STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily staffing information posted was for the current day. This failure had the potential to result in nurse staffing misinformation to residents, families, and visitors.Findings:During a concurrent observation and interview with the director of nursing (DON) on 4/15/2026 at 9:48 a.m., in nurse station AA (NS AA), there was no daily staffing information posted. The DON confirmed the observation and tried to look around NS AA. The DON walked to the lobby's glass covered cork board and found the daily staffing information posted was dated 1/9/2025.During an observation on 4/15/2026 at 9:53 a.m., in nurse station BB (NS BB), there was a daily staffing information posted, dated 1/9/2025.During an interview with the administrator (ADM) on 4/15/2026 at 10:07 a.m., informed the ADM about the daily staffing information found posted in the lobby and in NS BB were dated 1/9/2025. The ADM stated the daily staffing information should have been updated daily and posted at the lobby.During a review of the facility's policy and procedure titled, Posting Direct Care Daily Staffing Numbers, date revised 8/2022, indicated, Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to employ the director of food and nutrition services when the registered dietician was only employed part-time. This failure had the potential to negatively impact on food quality, sanitation, meal service, and residents' nutritional status for 92 residents in the facility.Findings:During a concurrent observation and interview on 4/13/2026 at 11:06 a.m. with the Head [NAME] (HC) in the kitchen, Dietary Manager (DM) was not present. The HC stated the prior DM resigned about 2 months ago, and the facility was in the process of recruiting a new one. The HC temporarily managed the kitchen.During an interview on 4/13/2026 at 11:30 a.m. with the administrator (ADM), the ADM stated the DM resigned since 2/12/2026. The facility only had part-time Registered Dietician (RD), who worked around 24 hours a week.During an interview on 4/13/2026 at 11:55 a.m., the ADM stated both the ADM and HC oversaw the overall operation of the kitchen now. RD's responsibilities were mainly to coordinate the menu, meet the residents, complete dietary profile, and resident assessment.During an interview on 4/14/2026 at 9:44 a.m., the HC stated he helped to oversee the dietary services temporarily. Previous DM taught him about dietary tasks.During an interview on 4/14/2026 at 2:37 p.m., the ADM stated there was no formal assignment for HC to manage the dietary tasks, he just temporarily took care of the kitchen because he had a lot of experience on food preparation and securing supplies. If HC had any issue, he would reach out to RD or ADM. The HC did not have dietary manager's degree.During a review of HC's credentials on 4/16/2026, HC's inservice training related to dietary tasks was requested. However, the ADM could not provide the inservice records.A review of undated Job Description of Director of Food & Nutrition Services (F&NS) indicated, . JOB DESCRIPTION: - Promote the core values of [facility name]. - Schedule and supervise the F&NS staff providing inservice training. - Responsible for the preparation and service of all food and ensures that approved menus and recipes are followed. - Plan the kitchen procedure to have food ready appropriately, serving hot food hot and cold food cold. - Test prepared food by taste to ensure properly cooked and seasoned. - Responsible for maintaining a clean and sanitary condition of kitchen equipment. - Maintain weekly inventory of food. - Make menu adjustments. - Maintain resident diet card. Verify diets. - Visit with residents to determine food acceptance and preferences. - Responsible for the ordering of food and supplies. - Complete Nutritional Screening form. - Attend weight variance meetings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper sanitation of two ice machines (one was in the utility room, one was in the hallway) when there was buildup around the ice dispenser chutes and ice discharge chutes of the two ice machines. These failures had the potential to increase the risk of food contamination to 92 residents in the facility.Findings:During an interview on 4/15/2026 at 9:46 a.m. with the Director of Environmental Services (DES), the DES stated there were two ice machines in the facility under the responsibility of maintenance services. The ice machines were cleaned internally by a contracted company every 90 days. The maintenance staff used sanitizer to wipe externally every day. 1. During a concurrent observation and interview on 4/15/2026 at 9:51 a.m. with the DES in the utility room near Station 2, an ice machine was observed to have white/yellow/orange/gray buildup around the ice dispenser chute. The DES stated the area around the ice dispenser chute looked like corrosive; it could be because of the age of the ice machine. He stated it was not clean and should be replaced.During a concurrent interview and record review on 4/15/2026 at 11:34 a.m. with the DES, an invoice of ice machines' cleaning from a contracted company, dated 1/14/2026 was reviewed. The invoice indicated on 1/8/2026 the company provided Maintenance the ice machines. Completion Notes: Completed preventative Maintenance the ice machines. Flushed out the evaporators, Started up the machines and tested operation both, Dumped the ice to flushed out, Cleaned machines, replaced water filters, tested operation both machines making ice properly. I did notice rust buildup on and around bin metal housing, . would like a quote for two new machines. The DES agreed that the report did not mention whether the ice dispenser chutes of the two ice machines were cleaned.During a concurrent observation and interview on 4/16/2026 at 8:54 a.m. with the contracted company's Refrigerator Technician (CRT) in the utility room near Station 2, ice dispenser chute was observed to have white/yellow/orange/gray buildup. CRT stated the buildup was the scale from the moisture and water due to hard water. CRT stated cleaning every three months was typical for ice machines because the manufacturer normally recommended every three to six months. It could be because the ice machine was getting up their age, it should be replaced.During a concurrent observation and interview on 4/16/2026 at 9:15 a.m. with the CRT in the utility room near Station 2, the company's Service Technician (CST) opened the top compartment of the ice machine, and the top of the ice discharge chute was observed to have black/yellow buildup. The CRT stated it was grease scale from hard water.During a concurrent observation and interview on 4/16/2026 at 10:20 a.m. with the CRT in the utility room near Station 2, the ice machine had been cleaned internally. The buildup on the top of the ice discharge chute was removed. For ice dispenser chute, the buildup was removed, but the area around the chute was rough and still had black/orange strains. The CRT stated it was because of the age of the machine, and they could only remove the scale.2. During a concurrent observation and interview on 4/15/2026 at 9:48 a.m. with the DES in the hallway near Station 2, an ice machine was observed to have white/yellow/black buildup around the ice dispenser chute. The DES stated the buildup was from hard water because the facility did not have water softener. He believed the buildup needed to be cleaned.During an observation on 4/16/2026 at 11:28 a.m. in the hallway near Station 2, the CST opened the top compartment of the ice machine. The top of the ice discharge chute was observed to have black/yellow buildup, and the ice dispenser chute had white/black/orange scale around the chute area. During an observation on 4/16/2026 at 11:55 a.m. in the hallway near Station 2, the contracted company staff had cleaned the top compartment of the ice machine. The buildup on the top of the ice discharge chute was removed and cleaned.During an observation on 4/16/2026 at 12:30 p.m. in the hallway near Station 2, the contracted company staff had cleaned the ice dispenser chute of the ice machine. The buildup could be removed, but the rough area around the chute still had black/white/yellow strains.According to the 2022 Federal Food Code, food-contact surfaces are to be (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	smooth, free of open seams, cracks, chips, inclusions, pits, and similar imperfections. Food-contact surfaces are to be clean to sight and touch. In addition, nonfood-contact surfaces are to be kept free of an accumulation if debris and are to be free of unnecessary projections, crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.

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	056055	A. Building B. Wing	04/17/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain respect and dignity for 9 of 18 sampled residents (Residents 61 69, 19, 95, 90, 3, 93, 54, and 39) when:1.Residents 61, 69, 19, 95, and 90's care instructions were posted above their head of bed's (HOB) wall, and other side of their room wall uncovered in a shared room;2. Residents 3, 93, and 54's care instructions were visibly posted; and,3. Resident 39's urine drainage bag (a pouch that attaches to a urinary catheter and collects urine) was not covered with a privacy bag.These failures had the potential to negatively affect residents' emotional and psychosocial well-being.Findings: 1a. Review of Resident 61's clinical record titled, admission Record, indicated Resident 61 was admitted to the facility with diagnoses including polyneuropathy (a condition where multiple nerves throughout the body are damaged simultaneously causing numbness, tingling or pain, typically starting in the feet and hands), type 2 diabetes mellitus (DM - a condition which affects the way the body processes blood sugar), and mild cognitive impairment (MCI – involves more frequent and noticeable issues, such as frequently forgetting important events or struggling to follow a conversation). Review of Resident 61's quarterly minimum data set (MDS – a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 61's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 07 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Review of Resident 61's Order Summary Report, indicated an order dated 1/2/2026, INSTRUCT CNA [certified nursing assistant] TO PUT PATIENTS DENTURES IN BEFORE BREAKFAST AND REMOVE AT NIGHT one time a day. During an observation on 4/13/2026 at 10:45 a.m., inside Resident 61's room, Resident 61 was seated on a chair, and the CNA was filing Resident 61's fingernails. There was a care instruction posted above her HOB wall indicated, CNA'S: Please assist patient with her dentures. ON before meals, and OFF after dinner. Thank you. During a concurrent observation and interview with certified nursing assistant O (CNA O) on 4/14/2026 at 9:12 a.m., inside Resident 61's room, the care instruction was still posted and CNA O confirmed above observation. CNA O stated the care instruction was a reminder for some people. During another observation on 4/15/2026 at 9:45 a.m., inside Resident 61's room, the care instruction was still visibly posted. 