STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055739	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salinas Valley Post Acute	637 East Romie Lane 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to develop a care plan to address non-compliance (not cooperating with care) for one of three sampled residents (Resident 1). This failure had the potential to compromise the facility's ability to implement interventions. Findings: Review of Resident 1's medical record indicated Resident 1 was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, a disease that causes breathing difficulty due to blocked airflow from the lungs) and respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide). During an interview with respiratory therapist B (RT B) on 8/12/24, at 10:49 a.m., RT B stated Resident 1 had a laryngectomy (surgical removal of the voice box) and would breath through the laryngectomy stoma (surgically created opening in the neck created during laryngectormy). RT B stated Resident 1 also had a laryngectomy tube (also known as a larytube, a small flexible tube placed in the laryngectormy stoma to prevent it from closing). RT B stated Resident 1 would sometimes take out the larytube. During an interview with licensed vocational nurse C (LVN C) on 8/12/24, at 11:26 a.m., LVN C stated Resident 1 was non-compliant with keeping the larytube in place. Review of Resident 1's Progress Notes, dated 5/27/24, indicated Resident 1 did not have the larytube in place. The Progress Notes indicated Resident 1 was placed on visual checks every 30 minutes. Review of Resident 1's Progress Notes, dated 6/6/24, indicated the resident was non-compliant with the larytube and did not want to wear it despite encouragement from staff. Further review of Resident 1's medical record indicated there was no care plan to address the resident's non-compliance with the larytube. During an interview and concurrent record review with registered nurse A (RN A) on 8/12/24, at 3:11 p.m., RN A confirmed if a resident was non-compliant, this should be care planned. RN A reviewed Resident 1's medical record and confirmed there was no care plan to address the resident's non-compliance with the larytube. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Care Plans, Comprehensive Person-Centered, dated 2001, indicated a comprehensive, person-centered care plan to meet physical, psychosocial, and functional needs is developed and implemented for each resident. The policy further indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to ensure a pain medication order was signed by the physician for one of three sampled residents (Resident 2). This failure had the potential to compromise the facility's ability to administer the pain medication to Resident 2 when needed. Findings: Review of Resident 2's medical record indicated Resident 2 was admitted on [DATE] and had diagnoses including polyneuropathy (a condition of the nerves that often causes weakness, numbness, and pain). During an interview with Resident 2 on 8/12/24, at 2:40 p.m., Resident 2 stated that over the past weekend, she was told she could not receive her oxycodone (medication used to treat pain) because the physician had not signed the order for the medication. Resident 2 explained the oxycodone was ordered as needed (PRN, only to be administered when requested by the resident) and she would normally be able to receive it every six hours. Review of Resident 2's physician's orders indicated there was an order, dated 8/9/24, for oxycodone 10 milligrams (mg, unit of dose measurement) to be administered every six hours PRN. Further review of the physician's orders indicated this oxycodone order was Pending Order Signature. Review of Resident 2's medication administration record (MAR), dated 8/2024, indicated the above oxycodone order was Pending Order Signature from 8/9/24 to 8/11/24. During an interview and concurrent record review with registered nurse A (RN A) on 8/12/24, at 2:53 p.m., RN A reviewed Resident 2's medical record and acknowledged that the above order for oxycodone was Pending Order Signature from 8/9/24 to 8/11/24. During a follow-up interview and concurrent record review with RN A on 8/14/24, at 10:22 a.m., RN A explained that Resident 2 was hospitalized and returned to the facility on [DATE]. When the resident returned, she needed a new prescription for oxycodone, which required a physician's signature for the medication to be refilled. RN A confirmed that if Resident 2 requested her oxycodone during the time the order was Pending Order Signature, the facility would not have been able to administer the medication. RN A stated the facility could have contacted Resident 2's physician, and the physician could have signed the oxycodone order remotely (without having to be present in the facility). RN A reviewed Resident 2's medical record and confirmed there was no documentation that indicated the facility attempted to obtain the physician's signature for the oxycodone order. During an interview with licensed vocational nurse D (LVN D) on 8/14/24, at 11:22 a.m., LVN D confirmed she worked with Resident 2 over the past weekend. LVN D confirmed she informed Resident 2 that she could not receive her PRN oxycodone, as the physician had not yet signed the order. LVN D stated she did not recall reaching out to the physician to obtain a signature for Resident 2's oxycodone order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Pharmacy Services Overview, revised 4/2019 indicated, Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. The policy further indicated nursing staff were responsible for contacting the pharmacy if a resident's medication is not available for administration.