

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Eden Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 612 Main Street Soledad, CA 93960	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>40141</p> <p>Based on interview, facility document review, and facility policy review, the facility failed to ensure a Registered Nurse (RN) provided services eight consecutive hours, seven days a week in the facility for 5 of 28 days reviewed.</p> <p>Findings included:</p> <p>A facility policy titled, Nursing Departmental Supervision, revised 08/2022, specified, 2. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.</p> <p>A December 2024 License Staff Schedule revealed there was not an RN scheduled for 12/25/2024 or 12/26/2024.</p> <p>During an interview on 01/21/2025 at 2:25 PM, the Director of Nursing (DON) stated she had been having a hard time covering the RN hours. The DON stated there was not an RN at the facility on 12/25/2024.</p> <p>During an interview on 01/21/2025 at 2:29 PM, the Director of Staff Development (DSD) reviewed the Nursing Staffing Assignment and Sign-in Sheets and the schedule, then confirmed there was no RN on 12/25/2024.</p> <p>During an interview on 01/22/2025 at 10:48 AM, the DON confirmed there was no RN at the facility on 12/25/2024 or 12/26/2024. The DON stated she was aware the requirement was for eight consecutive hours a day. The DON stated an RN was required to make sure staff had supervision for resident assessments and to do the things only a RN could do, like staging pressure ulcers and administering intravenous medications.</p> <p>A January 2024 License Staff Schedule revealed there was not an RN scheduled for January 11th, 12th, or 18th.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/22/2025 at 10:48 AM, the DON stated that the January schedule was labeled 2024, but it was actually for 2025 (indicating that the dates lacking RN coverage were 01/11/2025, 01/12/2025, and 01/18/2025.) The DON stated that January 11th, 12th, and 18th were highlighted in orange on the schedule and that it indicated there was no RN coverage at the facility for eight consecutive hours on those days.</p> <p>During an interview on 01/22/2025 at 11:00 AM, the Administrator stated she was aware the facility did not have RN coverage on some days. The Administrator stated she expected the regulation to be followed and for an RN to be in the facility for eight consecutive hours, seven days a week.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>31524</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure as-needed (PRN; pro re nata) orders for psychotropic drugs were limited to 14 days without documented rationale for 1 (Resident #9) of 5 residents reviewed for unnecessary medications. Specifically, Resident #9 had an order for hydroxyzine hydrochloric acid (HCl) (an antianxiety medication) started on 12/29/2024, with no stop date or documented rationale for continued use.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Monitoring Medication Management, dated 11/2017, indicated, PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>Resident #9's Admission Record indicated the facility admitted the resident on 12/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure and depression.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/05/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #9's care plan included a focus area initiated on 12/30/2024, that indicated a mood problem related to anxiety and depression. Interventions directed staff to administer hydroxyzine as ordered and to monitor and report any mood patterns of depression or anxiety to the physician.</p> <p>Resident #9's Order Summary Report contained an order dated 12/29/2024 for hydroxyzine HCl oral tablet 25 milligrams (mg), with instructions to give 1 tablet by mouth every eight hours as needed for anxiety.</p> <p>Resident #9's Scheduling Details for hydroxyzine HCl oral tablet 25 mg 1 tablet by mouth every eight hours as needed for anxiety revealed a start date of 12/29/2024 and an end date of indefinite.</p> <p>Resident #9's January 2025 Medication Administration Record [MAR] revealed a transcription of an order started on 12/29/2024 for hydroxyzine HCl oral tablet 25 mg with instructions to give 1 tablet by mouth every eight hours as needed for. The MAR revealed staff documented that Resident #9 received the medication 32 times from 01/01/2025 to 01/20/2025.