1b. Review of Resident 69's clinical record titled, admission Record, indicated Resident 69 was admitted to the facility with diagnoses including unspecified dementia (a decline in mental capacity affecting daily function), and type 2 DM. Review of Resident 69's Annual MDS assessment dated [DATE] indicated Resident 69's BIMS score was 10, with moderate cognitive impairment. (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/13/2026 at 10:47 a.m., inside Resident 69's room, Resident 69 was not in her room, and a care instruction was observed visibly posted above her HOB's wall indicated, PLEASE ONLY USE SOAP AND WARM WATER FOR BRIEF CHANGES. NO WIPES. During a concurrent observation and interview with CNA O on 4/14/2026 at 9:15 a.m., inside Resident 69's room, the care instruction was still posted and CNA O confirmed the above observation. CNA O stated the care instruction should not be posted without a cover. 1c. Review of Resident 19' clinical record titled, admission Record, indicated Resident 19 was admitted to the facility with diagnoses including atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers [atria} beat irregularly and often rapidly), age-related osteoporosis (a common disease where bones become weak, brittle, and porous over time because the body breaks down old bone faster), and dementia. Review of Resident 19's quarterly MDS assessment dated [DATE], indicated Resident 19's BIMS score was 06, with severe cognitive impairment. During an observation on 4/13/2026 at 10:41 a.m., inside Resident 19's room, Resident 19 was not in the room, and a care instruction was observed visibly posted above her HOB's wall indicated, Attention: Patient is Hoyer Lift [a mechanical, portable device used to safely lift and transfer people with limited mobility between a bed, wheelchair, toilet, or floor] Transfer. During a concurrent observation and interview with CNA O on 4/14/2026 at 9:10 a.m., inside Resident 19's room, the care instruction was still posted above Resident 19's HOB wall. CNA O confirmed the observation and stated it was nurses who usually posted care instructions to remind CNAs. 1d. Review of Resident 95's clinical record titled, admission Record, indicated Resident 95 was admitted at the facility with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (paralysis of one side of the body) following unspecified cerebrovascular disease (CVA/stroke, a condition resulting from a lack of oxygen in the brain potentially causing a loss of sensory and motor function) affecting left dominant side (the side of the body that a person prefers, uses more frequently, and is stronger or more skillful with), and epilepsy (a neurological disorder marked by episodes of loss of consciousness or convulsions). Review of Resident 95's annual MDS assessment indicated Resident 95's BIMS score of 14, cognitively intact. During an observation on 4/13/2026 at 11:18 a.m., inside Resident 95's room, Resident 95 was not in the room, and a care instruction was observed visibly posted above the HOB's wall indicated, CNA'S: Patient is a feeder. Please assist him. Another care instruction was posted under the first one indicated, CNA'S: Patient uses medicated shampoo on shower days. Mondays and Fridays. During a concurrent observation and interview with CNA O on 4/14/2026 at 9:18 a.m., inside Resident 95's room, the resident was out for an activity, and the care instructions were still posted. CNA O confirmed the observation, and stated staff should not post about Resident 95 as a feeder or called him a feeder. CNA O further stated the postings were against Resident 95's privacy. During an interview with Resident 95 on 4/15/2026 at 9:06 a.m., when asked about the care instructions posted, Resident 95 was slow in responding and stated, What is a feeder? When (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained what a feeder was, Resident 95 stated, I can feed myself. 1e. Review of Resident 90's clinical record titled, admission Record, indicated Resident 90 was admitted to the facility with diagnoses including senile degeneration of brain (a slow, permanent decline in mental abilities caused by the actual shrinking or death of brain cells in older adults), vascular dementia (a type of dementia describe the changes in thinking and memory that occur when there isn't enough blood flow to part of the brain, as can happen with a stroke), and personal history of transient ischemic attack (TIA – often called mini-stroke or warning stroke, it's a sudden, temporary episode where part of the brain doesn't get enough blood) and cerebral infarction (a type of stroke caused by a blockage in brain blood vessels, resulting in a lack of oxygen and brain cell death). Review of Resident 90's quarterly MDS assessment dated [DATE], indicated Resident 90 had short term memory (a temporary storage space that holds limited amount of information for a few seconds to minutes), and long term memory (the brain's system for storing, managing, and retrieving information for long periods – from a few minutes to a lifetime) problem. During an observation on 4/13/2026 at 12:07 p.m., inside Resident 90's room, Resident 90 was seated on a wheelchair, with right-sided weakness, and observed with multiple care instructions posted visibly at the HOB's wall, and left side of the wall (in a cork board). The care instructions posted at the HOB's wall indicated: 1. PLEASE ASK HIM IF HE IS HUNGRY OR THIRSTY UPON ENTERING He will acknowledge most fo the time when his eyes are closed with a nod or shake of the head. He does not always use a straw. Please put the edge of the cup to his lips and wait for him to respond. -Thank you 2. [Resident 90's NAME] CONDITION IS REFERRED TO AS POST STROKE REGRESSION. It also indicated the signs and symptoms of post stroke regression. 3. Brain and Body Wake-UP Plan Daily gentle stimulation and movement plan for post-stroke recovery after illness setback. The other care instructions posted at the left side of the wall on a cork board indicated: 1. PLEASE ASK HIM IF HE IS HUNGRY OR THIRSTY UPON ENTERING He will acknowledge most fo the time when his eyes are closed with a nod or shake of the head. He does not always use a straw. Please put the edge of the cup to his lips and wait for him to respond. -Thank you 2. [Resident 90's NAME] CONDITION IS REFERRED TO AS POST STROKE REGRESSION. It also indicated the signs and symptoms of post stroke regression. During a concurrent observation and interview with CNA O on 4/14/2026 at 9:24 a.m., inside Resident 90's room, all care instruction were still visibly posted. CNA O confirmed the above observations and stated nurses were the ones who posted the care instructions. During an interview with license vocational nurse A (LVN A) on 4/14/2026 at 9:27 a.m., LVN A stated the care instructions inside residents' rooms were posted to remind CNAs of what to do. When LVN A was asked if they needed to be visibly posted, LVN A stated, I guess it should be covered. I'll let our DON [director of nursing] know. During an interview with the director of staff development (DSD) on 4/17/2026 at 9:57 a.m., the DSD stated, My CNA does not post any care instructions, they know that they can check the inside of the closet. She further stated the care instructions should be posted inside the residents' closet doors, and they should be included in the shift change report and not posted. During an interview with the DON on 4/17/2026 at 10:04 a.m., the DON stated there should be a discreet posting of residents' care instructions. The DON further stated the care instructions should be covered and care planned. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled, Dignity, date revised 2/2021, indicated, Staff protect confidential clinical information. Examples include the following:.b. Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room.Discreet posting of important clinical information for safety reasons is permissible (e.g. taped to the inside of the closet door). 2 a. During initial room round on 4/13/2026 at 11:35 a.m., for Resident 3, observed typed fluid restriction breakdown for 1800 ml (milliliters, unit of volume equal to one thousandth of a liter) between dietary and nursing instructions posted clearly visible on the wall in room. 2 b. During initial room round for Resident 93 on 4/13/2026 at 12:20 p.m., noted hand written hearing aid (a small battery-operated medical device worn in or behind ear to improve hearing for resident with hearing loss) care instructions posted clearly visible on the wall above head of the bed and on storage unit in-front of the Resident 92's bed. Review of Resident 3's face sheet (FS, a document that gives information about resident at a quick glance) indicated Resident 3 was admitted to facility on 7/6/2023. Review of FS also indicated Resident 3's diagnoses included end stage renal disease (permanent stage of kidney [bean shaped organ, responsible for removing waste products from blood, producing urine] failure where kidney function decline below 10-15%) and dependence on renal dialysis (a life sustaining medical treatment that filters waste, excess fluids from blood when kidneys failed to function). Review of Resident 3's order summary report indicated fluid restriction1800 ml per day, dated 4/10/2026. Review of Resident 93's FS indicated Resident 93 was admitted to facility on 9/24/2018. Review of Resident 93's order summary report indicated insert hearing aids one time a day and remove hearing aids and charge at station 1 everyday, dated 3/17/2024. During an interview with certified nursing assistant M (CNA M) on 4/13/2026 at 12:25 p.m., CNA M confirmed visible posted instructions for Resident 3 and Resident 93. CNA M stated these instructions should not have posted to maintain both resident's privacy and dignity. 2 c. During room visit for Resident 54 on 4/13/2026 at 2:23 pm., observed typed fluid restriction breakdown for 1800 ml between dietary and nursing instructions posted clearly visible on the front door for Resident 54's room. Review of Resident 54's FS indicated Resident 54 was admitted to facility on 3/18/2026. Review of Resident 54's FS also indicated diagnoses included chronic kidney disease (long-term condition where kidneys damaged and cannot function properly) and congestive heart failure (a chronic and progressive condition of heart [organ, critical to life, that pumps blood throughout the body] muscle too weak or stiff to pump blood efficiently causing fluid buildup). Review of Resident 54's order summary report indicated fluid restriction 1800 ml per day, dated 4/7/2026. During an interview with registered nurse K (RN K) on 4/15/2026 at 8:57 a.m., RN K confirmed visible fluid restriction breakdown instructions posted on front door for Resident 54. RN K stated to protect (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	privacy and dignity for Resident 3, 93 and 54, above instructions should not be posted visibly. RN K also stated posted care instructions for these residents should be covered to maintain dignity of these three residents. 3. During an observation in Resident 39's room on 4/13/26 at 10:23 a.m., Resident 39 was lying in bed and had an exposed urine bag tied to the side of the bed. During a concurrent observation and interview on 4/13/26 at 10:36 a.m. with Licensed Vocational Nurse (LVN) D, LVN D verified Resident 39's urine bag was not covered. LVN D stated a privacy bag must be used to cover the urine bag. During an interview on 4/16/26 at 3:37 p.m. with the Director of Nursing (DON), the DON stated urine bag must be covered. A review of facility's policies and procedures (P&P) entitled Dignity revised February 2021, the P&P indicated, .12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered;.

