

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 03/27/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>055739                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Salinas Valley Post Acute                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
| F 0641<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686</b></p> <p>Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, an assessment tool) for one of three sampled residents (Resident 1). This failure had the potential to compromise the facility's ability to develop care plans and implement interventions to meet the resident's needs.</p> <p>Findings:</p> <p>1. Review of Resident 1's medical record indicated the resident was admitted on [DATE] and had diagnoses including hemiplegia/hemiparesis (one side of the body is paralyzed or weak), difficulty in walking, and muscle weakness.</p> <p>Review of Resident 1's Change in Condition Evaluation, dated 8/22/24, indicated Resident 1 had an unwitnessed fall.</p> <p>Resident 1's MDS, dated [DATE], was reviewed. Section J1800 of the MDS was designated to indicate if the resident had any falls during the specified time frame. The individual who completed the MDS coded 0, which indicated the resident did not have any falls during the specified time frame.</p> <p>During an interview and concurrent record review with the MDS nurse (MDSN) on 1/29/25 at 10:37 a.m., the MDSN reviewed Resident 1's medical record and confirmed the resident had a fall on 8/22/24. The MDSN stated this fall should have been coded on the MDS dated [DATE], but confirmed it was not. The MDSN confirmed the individual who completed the MDS should have coded 1 in section J1800 to indicate that Resident 1 did have a fall during the specified time frame.</p> <p>The Centers for Medicare &amp; Medicaid Services 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions) indicated for section J1800, Code 1, yes if the resident has fallen during the specified time frame.</p> <p>2. Review of Resident 1's Change in Condition Evaluation, dated 11/26/24, indicated Resident 1 had an open wound on her left arm due to pressure from a splint (a strip of rigid material used to immobilize a body part).</p> <p>Review of Resident 1's treatment administration record (TAR) indicated the resident received treatment for the above left arm pressure injury (injury to the skin and underlying tissue as a result of prolonged pressure) from 11/28/24 to 12/17/24.</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

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 03/27/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>055739                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Salinas Valley Post Acute                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
| F 0641<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Resident 1's MDS, dated [DATE], was reviewed. Section M0210 of the MDS was designated to indicate if the resident had any unhealed pressure injuries. The individual who completed the MDS coded 0, which indicated Resident 1 did not have any unhealed pressure injuries.</p> <p>During an interview and concurrent record review with the MDSN on 1/29/25 at 10:37 a.m., the MDSN reviewed Resident 1's medical record and confirmed the resident had a pressure injury that should have been coded on the MDS, dated [DATE], but was not. The MDSN confirmed the individual who completed the MDS should have coded 1 in section M0210 to indicated that Resident 1 did have an unhealed pressure injury.</p> <p>The 2023 RAI Manual indicated for section M0210, Code 1, yes if the resident had any pressure injuries during the 7-day look back period.</p> |                                                                                       |                                                 |