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/21/2025 at 12:52 PM, the Medical Director (MD) stated PRN antianxiety medication use should be limited to 14 days. The MD stated some patients became agitated in the hospital, and PRN antianxiety medications could be given even though there was no indication for use. The MD stated that when a resident was admitted from the hospital, a PRN antianxiety medication could carry over to the resident's consolidated orders in the facility, but the order should be discontinued. The MD stated hydroxyzine was typically used for itchiness, but if the resident's order specified the use of PRN hydroxyzine for anxiety, then the order should be discontinued. The MD stated if a resident used a PRN antianxiety medication daily then the nursing staff should notify him so he could evaluate the resident and determine if the medication should be used routinely instead of on a PRN basis. The MD stated he did not remember any indication for Resident #9 to continue the use of PRN hydroxyzine because the resident was new to him. The MD stated it was important to stop PRN antianxiety medication use because they did not want to give medications unnecessarily and polypharmacy was never good.</p> <p>During an interview on 01/21/2025 at 12:56 PM, the Pharmacist stated the use of PRN antianxiety medications should be evaluated within the first 14 days of use. The Pharmacist stated some physicians preferred to use PRN hydroxyzine for anxiety because it was short acting and had less side effects than benzodiazepines. The Pharmacist stated PRN hydroxyzine was typically used short term for itching instead of routine anxiety episodes. The Pharmacist stated she had not done the January 2025 medication reviews yet, so she had not reviewed Resident #9's medication list. The Pharmacist further stated it was unusual for facilities to continue the use of PRN hydroxyzine because it had more antianxiety effects in a short-acting formula, so the continued use needed to be re-evaluated.</p> <p>During an interview on 01/21/2025 at 3:25 PM, the Director of Nursing (DON) stated she spoke with Resident #9, who did not want hydroxyzine to be given routinely; the resident instead wanted to continue to use the medication on a PRN basis. The DON stated there was no documented rationale from the physician in Resident #9's medical record for the continued use of PRN hydroxyzine.</p> <p>During an interview on 01/22/2025 at 8:40 AM, the DON stated she reviewed the medication list for new admissions and saw Resident #9's PRN hydroxyzine, but the facility typically used PRN hydroxyzine for itching, so she missed the resident's indicated use for the medication. The DON stated she was aware of the 14-day stop date requirement for the use of PRN antianxiety medications. The DON stated they identified Resident #9's use of PRN hydroxyzine but the resident was scheduled to discharge the day after their last psychotropic meeting, so no changes were made. The DON stated Resident #9's stay was approved weekly by their insurance, and she initially thought Resident #9 would not be in the facility past 14 days. The DON stated she expected there to be a 14-day stop date on all PRN antianxiety medications so staff could re-evaluate the resident. The DON stated Resident #9 used their PRN hydroxyzine frequently, and when she talked to Resident #9, they wanted to keep the medication on a PRN schedule.</p> <p>During an interview on 01/22/2025 at 8:45 AM, the Administrator stated she was aware that stop dates were required for PRN psychotropic medications and expected there to be a stop date for PRN antianxiety medications per the regulations.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28196</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to implement enhanced barrier precautions (EBP) for 1 (Resident #41) of 2 residents reviewed for urinary catheters.</p> <p>Findings included:</p> <p>A facility policy titled, Enhanced Barrier Precautions, dated 08/2022, specified, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. The policy further specified, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). The policy revealed, 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: d. providing hygiene; and g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera; and so forth]). The policy revealed, 4. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following: g. Extended Spectrum Beta-Lactamase (ESBL)- producing Enterobacteriales. The policy revealed, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution or discontinuation of the indwelling medical device that places them at increased risk. The policy revealed, 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE [personal protective equipment] required. 11. PPE is available inside of the residents' rooms. 12. Residents, families, and visitors are notified of the implementation of EBPs throughout the facility.</p> <p>An Admission Record revealed the facility readmitted Resident #41 on 01/04/2025. According to the Admission Record, the resident had a medical history that included diagnoses of hydronephrosis with renal and ureteral calculous obstruction, sepsis due to Escherichia coli, urinary tract infection, bacteremia, other acute kidney failure, and calculus of ureter.