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	056055	A. Building B. Wing	04/17/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to follow their policy and procedure (P&P) for an advance directive (AD, a written instruction, such as a living will or durable power of attorney [a document that authorizes a person to act on behalf of resident] for healthcare when individual incapacitated) for 5 of 22 sampled residents (Resident 1, 9, 118, 121, and 6) and completion of physician orders for life-sustaining treatment (POLST, a document that specifies the medical treatments the resident wants to receive during serious illness) form for 4 of 22 sampled residents (Resident 3, 7, 19, and 95) when: There was no documentation of AD for Residents 1,9,118, 121, and 6; and,POLST forms for Residents 3,7,19, and 95 were incomplete.These failures could lead to the delivery of medical services against sampled residents' goals and wishes. Findings: 1a. Review of Resident 1's face sheet (FS, document that provides resident's information at a quick glance) indicated Resident 1 was admitted to facility on 1/8/2026. Review of Resident 1's clinical record indicated there was no documented evidence of AD, or verified and offered assistance to execute AD. 1b. Review of Resident 9's FS indicated Resident 9 was admitted to facility on 122/2022. Review of Resident 9's clinical record indicated there was no documented evidence of AD, or verified and offered assistance to execute AD. 1c. Review of Resident 118's FS indicated Resident 118 was admitted to facility on 4/2/2026. Review of Resident 118's clinical record indicated there was no documented evidence of AD, or verified and offered assistance to execute AD. 1d. Review of Resident 121's FS indicated Resident 121 was admitted to facility on 3/31/2026. Review of Resident 112's clinical record indicated there was no documented evidence of AD, or verified and offered assistance to execute AD. During an interview with facility's director of social service (DSS) on 4/16/2026 at 8:38 a.m., DSS stated they did not verify for executed AD or offer of assistance to execute AD for Residents 1, 9, 118 and 121. DSS also stated social service staff should have verified, offered, and provided assistance to execute AD for these four residents. DSS further stated they will follow up with these residents for AD and provide assistance as needed. 1e. Review of Resident 6's clinical record titled, admission Record, indicated Resident 6 was originally admitted to the facility on [DATE]. Review of Resident 6's attached documents to electronic medical records (EMR – a digital version of patient's chart, containing their medical and treatment history within a single clinician's office or organization) indicated, there was no advance directive found. During a concurrent interview with the DSS and record review of Resident 6's clinical records in EMR on 4/17/2026 at 11:06 a.m., DSS confirmed Resident 6 had no AD. The DSS stated they never talked about AD in Resident 6's previous care conferences. She stated she should have encouraged families (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and residents to complete an AD while they were still capable of making healthcare decisions. During a review of the facility's policy and procedure titled, Advance Directives, date revised September 2022, indicated, Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance. 2a. Review of Resident 3's FS indicated Resident 3 was admitted to facility on 7/6/2023. Review of Resident 3's clinical chart indicated there was documented evidence of AD, dated 3/7/2023. Review of Resident 3's document for POLST, date prepared 3/6/2023, indicated section D for AD's information unanswered, available all three options related to AD left blank. 2b. Review of Resident 7's FS indicated Resident 7 was admitted to facility on 8/9/2022. Review of Resident 7's clinical record indicated there was documented evidence of AD, dated 1/7/1998. Review of Resident 7's document for POLST, date prepared 9/19/2022, indicated section D for AD's information unanswered, available all three options related to AD left blank. During an interview with facility's director of health information management (DHIM) on 4/15/2026 at 10:26 a.m., DHIM confirmed POLST forms for Resident 3 and 7 were incomplete and information for AD left unanswered. DHIM stated nursing staff were responsible to complete this documentation, and nursing staff should have completed all sections without leaving them blank or unanswered. Review of facility's P&P titled, Advance Directives, revised September 2022, the P&P indicated, If the resident or representative indicates that he or she has not established advance directive, the facility staff will offer assistance in establishing advance directives. Review of www.caPOLST.org (official website for the California POLST program. Serves as primary resource for official POLST form, education for healthcare providers and residents) indicated, POLST must be completed by a health care provider based on patient preference and medical indications. 2c. Review of Resident 19's clinical record titled, admission Record, indicated Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's POLST form date prepared 12/26/2022, indicated the physician or nurse practitioner's signature was missing. During a concurrent interview with the assistant director of nursing (ADON) and record review of Resident 19's POLST form dated 12/26/2022 on 4/15/2026 at 9:45 a.m., the ADON confirmed Resident 19's POLST was prepared since 2022, and the doctor did not sign it. The ADON stated the physician should have signed it. During an interview with the DSS on 4/15/2026 at 9:55 a.m., the DSS stated it was not her responsibility to initiate the POLST form. The DSS stated nurses should have initiated the POLST form upon Resident 19's admission and completed during care. At 10:11 a.m., the DSS stated the doctors visited their residents once a month, and Resident 19's POLST form should have been signed. During an interview with minimum data set coordinator (MDSC) on 4/16/2026 at 1:05 p.m., MDSC confirmed they reviewed resident's POLST form during care conferences and during their (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive minimum data set (MDS-a federally mandated resident assessment tool) assessment. MDSC stated if resident's POLST was incomplete, they (MDS nurses) should notify the nurse. She further stated, Resident 19's POLST form should have been completed with the physician's signature. 2d. Review of Resident 95's clinical record titled, admission Record, indicated Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's undated POLST form, indicated the physician signed the form on 6/2/2010 and there was no resident, decisionmaker or conservator's signature obtained. During a concurrent interview with ADON and record review of Resident 95's POLST form on 4/15/2026 at 9:38 a.m., ADON confirmed the POLST form was incomplete without the responsible party's (RP – a person empowered to make decisions for the resident/person legally responsible and liable for a decision or an action) signature. ADON stated Resident 95 did not have a capacity in decision making and his family member should have signed the POLST form since the form was prepared. During an interview with the DSS on 4/15/2026 at 10:09 a.m., the DSS stated Resident 95's POLST form should have been signed by the RP and should have been reviewed every quarterly care conference for completeness. During a review of an official POLST form, indicated, POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature in accordance with family/community policy.Any incomplete section of POLST implies full treatment for that section.It is recommended that POLST be reviewed periodically.

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	056055	A. Building B. Wing	04/17/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 3 out of 5 sampled residents (Residents 4, 7, and 87) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when:1. Resident 4 received an order for PRN (as needed) lorazepam (an anti-anxiety medication) without a 14-day limit as required by the regulations and facility policy and procedures (P&P).2. Resident 7 received Seroquel (quetiapine- an antipsychotic medication) without documented evidence of attempted non-pharmacological (non-drug) interventions and without implementation of non-pharmacological interventions from the care plan.3. Resident 87 received citalopram (an antidepressant) and zolpidem (medication to manage insomnia) without evidence of non-pharmacological intervention implementation.These failures resulted in the potential for longer and unnecessary use of psychotropic medications, which has increased risks associated with psychotropic medication use that include but are not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, and memory loss.Findings: 1. A review of Resident 4's clinical record indicated she was admitted to the facility with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and anxiety disorder. Review of Resident 4's physician orders indicated an order for lorazepam (medication for agitation and anxiety) 0.5 milligram, give 1 tablet by mouth every 1 hour as-needed for agitation, dated 3/17/26 (more than a month ago). This order did not have a 14-day end date or specified duration. During a concurrent interview and record review with the Director of Nursing (DON) and the Assistant DON (ADON), on 4/16/26 at 12:34 p.m, the DON reviewed Resident 4's PRN lorazepam order and stated it indicated indefinite end date. Both the DON and ADON acknowledged PRN orders for psychotropic medications are limited to 14 days. A review of the facility's P&P titled Psychotropic Medication Use, dated July 2022, indicated, PRN orders for psychotropic medications are limited to 14 days. 2. Review of Resident 7's face sheet (FS, a document that provides resident's information at a quick glance) indicated Resident 7 was admitted to facility on 8/9/2022. Review of Resident's 7's FS indicated diagnoses included dementia with other behavioral disturbance (progressive cognitive decline including memory loss, communication and reasoning with behaviors like agitation, aggression, and mood changes). Review of Resident 7's order summary report indicated Seroquel 25 mg (milligram, unit of mass equal to one thousandth of a gram) by mouth two times a day for dementia with other behavior disturbance, dated 12/8/2025. Review of Resident 7's clinical chart indicated there was no documented evidence for nursing staff attempted non-pharmacological (treatment approaches for preventing or managing health conditions that do not use medications) interventions while receiving Seroquel. Review of Resident 7's care plan for dementia date initiated 9/14/2025 indicated intervention of Non-Pharmacological Interventions for those on Psychotropic medication . (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with facility's director of nursing (DON) on 4/17/2026 at 11:21 a.m., DON stated non-pharmacological interventions documented just in Resident 7's care plan only, nowhere else. During an interview with minimum data set (resident's clinical and functional assessment tool) coordinator (MDSC) on 4/17/2026 at 11:57 a.m., MDSC confirmed there was no documented evidence of license staff attempted and documented non-pharmacological approaches for Resident 7 while receiving Seroquel. MDSC also stated nursing staff should have provided non-pharmacological approaches to implement care plan's intervention for Resident 7. 3. Review of Resident 87's clinical record titled, admission Record, indicated Resident 87 was admitted to the facility on [DATE] with diagnosis including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 87's physician orders indicated an order dated 3/15/2026 of citalopram 20 milligrams (mg – unit of measurement), one tablet by mouth once a day for depression and an order of zolpidem extended release 12.5 mg to be given one tablet by mouth at bedtime for difficulty sleeping. Review of Resident 87's clinical records, nursing progress notes and medication administration record (MAR – a daily documentation record used by licensed nurse to document medications and treatments given to a resident) there was no documented evidence for licensed nurses implementation (putting the plan into action) of non-pharmacological interventions for Resident 87's depression and difficulty in sleeping. Review of Resident 87's care plan for use of citalopram dated 3/15/2026, indicated to offer Resident 87 with emotional support. Review of Resident 87's care plan for use of hypnotics dated 3/15/2026, there were no non-pharmacological interventions planned to address his difficulty in sleeping. During a phone interview with the consultant pharmacist (CP) on 4/16/2026 at 2:07 p.m., CP stated non-pharmacological interventions should be provided to residents on psychotropic medications and should be documented in resident's MAR and care plan. CP further stated, Yes, it is a requirement, to provide non-pharmacological interventions to residents on psychotropic medications. During a review of the facility's policy and procedure titled, Psychotropic Medication Use, dated 7/2022, indicated, Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible.

