning, dated ,d+[DATE], revealed Ice machine and equipment will be cleaned on a regular schedule. Daily Housekeeping will wipe down the exterior of the ice machine daily, with special attention to the hard water deposits.</p> <p>During a concurrent interview and observation of the kitchen on [DATE] at 9:19 AM, the surveyor noted forks on a three-tier rack that were not inverted and eight bags of extra lean pork tenderloin in a clear container of room temperature water on the sink. [NAME] #2 stated the extra lean pork tenderloin was in the sink thawing as it was to be served for lunch on [DATE]. Also noted was a huge crack in the unlevelled floor from the entry door of the kitchen to the back of the freezer.</p> <p>During an interview on [DATE] at 9:39 AM, the Certified Dietary Manager (CDM) stated she pulled the pork out on [DATE] at 6:30 AM. Per the CDM, the pork should not have been thawing in the sink. The CDM stated it was an ongoing issue with the floor in the walk-in freezer. The CDM stated the forks should have been inverted.</p> <p>During an observation on [DATE] at 10:33 AM, the surveyor noted the ice machine in the hallway outside of room [ROOM NUMBER] had a whitish build-up around the dispenser.</p> <p>During an observation on [DATE] at 10:45 AM, the surveyor noted the drain underneath the dish machine was filled with food debris.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation of the nourishment refrigerator on Unit 2 on [DATE] at 10:50 AM, there were two 5.3-ounce containers of low-fat plain yogurt with an expiration date of [DATE].</p> <p>During a concurrent observation and interview on [DATE] at 11:09 AM, the surveyor noted the drain underneath the dish machine was filled with food particles. The CDM stated the drains should be cleaned every night.</p> <p>During an interview on [DATE] at 11:10 AM, the CDM stated utensils should be inverted because if someone was to pick a utensil up that was inverted, they would be touching the part of the utensil used to eat, which could cause cross contamination. The CDM stated food should be thawed under running water.</p> <p>During a follow-up interview on [DATE] at 11:24 AM, the CDM stated expired food items should be discarded.</p> <p>During an interview on [DATE] at 1:18 PM, the Director of Nursing (DON) stated utensils should be stored inverted and meat should be thawed in the refrigerator or under a steady flow of cold water. The DON stated she did not know the process for the cleaning of the food drains.</p> <p>During a follow-up interview on [DATE] at 1:27 PM, the DON stated the floor in the walk-in freezer buckled and the facility had a bid out to get it repaired.</p> <p>During an interview on [DATE] at 8:02 AM, the Administrator stated the utensils should be inverted and handled by the handle and food should be thawed in the refrigerator or under a steady stream of water. The Administrator stated he expected the ice machine to get wiped down daily by housekeeping and cleaned quarterly by a service technician. Per the Administrator, the floor could pose a safety hazard. According to the Administrator, dietary and nursing staff should check the dates on food in the nourishment refrigerator for expiration dates and the food drains should be cleaned daily.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28193</p> <p>Based on interview, document review, and facility policy review, the facility failed to develop a water management program that specified a detailed description and diagram of the water system in the facility. This deficient practice had the potential to affect all 91 residents who currently reside in the facility.</p> <p>Findings included:</p> <p>A facility policy titled, Legionella Water Management Program, revised 07/2017, revealed</p> <p>3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria could grow and spread, and to reduce the risk of Legionnaires' disease. The policy specified, 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers; (7) Hot tubs; (8) Fountains; and (9) Medical devices such as CPAP [continuous positive airway pressure] machines, hydrotherapy equipment, etc. [et cetera].</p> <p>The undated facility Legionella Environmental Assessment Form, revealed no evidence to indicate a detailed description and diagram of the water system in the facility.</p> <p>During an interview on 12/18/2024 at 2:15 PM, the Maintenance Supervisor stated the facility briefly discussed the need to have a water management program; however, they did not currently have water flow diagram.</p> <p>During an interview on 12/18/2024 at 2:35 PM, the Administrator stated the facility did not have a water flow diagram for the facility.</p> <p>During an interview on 12/19/2024 at 8:36 AM, the Director of Nursing stated she deferred to the Administrator for expectations of the facility water management system.</p> <p>During an interview on 12/19/2024 at 8:28 AM, the Administrator stated the facility should have assembled a flow diagram of the facility's water flow to learn how to identify and prevent the growth of Legionella.</p>		