</p> <p>A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/07/2025, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial to maximal assistance with toileting hygiene, had an indwelling catheter, and was frequently incontinent of bowel. The MDS indicated the resident had active diagnoses that included renal insufficiency, obstructive uropathy, septicemia, and urinary tract infection.</p> <p>Resident #41's care plan included a focus area initiated 01/14/2025, that indicated the resident had an alteration in urinary elimination related to neurogenic bladder, right ureteral stone with hydronephrosis status post nephrostomy tube, chronic use of Foley catheter, and history of urinary tract infections with ESBL. Interventions directed staff to monitor and perform regular catheter care for the Foley and nephrostomy tube, ensuring sterile technique during insertion or dressing changes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A hospital Discharge Summary dated 01/04/2025 indicated Resident #41 was hospitalized from 12/25/2024 through 01/04/2025 with discharge diagnoses that included septic shock secondary to complicated urinary tract infection and gram-negative rod bacteremia.</p> <p>An observation of Resident #41's catheter care on 01/21/2025 at 9:22 AM revealed no EBP sign or PPE outside the resident's room. Certified Nurse Assistant (CNA) #1 and CNA #2 were already in the resident's room with catheter cleaning supplies set up on the over-the-bed table next to the resident's right side of the bed, and the catheter bag was lying on top of the mattress to the left side of the resident's legs. Staff were wearing N95 masks and gloves, but neither of them were wearing gowns. While CNA #1 was performing catheter care, the front of her top was touching the resident's bed linens. CNA #2 was assisting with positioning the resident during catheter care and her top also touched the resident's bed linen.</p> <p>During an interview on 01/21/2025 at 9:33 AM, the Director of Nurses (DON) stated that they were currently working on the EBP policy and procedure but had not implemented or in-serviced their staff. She stated that the EBP protocol should have already been implemented. She indicated the EBP protocol should be used on residents with Foley catheters, percutaneous esophageal gastric (PEG) tubes, anyone with MDRO wounds, central lines, and peripherally inserted central catheter (PICC) lines. She stated they expected to roll out the EBP policy and procedure as soon as possible and were going over the guidelines from the Centers for Disease Control (CDC) and seeing how it would be used in their facility.</p> <p>During an interview on 01/21/2025 at 9:48 AM, CNA #1 stated that they performed Resident #41's catheter care three times a shift (7:00 AM - 3:00 PM), after breakfast, after or before lunch, and before the end of the shift. She stated that they changed gloves and washed their hands before and after care and if they became soiled. She stated that she had not received any other infection control instructions while providing catheter care, other than to be very careful with peri care with Resident #41 since they got a lot of urinary tract infections (UTIs). She stated that she did not remember the last UTI the resident had but thought it may have been a month prior. CNA #1 stated that she did not know what enhanced barrier precautions meant.</p> <p>During an interview on 01/21/2025 at 9:56 AM, CNA #2 stated that they provided catheter care three times a shift, in the morning, mid-day, and before shift change. CNA #2 stated that if the resident had a bowel movement, they cleaned them up again. She stated she had received in-service regarding catheter care and was taught to use standard precaution protocols. She stated Resident #41 had a history of UTIs. She stated she had not received any in-services or training on EBP that she could remember.</p> <p>During an interview on 01/21/2025 at 10:02 AM, the Director of Staff Development (DSD) stated that they were going to in-service their staff and implement the EBP protocol by the end of that day.</p> <p>During an interview on 01/22/2025 at 9:45 AM, the DSD stated that she had read about EBP on the CDC site and had mentioned it to the DON. The DSD stated that they were going to meet with the interdisciplinary team (IDT) regarding it but had not begun in-servicing staff regarding EBP until the previous day after it had been brought to their attention. She stated she thought it was recommended to reduce the potential spread of infections during high contact care procedures like Foley catheters. She stated that she was aware Resident #41 had frequent UTI's and was susceptible to infections and would have benefited from the EBP protocol.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/2025 at 10:07 AM, the Administrator stated that her expectation was that the facility implemented the EBP right away to protect the resident from acquiring infections.		