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	056055	A. Building B. Wing	04/17/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review, the facility failed to provide restorative services for one of three residents (Resident 10) when documentation was missing or lacking regarding the service. This failure has the potential of the residents to experience a decrease in their range of motion (ROM) and possibly psychosocial well-being. Findings: During a review of Resident 10's Restorative Nursing Assistant (RNA) documentation, under the Tasks tab on 4/15/2026 at 1:32 PM, there was an entry for active Range of Motion (ROM), which indicated had been performed on 3/17/26 at 2:17 PM for 10 minutes, and passive ROM was performed on 3/17/26 at 2:17 PM for 5 minutes. During an interview with the director of staff development (DSD) on 4/15/2026 at 1:51 PM, the DSD stated RNAs document in alert listing report. The DSD stated there was nothing documented for ROM, so either Resident 10 refused or she was not seen from 1/15/26 - 2/14/26. She also stated there was no documentation from 2/15/26 - 3/16/26. She stated there is a note for ROM on 3/17/26 for passive ROM on upper extremity on one side for 10 minutes and active ROM for upper extremity on other side for 5 minutes, and documentation for 4/1/26 for refusal of ROM. She stated those were the only two entries that she saw. During an interview with RNA G, on 4/15/2026 at 2:51 PM, RNA G stated Resident 1 has bipolar disorder, so her ROM depends on her mood. RNA G stated, I believe one side of Resident 1's body is weaker than the other. She should be getting RNA services 2-3 times per week. We try to see everyone at least 2x/wk. We document on alert charting, but recently started charting on progress notes. That should be done every time, whether she gets ROM or refuses. During an interview with the DSD on 4/15/2026 2:58 PM, she stated the facility had a Quality Assurance and Quality Improvement (QAPI) meeting on Monday. She stated, We were going over the entire building for RNA services. We found 65% of our residents are the average case load for RNA services, 75% of the residents were being seen, and 25% were being missed. During an interview with RNA H on 4/15/2026 at 3:01 PM, he stated, Resident 10 refuses RNA services a lot. I think that there is no documentation because we are not putting it in entirely. We, also, are not able to get through our entire list of residents who should be getting RNA services. We may be missing her sometimes, and thus not charting. She is assigned RNA twice per week, on Tues & Thur. I cannot say when the last time was that I saw her; she is not scheduled on the days that I am RNA. I am scheduled for Wednesday & Saturday. All the missed documentation could possibly be from her not being worked with or her refusing. During a review of Resident 1's Progress Notes, there was no progress note documented for Tuesday 4/14/26, which was her scheduled day for RNA service. The RNAs were supposed to start documenting in her Progress Notes on Monday 4/13/26. During a concurrent review of the QAPI Project Report: RNA Resident Coverage Compliance, and interview with the DSD on 4/15/2026 4:01 PM, for 03/2026, there were approximately nine residents from station 1 and nine residents from station 2 who were frequently not seen by a RNA. During an interview with the DSD along with the director of nursing (DON) on 4/16/2026 at 11:24 AM, they stated Resident 1 has not had PT/OT for many years, the PT/OT evaluation order was from 2/17/2016. We don't need an order for RNA, they just transition over. We discuss it in interdisciplinary team (IDT) meeting. When they transition from skilled to long-term care, and we think they could benefit from RNA, they are started on RNA. There is an order for RNA on 6/15/2016. During an interview with the assistant director of nursing (ADON) on 4/16/2026 at 2:21 PM, she stated she believed Resident 1 had contractures and did not like getting out of bed, as mentioned in a note dated 1/17/2020. During an interview with the DSD on 4/17/2026 at 1:13 PM, she stated there was no note for yesterday (Thursday) and there should have been. There was only one RNA yesterday, the other one called in. Resident 10 may not have been seen. RNA I worked station 1 yesterday, while Resident 1 was on station 2. RNA I did document for the residents she saw on station 1. During a review of a document titled On Therapy Caseload for station1 and station 2. It indicated Before seeing a resident a 3rd time, make sure all (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents have been offered RNA services at least 2x. Also, Please remember to chart refusals. Resident 10 was listed for PROM BUE/BLE (passive ROM to both upper extremities and lower extremities) exercise for all panes 2x10. Resident 10 was scheduled for exercise every Tuesday, Thursday, and Sunday. During a review of Resident 1's Alert Charting from 3/17/26 through 4/12/26, there was only one entry for exercise on 3/17/26 at 2:18 PM, which indicate she was active for ROM on right side of upper extremity; passive for ROM on left side upper extremity, and refused ROM for lower extremity. There was also one entry on 4/1/26 at 2:21 PM for refusal of RNA service. There were a total of 16 days with entries, some days with multiple entries; however, out of a total of 24 entries, which were mainly regarding what percentage of meals she had eaten, only two were regarding RNA. During a review of the facility's policy and procedure (P&P), Resident Mobility and Range of Motion, revised 07/2017, it indicated,Policy Statement . Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM . Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Policy Interpretation and Implementation . The care plan will be developed by the interdisciplinary team based on the comprehensive assessment, and will be revised as needed . The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion . Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility failed to provide renal dialysis (a life sustaining medical treatment that filters waste, excess fluids from blood when kidneys [bean shaped organ, responsible for removing waste products from blood, producing urine] failed to function) care and services consistent with professional standards of practice for two of two sampled residents (Resident 121 and 3) when dialysis follow up information forms were incomplete for 5 of 7 dialysis treatment days for Resident 121, and 7 of 10 dialysis treatment days for Resident 3. These failures had the potential to result in inappropriate follow-up care for Residents 121 and 3.Findings:Review of Resident 121's face sheet (FS, a document that gives information about resident at a quick glance) indicated Resident 121 was admitted to facility on 3/31/2026. Review of Resident 121's diagnoses included end state renal disease (permanent stage of kidney failure where kidney function decline below 10-15%) and dependence on renal dialysis.Review of Resident 121's clinical record indicated Resident 121 was scheduled for dialysis on every Monday, Wednesday, and Friday at a dialysis center, dated 4/2/2026.Review of Resident 121's documentation for Dialysis Follow Up Information indicated three sections to complete for each dialysis treatment day included pre dialysis visit, dialysis center (a specialized medical facility where residents with kidney failure and kidney disease receive treatment to clean the blood, remove extra fluids), and upon return to facility. Review of this form dated 4/1/2026 indicated incomplete documentation for vital signs (objective, measurable indicators of the body's most essential, core physiological functions) signature and title upon return to facility, no documented evidence of form for 4/6/2026, form for 4/10/2026 no signature and title upon return to facility, 4/13/2026 and 4/15/2026 forms indicated no documentation, left blank by dialysis nurse (specializes in treating residents with kidney failure and dialysis treatment) at the dialysis center.During a concurrent record review of above forms for Resident 121 and interview with facility's director of health information management ((DHIM) on 4/16/2026 at 2:40 p.m., DHIM confirmed above dated forms and incomplete documentation. DHIM stated nursing staff were responsible for completion this document before and after dialysis visit and verify for documentation completion by dialysis nurse at the dialysis center after resident comes back to facility.During a concurrent review of above forms for Resident 121 and interview with licensed vocational nurse L (LVN L) on 4/17/2026 at 10:22 a.m., LVN L confirmed above findings. LVN L stated this form facilitates communication between facility and dialysis center for resident's dialysis care and treatment. LVN L stated license nurse should complete all information before, after dialysis treatment, and verify information completion by dialysis nurse at the dialysis center upon resident return to facility. LVN L also stated license nurse should have completed, verified, and follow up with dialysis nurse for completion of dialysis follow up information for Resident 121. LVN L further stated missing communication between facility and dialysis center for resident's vital medical information potentially effect on dialysis care and health condition for Resident 121. Review of Resident 3's FS indicated Resident 3 was admitted to facility on 7/6/2023. Review of Resident 3's diagnoses included end state renal disease and dependence on renal dialysis.Review of Resident 3's clinical record indicated Resident 3 scheduled for dialysis on every Tuesday, Thursday, and Saturday at dialysis center, dated 4/10/2026.Review of Resident 3's document for Dialysis Follow Up Information dated 2/28/2026 indicated missing information by dialysis nurse and no documentation upon return to facility. Documents dated on 3/3/2026, 3/12/2206, 4/11/2026, and 4/13/2206 indicated no documentation by dialysis nurse and upon return to facility. Document dated 3/10/2026 indicated no documentation by dialysis nurse. Document dated 3/7/2026 indicated no documentation, signature and title upon return to facility. During a concurrent record review of above forms for Resident 3 and interview with DHIM on 4/16/2026 at 3:35 p.m., DHIM confirmed above dated forms and incomplete documentation. During a concurrent review of above forms for Resident 3 and interview with LVN L on 4/17/2026 at 10:22 a.m., LVN L confirmed above findings. LVN L stated license nurse should (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complete all information before, after dialysis treatment, and verify for completion by dialysis nurse at the dialysis center for each dialysis treatment day. LVN L also stated license nurse should have completed, verified, and follow up with dialysis nurse for completion of dialysis follow up information documents for Resident 3. LVN L further stated missing communication between facility and dialysis center for Resident's vital medical information potentially effect on dialysis care and health condition for Resident 3.Review of facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, revised September 2010, the P&P indicated, Agreement between this facility and the contracted ESRD (end stage renal disease) facility include all aspects of how the resident's care will be managed, including . how information will be exchanged between the facilities .

