| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055739 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Salinas Valley Post Acute | 637 East Romie Lane<br>Salinas, CA 93901 |

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 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686<br><br>Based on interview and record review, the facility failed to ensure the Ombudsman (resident advocate) office was notified of hospital transfers for two of three sampled residents (Residents 2 and 3). This failure had the potential to result in the residents not having someone to advocate for their admission, transfer, and discharge rights.<br><br>Findings:<br><br>1. Review of Resident 2's clinical record indicated he was admitted on [DATE] and had a fracture (break) of the left foot and a laceration (cut) on the left hand.<br><br>Review of Resident 2's Progress Notes, dated 11/9/23, indicated the physician examined Resident 2's left hand wound and told the facility to transfer the resident to the hospital.<br><br>Review of Resident 2's Hospital Transfer Form, dated 11/9/23, indicated he was transferred to the hospital at 6:58 p.m. There was no documentation in the clinical record that indicated the facility notified the Ombudsman office of Resident 2's hospital transfer.<br><br>During an interview and concurrent record review with social services staff A (SS A) on 8/1/24, at 11:19 a.m., SS A stated the facility was supposed to notify the Ombudsman office of hospital transfers either by fax or email. SS A reviewed Resident 2's clinical record and confirmed there was no documentation that indicated the facility notified the Ombudsman office of Resident 2's hospital transfer on 11/9/23.<br><br>2. Review of Resident 3's clinical record indicated he was admitted on [DATE] and had diagnoses including subarachnoid hemorrhage (bleeding in the brain).<br><br>Review of Resident 3's Progress Notes, dated 2/28/24, indicated Resident 3 was lethargic (sluggish), pale, and clammy (damp and sticky). The Progress Notes indicated the physician gave an order indicating it was okay to transfer Resident 3 to the hospital.<br><br>Review of Resident 3's Hospital Transfer Form, dated 2/28/24, indicated he was transferred to the hospital at 1:40 p.m. There was no documentation in the clinical record that indicated the facility notified the Ombudsman office of Resident 3's hospital transfer.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055739 | A. Building<br>B. Wing | 08/01/2024 |

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| Salinas Valley Post Acute | 637 East Romie Lane<br>Salinas, CA 93901 |

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 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and concurrent record review with SS A on 8/1/24, at 11:19 a.m., SS A reviewed Resident 3's clinical record and confirmed there was no documentation that indicated the facility notified the Ombudsman office of Resident 3's hospital transfer on 2/28/24.<br><br>All Facilities Letter (AFL) 17-27, dated 12/26/17 and addressed to long-term care facilities, indicated, Effective January 1, 2018, AB 940 requires a LTC facility to notify the local LTC Ombudsman at the same time notice is provided to the resident or the resident's representatives when a facility-initiated transfer or discharge occurs. The facility must send notice to the local LTC Ombudsman for any transfer or discharge that is initiated by the facility, whether or not the resident agrees with the facility's decision. AFL 17-27 further indicated, The facility is required to provide a copy of the notice to the LTC Ombudsman as soon as practicable if a resident is subject to a facility-initiated transfer to a general acute care hospital on an emergency basis. |