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	056055	A. Building B. Wing	04/17/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure accurate administration and disposal of medications when:1. An insulin pen (a pre-filled pen containing insulin-medication to lower blood sugar) was not correctly primed (the process of removing any air bubbles from the pen's needle and cartridge before an injection) during the medication administration observation for 1 of 1 resident (Resident 115). This had the potential for the resident to receive the incorrect amount of insulin for treatment.2. A nursing staff disposed of 3 medications in the sharps container instead of a designated pharmaceutical bin. This resulted in inappropriate waste of medications.3. A nursing staff prepared the wrong dose of spironolactone (medication for high blood pressure [BP] and heart conditions) during the medication administration observation for one of 7 residents (Resident 54). This had the potential for a medication error, which would lead to too low BP for the resident.4. Alendronate (medication to treat or prevent osteoporosis - a disease where decreased bone strength and mass significantly increase the risk of fractures) was scheduled and administered at the same time with three other medications for 1 of 1 resident (Resident 19) receiving alendronate. This had the potential for reduced effect for alendronate when administered within 30 minutes of other medications as per manufacturer's specifications.1. During the medication administration observation on 4/14/26 at 8:21 AM, Registered Nurse (RN) J was observed preparing 10 medications for Resident 115. RN J stated the resident needed 17 units of insulin this morning. RN J was observed removing Resident 115's Humalog Kwikpen (a prefilled pen containing Humalog, a fast-acting insulin) from the medication cart, removed the pen cap, wiped the rubber stopper with an alcohol swab, attached a new needle to the pen, and dialed the dose selector to 2 units. Then, while holding the pen side-way and leaving the needle cap on, she pressed on the push-button at the end of the pen, then quickly turned the dose selector to 17 units.On 4/14/26 at 8:29 a.m., at Resident 115's bedside, RN J was observed injecting the insulin into the resident's left upper arm. During an interview on 4/14/26 at 8:35 a.m., RN J was asked how she primed the insulin pen for Resident 115. She used his Humalog Kwikpen to demonstrate by placing the pen side-way, dialed to 2 units on the dose selector, and press the bottom of the pen to prime it.A review of Resident 115's physician's orders indicated an order for Humalog, inject 17 unit subcutaneously with meals for high blood sugar prime 2 units prior to each injection, dated 4/11/26. On 4/14/26 at 10:45 a.m., a review of the instruction video on how to prime an insulin pen (https://www.youtube.com/watch?v=11fWsFi-3CA; accessed 4/14/26) with RN J indicated to prime the pen and needle, dial the dose selector to 2 units, hold the pen upright, tap lightly on the pen to move any air to the top, press on the dose selector until you see insulin coming out of the needle. If no insulin is observed at the needle tip, repeat the priming process. If no insulin comes out of needle after three tries, attach a new needle and repeat the priming steps. During this review, RN J acknowledged she placed the pen sideway instead of upright and did not observe the insulin at the tip of needle during the priming process.2. During the medication administration observation on 4/14/26 at 8:57 a.m., RN K was observed preparing 15 medications for Resident 54 including 3 medications for congestive heart failure (long-term condition that happens when your heart can not pump blood well enough to give your body a normal supply): 1 tablet of spironolactone 25 milligrams (mg, unit of measurement), 1 tablet of Entresto 24-25 mg, and 1 tablet of metoprolol extended release 25 mg.On 4/14/26 at 9:06 a.m., RN K was observed taking Resident 54's BP, which came out to be 105/60 mmHg (millimeters of mercury, unit of measurement for BP). RN K stated he will hold these 3 medications as the BP was below the prescribed parameters for administration.On 4/14/26 at 9:14 a.m., RN K was observed placing the held medications in the sharps container which was on the side of the medication cart. When asked if there was a designated pharmaceutical bin to waste the medications, RN K opened the medication cart showing the bottom drawer, and stated, No, there's not.During an interview with the Director of Nursing (DON) and the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant DON (ADON), on 4/14/26 at 1:25 p.m., the ADON stated non-controlled medications are to be wasted in a designated container called the Drug Buster, not in the sharps container.A review of the facility's policy and procedures (P&P) titled Syringe and Needle Disposal, revised 1/1/23, indicated, Facility staff should not dispose of medications . in sharps containers.3. During the medication administration observation above with RN K on 4/14/26 at 8:57 a.m., one of 15 medications prepared for Resident 54 included 1 tablet of spironolactone 25 mg.On 4/14/26 at 9:07 a.m., RN K stated he will hold 3 medications including the spironolactone as the BP was outside of the prescribed parameter for administration.A review of Resident 54's physician's orders indicated an order, dated 4/10/26, for spironolactone 12.5 mg by mouth one time a day related to ACUTE ON CHRONIC DIASTOLIC (CONGESTIVE) HEART hold if SBP [systolic blood pressure] < [less than] 110.During a concurrent interview and record review with RN K on 04/14/26 at 11:28 a.m., RN K reviewed Resident 54's physicians orders and stated the spironolactone order was changed from 25 mg to 12.5 mg on 4/10/26. He opened the medication cart and showed two medication cards: one contained spironolactone 25 mg in whole tablet, and the other in half tablets (12.5 mg). RN K stated he prepared the morning medication from the old whole-tablet 25 mg card. RN K confirmed that had the resident's BP been within prescribed parameter, the 25 mg tablet would have been given, which would have been an error. He also confirmed the old card should have been removed from the medication cart to avoid medication errors.A review of the facility's P&P titled Administering Medications -General Guidelines, revised 1/1/23, indicated the individual administering the medication observes the 5 rights Right resident, right drug, right dose, right route and right time. The P&P also indicated, Select the Medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights.4. A review of Resident 19's clinical record indicated the resident was admitted to the facility with diagnoses including gastroesophageal reflux disease (GERD- stomach acid flows back up into the esophagus and causes heartburn), hypothyroidism (underactive thyroid), and osteoporosis (disease where decreased bone strength and mass significantly increase the risk of fractures).A review of her physician's orders included the following:a. Alendronate 70 mg, give 1 tablet by mouth one time a day every Sat[urday] for osteoporosis Take 1st thing in the morning with at least 6 oz water, at least 30 min before any other beverage, food or medication ., dated 4/1/23.b. Prilosec 20 mg, 1 capsule by mouth in the morning for GERD, dated 12/28/22.c. Levothyroxine (medication to treat hypothyroidism) 150 micrograms, give 1 tablet by mouth in the morning for thyroid disease, dated 3/28/26.d. Acetaminophen (Tylenol) 500 mg, give 1 tablet by mouth in the morning for musculoskeletal [muscle and skeletal] pain, dated 11/21/24.A review of Resident 19's April 2026 MAR indicated all 4 medications were scheduled to be administered at 6:30 a.m. despite the administration instructions for alendronate indicated at least 30 minutes before any other .medication.A review of the Prescribing Information from the manufacturer for alendronate, pulled from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs), updated 2/2/21, indicated, Take alendronate sodium tablets at least one-half hour before the first food, beverage, or medication of the day with plain water only . Waiting less than 30 minutes, or taking alendronate sodium tablets with . other medications will lessen the effect of alendronate sodium tablets by decreasing its absorption into the body.During a concurrent interview and record review with the DON and ADON on 4/16/26 at 12:44 p.m., the DON was asked to review the MAR to see whether the 4 above medications were administered together. After review, the DON stated the nursing staff administered all 4 medications at 5:34 a.m. on 4/3/26; and at 5:49 a.m. on 4/11/26, the days the alendronate was due. Both the DON and ADON acknowledged the staff did not administer the alendronate as per the doctor's order and manufacturer's specifications.A review of the facility's P&P titled Administering Medications -General Guidelines, revised 1/1/23, indicated, When defining the schedules for administering medication the facility should work to maximize the effectiveness of the medication, prevent potential significant medication interactions .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

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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 1 of 5 sampled residents (Resident 19) was free from an unnecessary medication. Resident 19 has been receiving Prilosec (omeprazole, a medication in a class called proton pump inhibitors [PPI] to treat gastroesophageal reflux disease [GERD- condition where stomach acid flows back up into the esophagus and causes heartburn]) for approximately 3.5 years without documented risk versus benefit (R/B) assessment for continued, long-term use despite having osteoporosis (disease where decreased bone strength and mass significantly increase the risk of fractures), being at risk for osteoporosis-related fractures, and receiving multiple medications that increase fall risk. The failure resulted in the lack of documented R/B assessment and potential for increased risk for fractures from long-term use of a PPI, which according to the manufacturer, may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine.A review of Resident 19's clinical record indicated she was an over-[AGE] year-old resident admitted to the facility with diagnoses including age-related osteoporosis and gastro-esophageal reflux disease without esophagitis [inflammation or swelling of the esophagus]. The record indicated the GERD was diagnosed on [DATE] (3 years and 5 months ago). The clinical record indicated the resident had no active GERD or other bowel disorders.A review of Resident 19's Minimum Data Set (MDS, a care area assessment and screening tool), dated 2/4/26, indicated she had a BIMS (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15) score of 6, which indicated she had severe cognitive impairment.A review of her physician's orders indicated the resident has been receiving:a. Alendronate (medication to treat or prevent osteoporosis) 70 milligrams (mg, unit of measurement) once every Saturday for osteoporosis, dated 4/1/23.b. Prilosec (omeprazole) 20 mg, 1 capsule by mouth in the morning for GERD, dated 12/28/22 (3 years and 5 months ago).A review of the Prescribing Information (PI - detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians), revised 2/17/25, from the manufacturer of omeprazole, indicated omeprazole is a PPI indicated for multiple bowel conditions including GERD. For GERD, it is for up to 8 weeks to heal acid-related damage to the lining of the esophagus .If needed, your doctor may decide to prescribe another 4 weeks of omeprazole delayed-release capsules to maintain healing of the esophagus. It is not known if omeprazole delayed-release capsules is safe and effective when used for longer than 12 months (1 year) for this purpose.Continued review of the PI, under Warnings and Precautions, indicated, Several published observational studies suggest that proton pump inhibitor (PPI) therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. The risk of fracture was increased in patients who received high-dose . and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines [as indicated above].Review of the physician's orders also indicated Resident 19 has been receiving three psychotropic medications (drugs that affect brain activities associated with mental processes and behavior), each of which has the ability to cause falls:a. Quetiapine (an antipsychotic) 25 mg, give 0.5 tablet by mouth one time a day related to UNSPECIFIED DEMENTIA, dated 5/22/24.b. Escitalopram (an anti-depressant) 10 mg, 1 tablet by mouth one time a day for anxiety disorder, 6/5/24c. Mirtazapine (an anti-depressant) 30 mg, 1 tablet by mouth at bedtime for anxiety, dated 3/11/24 Despite having age-related osteoporosis, being at risk for osteoporosis-related fractures, and receiving 3 medications that increase the risk for falls, there was no documented evidence in Resident 19's clinical record of a R/B assessment or clinical rationale for the long-term use of omeprazole.On 4/15/26 at 11:53 a.m., Resident 19 was observed sitting on a wheelchair, at a table in the Activity Room with three other residents. She was quiet and (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observant. There were no distress or any behaviors.On 4/15/26 at 1:36 p.m., Resident 19 was observed sitting on a wheelchair in the hallway, polite and observing people passing by. She responded politely when greeted.On 04/16/26 at 9:01 a.m., Resident 19 was observed in her room, eating breakfast in bed. She was not in any distress or had any behaviors.During a concurrent interview and record review with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/16/26 at 12:44 p.m., they stated they could not find anything to support the long-term use of omeprazole. They said they would defer to the consultant pharmacist (CP) for response.On 4/16/26 at 2:29 p.m., Resident 19 was observed on a wheelchair, in the hallway. She pleasantly responded to the surveyor's greetings. During a telephone interview with the CP on 4/16/26 at 1:55 p.m., the CP stated, I understand the fracture risk, and I check every month for opportunity. The reason I hesitate to recommend a GDR [gradual dose reduction] for her omeprazole is because she has some psych issues, I feel nervous about reducing her PPI. When asked whether her clinical rationale was documented or a R/B assessment was conducted, the CP stated she will check her notes and check with the doctor and get back to the surveyor later. The CP acknowledged that Resident 19 has been receiving 3 psychotropic medications which would increase her risk for falls.During another telephone interview with the CP on 4/16/26 at 3:41 p.m., the CP stated, I couldn't find anything on my end but the DON may provide additional information via email if found. In an email communication, on 04/17/26 at 8:31 a.m., the DON wrote, Despite the consultant pharmacist's general practice of recommending PPI reduction when appropriate, no recommendation to discontinue Omeprazole was made for this resident, reflecting individualized clinical judgment based on her condition and risk profile.A policy related to medication utilization and monitoring was requested during the survey. In an email communication, 4/17/26 at 8:35 a.m., the DON wrote, I will see what policies I have that fall under those categories. No policies related to this were provided.A review of the facility's policy and procedures titled Consultant Pharmacist Services Provider Requirements, revised 1/1/23, indicated the CP reviews the medication regimen of each resident each month, identifies and assesses for medication-related issues including duration of therapy and indications for use and therapeutic goals . consistent with current medical literature and clinical practice guidelines, and documents the review and findings in the pharmacist's report to the director nursing, and/or prescriber, and the medical director as appropriate.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 food was served at an appetizing temperature when 11 out of 92 residents (Resident 34, 68, 9, 54, 123, 36, 59, 16, 85, 46, 74) complained hot food was served cold to them. This failure had the potential to affect the amount of food residents consume, which could decrease their food intake and lead to poor nutrition and health outcomes.Findings: During an initial room rounds and interview with Resident 34 on 4/13/2026 at 10:43 a.m., Resident 34 stated hot foods always served cold for all three meals. During an initial room rounds and interview with Resident 68 on 4/13/2026 at 11:19 a.m., Resident 68 stated hot foods always served cold, not even warm to eat. Resident 68 also stated likes to drink hot coffee, facility serving coffee not hot. During room rounds and interview with Resident 9 on 4/13/2026 at 1:55 p.m., Resident 9 stated hot foods always served cold. During room visit and interview with Resident 54 on 4/13/2026 at 2:23 p.m., Resident 54 stated hot foods always served cold and not appetizing to eat cold food. Review of Resident 34's face sheet (FS, a document that gives information about resident at a quick glance) indicated Resident 34 was admitted to facility on 3/18/2026. Review of Resident 34's minimum data set (MDS, resident assessment tool) assessment dated [DATE] indicated Resident 34's brief interview for mental status (BIMS) score of 15/15 (score of 0-7, severe cognitive impairment, 8-12, moderate cognitive impairment, 13-15, cognitively intact), intact cognition. Review of Resident 68's FS indicated Resident 68 was admitted to facility on 1/16/2024. Review of Resident 68's MDS assessment dated [DATE] indicated Resident 68's BIMS score of 15/15, intact cognition. Review of Resident 9's FS indicated Resident 9 was admitted to facility on 12/22/2022. Review of Resident 9's MDS assessment dated [DATE] indicated Resident 9's BIMS score of 15/15, intact cognition. Review of Resident 54's FS indicated Resident 54 was admitted to facility on 3/18/2026. Review of Resident 54's MDS assessment dated [DATE] indicated Resident 54's BIMS score of 15/15, intact cognition. During an interview with Resident 123 on 4/14/2026 at 10:35 a.m., she stated her Food is lukewarm. During an interview with Resident 36 on 4/14/2026 at 11:10 a.m., she stated the food is horrible. The food is not warm. (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 59 on 4/14/2026 at 11:41 a.m., he stated he had learned to eat how the food comes. He did state the food was not warm. During an interview with Resident 16 on 4/14/2026 at 11:48 a.m., he stated the food was not warm. He stated the oatmeal and eggs were specific foods that were cold. During an interview with Resident 85 on 4/14/2026 at 2:02 p.m., he stated the food is so-so and same with the temperature of the food. During an interview with Resident 46 on 4/14/2026 at 1:18 p.m., she stated the food temperature was cold. During an interview on 4/14/26 at 9:17 a.m. with Resident 74, Resident 74 stated they get the food last and nothing is warm. A review of Resident 74's Physician Orders dated 8/23/25 indicated, Regular diet, regular texture, regular consistency During Lunch Test Tray on 4/14/26 at 1:36 p.m., the food temperature of Regular Diet tray was checked. The temperature ranged from 109.8 F to 127.8 F. As a result of multiple resident complaints about the hot food served cold, two test trays (one regular puree diet and one regular diet) were requested for samples during lunch time on 4/14/2026. The trayline in the kitchen started on 4/14/2026 at 12:17 p.m., and the last food cart was out of the kitchen at 1:15 p.m. The staff finished distributing the food trays to each room at 1:33 p.m. The test tray evaluations were conducted at 1:34 p.m in surveyors' meeting room. The Head [NAME] (HC) was in attendance when the test tray contents were sampled by four surveyors. At 1:36 p.m., the temperature of the food contents were measured as follows: Puree regular diet:- Roasted Greek Chicken: 124 degrees Fahrenheit (degrees F) (a unit of temperature)- Couscous: 126 degrees F- Bread: 122.4 degrees F- [NAME] Peas: 114 degrees F Regular diet:- Roasted Greek Chicken: 127.8 degrees F- Couscous: 127.4 degrees F- [NAME] Peas: 122 degrees F - Bread: 109.8 degrees F During an interview on 4/14/2026 at 1:45 p.m., the HC stated the food temperature to be served to residents should not be below 140 degrees F. The HC stated the plates were warmed before putting the food on, but the plate's base and the cover were not warmed. A review of the facility's policy and procedure titled, HACCP (Hazard Analysis and Critical Control Points) and Food Safety, dated 2017, indicated, . The U.S. Department of Health and Human Services Food Code uses 41 degrees F for cold foods and 135 degrees F for hot foods. The food service manager and the registered dietitian nutritionist (RDN) should determine the appropriate temperature ranges for the food service operation.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained prior to the administration of a psychotropic medication (drug that affect brain activities associated with mental processes and behavior) for 1 out of 7 residents (Resident 4). The failure had the potential for the resident/resident representative not being informed in advance of the risks and benefits of the medication, the treatment alternatives, or other options before making the decision for treatment.A review of Resident 4's clinical record indicated she was admitted to the facility with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and anxiety disorder.Review of Resident 4's physician orders indicated an order, dated 3/17/26, for lorazepam (medication for agitation and anxiety) 0.5 milligram, give 1 tablet by mouth every 1 hour as-needed for agitation.A review of Resident 4's clinical record indicated there was no documented evidence an informed consent was obtained for the administration of lorazepamA review of Resident 4's April 2026 medication administration record indicated Resident 4 received five as-needed doses of lorazepam 0.5 mg for agitation in April 2026.During a concurrent interview and record review with the Director of Nursing (DON) and the Assistant DON (ADON), on 4/16/26 at 12:34 p.m., both nursing staff reviewed Resident 4's clinical record and verified it did not contain an informed consent for the use of lorazepam.During a follow-up interview with the ADON on 4/14/26 at 3:01 p.m., she stated the nurse who received the lorazepam order did not get an informed consent; she thought the hospice nurse was to get it. The ADON stated, We are to do it and acknowledged an informed consent was required before the initiation of lorazepam.A review of the facility's policy and procedures titled Psychotropic Medication Informed Consent dated October 2019, indicated, The facility will obtain and document informed consent from the resident or their legal representative prior to initiating any psychotropic medication, except in emergency situations. Psychotropic medications include, but are not limited to . Antianxiety agents . and Completed consent form will be placed in the medical record.

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	056055	A. Building B. Wing	04/17/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure an even floor surface in facility's hallways. This failure presented a potential tripping hazard for residents who were using these hallways. Findings:During an observation on 4/13/2026 at 12:55 p.m., there was an uneven floor surface where carpeted flooring transitioned to wooden flooring in a hallway near Resident's room [ROOM NUMBER] (RR 1). Further observation indicated residents were passing by often, using walkers (a mobility aid designed with four legs with wheels and light weight to provide support while walking), wheel chairs (W/C, a mobility device designed for residents with mobility impairments to move around, propelled manually by user or by staff or powered electrically), and walking without a mobility device.During an observation on 4/14/2026 at 1:30 p.m., there was an uneven floor surface with missing and broken tile pieces in hallway near RR 2. This area was frequently used by residents that used walkers, W/C, and walked independently without a mobility device.During a concurrent observation of these areas and interview with facility's director of environmental services (DES) on 4/16/2026 at 11:49 a.m., ESD observed and confirmed both of the aforementioned uneven floor surfaces of both hallway areas. DES stated the facility started replacing carpeting with wooden flooring in the hallway near RR 1 in March of this year; and that, work was in progress. DES stated a threshold strip was not placed to fill the gap of the transition area between carpeting and wooden flooring, which created an uneven surface at this area. DES acknowledged the broken pieces of tile that created an uneven surface in the hallway near RR 2. DES stated the uneven floor surfaces in both hallways posed a tripping hazard for residents that traveled through those areas; and that, the facility should have replaced the missing and broken tiles, and installed a threshold strip to make even those surfaces of concern in both hallways.Review of facility's policy and procedure (P&P) titled, Hazardous Areas, Devices and Equipment, revised July 2017, the P&P indicated, As part of the facility's overall safety and accident prevention program hazardous areas and objects in the resident environment will be identified and addressed by the safety committee . Identification of Hazards . Irregular floor surfaces (cords, buckled carpeting, etc) .

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	056055	A. Building B. Wing	04/17/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fluid restrictions were followed for one of five sampled residents (Resident 3) and failed to initiate a care plan (an individualized, collaborative document that focuses on a resident specific needs, goals, preferences and values) for restricted fluids for one of three sampled resident (Resident 54). These failures had the potential to negatively affect Resident 3 and Resident 54's fluid balance.Findings:During a concurrent observation of Resident 3's room and interview with Resident 3 on 4/13/2026 at 11:35 a.m., a plastic re-usable cup with built-in straw was full of water atop a tray table next to Resident 3's bed and within reach of Resident 3. A posted fluid restriction with breakdown between dietary and nursing for total of 1800 ml ((milliliters, unit of volume equal to one thousandth of a liter) was on a wall within this room. Resident 3 stated nursing staff replaced water in the cup for him to drink throughout the day.Review of Resident 3's face sheet (FS, a document that gives information about resident at a quick glance) indicated Resident 3 was admitted to the facility on [DATE]. It also indicated Resident 3's diagnoses included end stage renal disease (permanent stage of kidney [bean shaped organ, responsible for removing waste products from blood, producing urine] failure where kidney function decline below 10-15%) and dependence on renal dialysis (a life sustaining medical treatment that filters waste, excess fluids from blood when kidneys failed to function).Review of Resident 3's minimum data set (resident assessment tool) assessment dated [DATE] indicated Resident 3's brief interview for mental status (BIMS) score of 15/15 (score of 0-7, severe cognitive impairment, 8-12, moderate cognitive impairment, 13-15, cognitively intact), intact cognition.Review of Resident 3's order summary report indicated a fluid restriction of 1800 ml per day, dated 4/10/2026. Review of Resident 3's care plan for renal failure/hemodialysis dated 2/28/2026 indicated intervention included daily fluid restrictions.During an interview with certified nursing assistant F (CNA F) on 4/14/2026 at 8:58 a.m., CNA F confirmed the full cup of water within reach of Resident 3. CNA F stated restricted fluids were divided for each meal and with medications given by the nurse for Resident 3. CNA F also stated water from the cup was not included in restricted fluids divided between dietary and nursing. CNA F stated nursing staff should not have provided extra water for Resident 3. CNA F further stated uncertainty of who provided the cup with water for Resident 3.During an interview with registered nurse K (RN K) on 4/15/2026 at 8:57 a.m., RN K stated Resident 3 should not have been provided extra water in a cup in order to maintain the fluid restriction and prevent complications from fluid overload.Review of Resident 54's FS indicated Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's FS also indicated diagnoses included chronic kidney disease (long-term condition where kidneys damaged and can not function properly) and congestive heart failure (a chronic and progressive condition of heart [organ, critical to life, that pumps blood throughout the body] muscle too weak or stiff to pump blood efficiently causing fluid buildup).Review of Resident 54's order summary report indicated fluid restriction 1800 ml per day, dated 4/7/2026.Review of Resident 54's care plans lacked mention of fluid restriction.During a concurrent review of order summary and care plans for Resident 54 with license vocational nurse L (LVN L) on 4/17/2026 at 11:41 a.m., LVN L verified orders for fluid restriction and the lack of mention of fluid restriction in the care plans for Resident 54. LVN L stated nursing staff should have initiated a care plan for restricted fluid management for Resident 54.During an interview with minimum data set (resident's clinical and functional assessment tool) coordinator (MDSC) on 4/17/2026 at 11:49 a.m., MDSC stated nursing staff should have initiated and implemented a care plan for restricted fluid management for Resident 54, and did not.Review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, The interdisciplinary team (IDT, a group of healthcare professionals who work together to create, implement and evaluate a care plan for residents), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and document review, the facility failed to conduct the Certified Nursing Assistant's (CNA) Annual Performance Evaluation (a formal, documented review of an employee's work over the past year, assessing their performance against established goals and expectations) for one (CNA M) of three sampled employees.This failure did not ensure CNA M had the necessary knowledge to provide safe resident care.Findings:Review of the facility's randomly selected three employee files indicated, CNA M was hired at the facility on 7/9/2013. There was no current annual performance evaluation found in CNA M's file.During an interview with the director of staff development (DSD) on 4/17/2026 at 10:22 a.m., DSD stated according to the business office records, CNA M had her last annual performance evaluation on 8/27/2023. DSD further stated they could not find the hard copy of the evaluation and the only reason they knew the date of her last evaluation was CNA M got a raise on that date. DSD confirmed all employees would get a raise every time they had their annual performance evaluation.During an interview with the director of nursing (DON) on 4/17/2026 at 10:47 a.m., the DON stated the DSD tracked down the CNAs annual performance evaluation and CNA M was out for awhile and she just came back. The DON further stated the performance evaluation should have been done annually and she was not sure why it was missed.During a follow up interview with the DSD on 4/17/2026 at 11:38 a.m., the DSD stated CNA M went on leave on 6/2025 and she came back on light duty on 1/18/2026. The DSD further stated she had a spread sheet to track down who was due for an annual performance evaluation. When the DSD was asked should CNA M's performance evaluation been completed when she came back to work, the DSD stated, yes.During a review of the facility's document titled, EMPLOYEE HANDBOOK, dated 6/1/2017, indicated, All Carmel Hills all staff members generally receive a performance evaluation at the same time. Although there is no established evaluation date, evaluations will generally occur in December. Based on this evaluation you may, at Carmel Hills discretion, receive an increase in pay.PERFORMANCE EVALUATION: At the time of your evaluation, your work during the year will be evaluated by your supervisor .

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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 6.06% when 2 medication errors occurred out of 33 opportunities during the medication administration for 2 out of 7 residents (Residents 18 and 61). For Resident 61, metformin (medication to manage diabetes) was not administered with a meal as per manufacturer's specifications. Resident 18's olanzapine (an antipsychotic medication) ODT (oral disintegrating tablet - a solid dosage form that dissolves rapidly on the tongue) was crushed, a practice contrary to the accepted standards of practice.The deficient practice had the potential for adverse effects (such as stomach irritation) and ineffective use of medications for the residents.1. During the medication administration observation on 4/13/26 at 4:42 p.m., Licensed Vocational Nurse (LVN) C was observed preparing 2 medications for Resident 61 including a tablet of metformin 500 milligrams (mg, unit of measurement). On 4/13/26 at 4:43 p.m., LVN C brought the 2 medications with a small cup, about 3-4 ounces, of applesauce into Resident 61's room. Then she administered the medications to the resident along with the applesauce.During a concurrent interview and record review, on 4/13/26 at 4:46 p.m., LVN C was asked to look up the drug information for metformin. She reviewed the administration instructions, under INDICATIONS & DOSAGES, for metformin from the Nursing 2025-2026 Drug Handbook. which indicated to administer metformin with morning and evening meals. LVN C acknowledged Resident 61 did not receive her metformin with a meal, and stated dinner is scheduled daily at 5:30 p.m.A review of Resident 61's physician's orders indicated an order, dated 1/2/26, for metformin 500 mg two times a day for diabetes.During an interview with the Director of Nursing (DON) on 4/13/26 at 4:54 p.m., she acknowledged metformin should be given with a meal. She additionally stated, The pharmacy is usually very good with catching this and tells us to change in the MAR [medication administration record].By the time the surveyor left the facility, on 4/13/26 at 5:15 p.m., there was no dinner cart or trays observed in Resident 61's hallway yet.A review of the Prescribing Information for metformin from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs), updated 9/6/12, indicated, Metformin . should be given in divided doses with meals and Common side effects of Metformin .include diarrhea, nausea, and upset stomach . Taking your medicine with meals can help reduce these side effects.2. During the medication administration observation on 4/14/26 at 8:48 a.m., LVN D was observed preparing 2 medications for Resident 18: half a tablet of metoprolol (medication for high blood pressure) 25 mg and half a tablet of olanzapine ODT 5 mg. After punching them out from the respective bubble pack, LVN D placed the two half pills in a small plastic bag and crushed them into fine powder. Then she poured the powder into a small medication cup, added applesauce to it, and brought to Resident 18's bedside.On 4/14/26 at 8:49 a.m., LVN D was observed spoon-feeding the resident the medication-applesauce mixture followed by some water.A review of Resident 18's physician's orders included an order, dated 3/22/26, for Zyprexa Zydis (olanzapine) Oral Disintegrating Tablet 2.5 mg by mouth two times a day for agitation related to neurocognitive disorder (condition involving decreased mental function due to brain nerve cell damage).A review of an online article titled Which tablets should never be crushed?, updated 3/31/26, on www.Drugs.com (a highly reputable source for medication information website used by both consumers and healthcare professionals), it indicated the following for dissolvable dosage forms including ODTs: These are designed to dissolve on the tongue or under the tongue. Crushing or chewing these may cause a loss of dosage.During an interview with LVN D on 4/14/26 at 11:45 a.m., she stated Resident 18 could not take anything non-crushable that was the reason why she crushed all her medications. When asked to look up whether olanzapine ODT could be crushed, she reviewed an online resource on her laptop and stated, It says here it should not be crushed. During an interview with the DON on 04/14/2026 at 1:37 p.m., she stated olanzapine ODT should not be crushed.During a telephone interview with the Consultant Pharmacist (CP), on 4/16/2026 at 1:32 p.m., she stated Zyprexa Zydis is not crushable as it dissolves (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quickly on the tongue.A review of the Prescribing Information for olanzapine ODT, updated 1/6/16, from DailyMed indicated, As soon as you open the bottle, remove the tablet and put it into your mouth. The tablet will disintegrate quickly in your saliva so that you can easily swallow it with or without drinking liquid.

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	056055	A. Building B. Wing	04/17/2026

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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 3 inhalers and 3 insulin pens (pre-filled pen containing insulin - medication to lower blood sugar) were given the expiration date in accordance with the manufacturer's specifications, and an expired and discontinued insulin pen was removed, in 1 out of 2 inspected medication carts. The failure had the potential for medication errors or residents being administered expired medications or given beyond the effective period.During an inspection of the Station 2 Pebble Beach Medication Cart with Licensed Vocational Nurse (LVN) A and LVN B on 4/13/26 at 2:40 p.m., the following was identified and verified with both staff:a. The Incruse Ellipta inhaler (medication to treat chronic breathing problems) for Resident 24 was labeled with open date of 3/26/26 and the expiration date of 5/26/26 (2 months from open date). A review of the manufacturer's instructions on the inhaler box indicated, Discard the inhaler 6 weeks after opening the moisture-protective foil tray or when the counter reads '0' (after all blisters have been used), whichever comes first.b. The Breo Ellipta inhaler (medication to treat breathing problems) for Resident 24 had a written Date Opened 3/23/26 and Date Expired 5/23/26 (2 months from open date). A review of the manufacturer's instructions on the Breo box indicated, Discard the inhaler 6-weeks after opening .c. The Trelegy Ellipta inhaler (medication to treat breathing problems) for Resident 11 had a labeled opened date of 3/18/26 and expired date of 6/18/26 (3 months from opening). The manufacturer's instructions on the Trelegy box indicated, Discard the inhaler 6 weeks after opening .d. The Lantus (long-acting insulin) pen for Resident 43 had the label sticker indicating Date Opened 4/2/26 and Date Expired 5/2/26 (30 days from opening). A review of the pharmacy label with LVN A indicated, .Use a Pen for Up To 28 days After First Use Then Throw [Away].e. The Lantus pen for Resident 96 had a labeled open date of 4/5/26 and expired date of 5/5/26 (30 days after opening). The pharmacy's label indicated, .Use a Pen for Up To 28 days After First Use Then Throw.f. The Lispro (short-acting insulin) pen for Resident 96 had a labeled open date of 2/25/26 and expired date of 3/27/26 (30 days after opening). The pharmacy's label indicated, .Throw away Any Medicine That Remains 28 Days After First Use.During this inspection, on 4/13/26 at 2:50 p.m., both LVN A and LVN B stated the nursing staff use the pharmacy's Multi-Dose Medications Expiration Date Reference Guide, revised January 2026, from the pharmacy for dating multi-dose medications. Its review with LVN A and LVN B indicated Incruse, Breo, and Trelegy inhalers had 6-week expiration date after opening; and insulin pens were good for 28 days (not 30 days) after opening. LVN A and LVN B acknowledged the above products were given longer expiration date than required by the manufacturers. Furthermore, LVN A confirmed Resident 96's Lispro pen had expired and stated the resident no longer had an order for it. She acknowledged the pen should have been removed from the medication cart to avoid error.A review of Resident 96's medication orders indicated the Lispro order was discontinued on 3/6/26 (more than a month before survey date).During a telephone interview with the Consultant Pharmacist (CP), on 4/16/2026 at 1:32 p.m., she stated the Incruse, Breo, and Trelegy inhalers have 6-week expiration date after opening. A review of the facility's policy and procedures titled Medication Labeling and Storage, revised 2/2023, indicated, Multi-dose vials that have been opened or accessed . are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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	056055	A. Building B. Wing	04/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow standard infection control practices when the following were observed:1. Undated nasal cannula (NC, light weight, flexible, medical device tube used to deliver oxygen [O2, a colorless, odorless and tasteless gas that is essential for life on earth, supplements for residents with breathing problem] for residents) for Resident 31,1, 44, 3, and 84;2. Undated nebulizer face mask (a medical device that fits over the nose and mouth to deliver liquid medication directly into the lungs [pair of organs, responsible to take O2 from air and transfer to blood] as a fine mist) for Resident 25 when not in use;3. Uncovered C-Pap (continuous positive airway pressure by delivering a steady, gentle stream of pressurized air through a mask to keep airway [the anatomical pathway from air to travel from nose and mouth to the lungs] open during sleep) face mask (designed to fit different breathing styles and sleeping positions) for Resident 34 and 118 when not in use;4. Wet wash cloth and bath towel on floor;5. Unlabeled resident's personal care items left in resident's bathroom.These failures could result in the spread of infections that could affect the 92 residents who reside in facility. Findings: 1. During Resident 31's room observation on 4/13/2026 at 10:39 a.m., noted unlabeled and uncovered NC one end attached to room air concentrator (RAC, a medical device collect O2 from room air, purify and deliver 90-95% O2 to residents), rest of the tube coiled around and left on RAC when O2 not in use next to Resident 31's bed when O2 not in use. During room rounds for Resident 1 on 4/13/2026 at 10:45 a.m., observed unlabeled NC one end attached to RAC and rest of the tube on floor next to Resident 1's bed, O2 not in use. During initial room rounds for Resident 44 on 4/13/2026 at 11:15 a.m., noted unlabeled NC connected one end to RAC, NC prongs (two small, curved plastic tips that are inserted in nostrils to deliver o2) was in Resident 44's nostrils, receiving O2. During room observation for Resident 3 on 4/13/2026 at 11:35 a.m., noted, Resident 3 was receiving O2, unlabeled NC attached to RAC, NC prongs was in Resident 3's nostrils. During room rounds for Resident 84 on 4/13/2026 at 2:07 p.m., noted one RAC and one emergency oxygen tank (E-tank, a portable, high pressured, 3 foot tall metal cylinder used to delivery O2), NCs were attached to both, NCs other end on the floor, uncovered. O2 was not in use. During an interview with facility's assistant director of nursing (ADON) on 4/15/2026 at 11:58 a.m., ADON stated NC should be changed every week, labeled when changed and stored in a black bag when not in use. During an interview with facility's director of staff development/interim infection preventionist (DSD/IIP) on 4/16/2026 at 11:12 a.m., DSD/IIP stated nursing staff should have changed NC every week, labeled when changed, and stored in a assigned black bag when not in use for infection control. 2. During initial room round on 4/13/2026 at 10:35 am for Resident 25, observed nebulizer face mask uncovered and left on top of the nebulizer machine on night stand next to Resident 25's bed. Resident 25 stated nursing staff left the mask after completed nebulizer treatment in the morning. Resident 25 (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also stated staff leaves the mask on top of the machine every day. Review of Resident 25's face sheet (a document that provides resident's information at a quick glance indicated Resident 25 was admitted to facility on 3/26/2026. Resident 25's diagnoses included chronic obstructive pulmonary disease (COPD, a progressive lung disease that makes difficulty breathing and reduced airflow) and acute respiratory failure (a life threatening, sudden onset where lungs cannot properly oxygenate the blood, caused significant difficulty breathing). Review of Resident 25's minimum data set (MDS, assessment tool) assessment dated [DATE], indicated Resident 25's brief interview for mental status (BIMS) score of 15/15 (score of 0-7, severe cognitive impairment, 8-12, moderate cognitive impairment, 13-15, cognitively intact), intact cognition. Review of Resident 25's order summary report indicated Ipratropium (a liquid medication used to treat COPD)-Albuterol Solution (liquid medication used to treat or prevent difficulty breathing) 0.5-2.5 (3) MG (milligram, unit of mass, equal to one thousandth of a gram) /3 ML (milliliter, unit of volume equal to one thousandth of a liter) via inhale orally two times a day for COPD, dated 3/26/2026. During an interview with ADON on 4/15/2026 at 11:58 a.m., ADON stated nebulizer face mask should be cleaned, air dry, and stored in a black when not in use. During an interview with DSD/IIP on 4/16/2026 at 11:07 a.m., DSD/IIP stated nebulizer mask should be cleaned, air dry after each use, and stored in a assigned black bag when not in use for infection control. 3. During an initial room observation for Resident 118 on 4/13/2026 at 10:15 a.m., noted C-Pap face mask, uncovered and left on Resident 118's bed. During an initial room observation for Resident 34 on 4/13/2026 at 10:43 a.m., noted C-Pap face mask in an opened plastic white bag stored in night stand's top drawer, this drawer was opened, exposing face mask. During an interview with ADON on 4/15/2026 at 11:58 a.m., ADON stated C-Pap face mask should be cleaned, air dry, and store in a black storage bag when not in use. During an interview with DSD/IIP on 4/16/2026 at 11:02 a.m., DSD/IIP stated nursing staff should have stored C-Pap face mask in a black storage bag when not in use for infection control. 4.During room rounds on 4/13/2026 at 10:18 a.m., observed wet wash cloth and wet bath towel on floor next to Resident 107's bed. During an interview with certified nursing assistant P on 4/13/2026 at 11:50 a.m., CNA confirmed above observation. CNA P stated wet wash cloth and bath towel were used to clean Resident 107, should have sent for laundry not to left on floor after use for resident. During an interview with facility's DSD/IIP on 4/16/2026 at 11:00 a.m., DSD/IIP stated nursing staff should have sent wash cloth and bath towel to laundry after use and should not left on floor to maintain infection control. 5.During an observation and interview with CNA P on 4/13/2026 at 11:50 a.m., noted two unlabeled, (continued on next page)

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	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	23795 W. R. Holman Highway Monterey, CA 93940

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plastic gray color wash basins (lightweight and durable reuseable container designed to use for resident's personal care and hygiene) on counter near sink in bathroom between Resident Room (RR) 3 and 4. CNA P confirmed this observation and bathroom was shared between three residents from RR 3 and 4. CNA P stated both wash basins were in use, without label with resident's name, risk for using for unassigned resident. CNA also stated nursing staff should label, clean and store wash basin in resident's closet or in night stand when not in use. During observation of bathroom between RR 5 and 6 on 4/14/2026 at 8:30 a.m., noted two unlabeled, plastic gray color wash basins left under the sink. During an interview with CNA Q on 4/14/2026 at 8:37 a.m., CNA Q confirmed this observation and bathroom been shared between three residents from RR 5 and 6. CNA Q stated both wash basins were in use, should be labeled, and stored in resident's closet. When not in use. During an interview with license vocational nurse L (LVN L) on 4/15/2026 at 11:44 a.m., LVN L stated resident's wash basins should labeled and stored in resident's closet or in night stand when not in use for infection control. During an interview with DSD/IIP on 4/16/2026 at 10:53 a.m., DSD/IIP stated resident's personal care items such as wash basin should be labeled and stored in a closet when not in use to prevent use for unassigned resident and maintain infection control. Review of facility's policy and procedure (P&P) titled, Reusable Resident Care Items, effective date June 2015, the P&P indicated, To prevent cross-contamination and ensure proper infection control practices related to reusable care items. Basins and personal care items are designated for individual resident use and are not shared. Clean items are stored in a designated clean area. Items are not stored on the floor or in contaminated areas. Heavily soiled or contaminated items will be cleaned immediately.

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	056055	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Care Center	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe and functional environment for kitchen staff when there was broken and buckled concrete flooring and condensed ice accumulation on the ceiling and on the floor in the walk-in freezer of the kitchen. These failures had the potential to create an unsafe environment for 23 staff in the kitchen.Findings:During a concurrent observation and interview on 4/13/2026 at 11:15 a.m. with the Head [NAME] (HC) in the walk-in freezer in the kitchen, the concrete floor was observed to be buckled and broken with multiple lines. The HC stated the floor had been in this condition for about three years, and the facility had a plan to fix it. In addition, some condensed ice accumulations were observed to be on the floor and on the ceiling. The HC stated it was slippery and not safe for the staff.During an interview on 4/14/2026 at 2:44 p.m. with the administrator (ADM), the ADM was aware of the damaged floor in the walk-in freezer in the kitchen. He stated it was found during the last recertification survey in December 2024, and the facility had submitted the plan of correction by caulking to seal the crack of the concrete floor, but it was not better. The ADM stated the floor was buckled, uneven, and it had a potential for tripping staff. Showing the picture of condensed ice in the walk-in freezer to the ADM, he stated it could be condensed ice from the condenser and needed to be fixed.During a concurrent observation and interview on 4/15/2026 at 9:26 a.m. with the Director of Environmental Services (DES) and Maintenance Assistant (MA) N in the walk-in freezer in the kitchen, buckled and cracked concrete floor and condensed ice on the floor and ceiling were observed. The DES stated the building underneath was moving due to geologic forces, which created an open area underneath the floor and the crack, then when the ice dropped from the condenser and got into the crack area, the flooring buckled and became uneven. The facility solved it by caulking to seal the crack area to avoid water or ice getting into the crack area, but it worked only for a few months. The buckling was smaller in 2024, but then became bigger. He stated the floor was supposed to be even and smooth. The kitchen staff was informed to be careful of the floor condition.A review of the facility's policy and procedure titled, Hazardous Areas, Devices and Equipment, dated July 2017, indicated, . A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following: . e. Irregular floor surfaces.According to the 2022 Federal Food Code, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be smooth, durable, and easily cleanable for areas where food establishment operations are conducted