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	07/02/2025

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 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. (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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure fall management was implemented for one of three sampled residents (Resident 1) when: 1. Resident 1 was not monitored after 5 falls;2. No interdisciplinary team meeting was conducted after 3 falls;3. No care plan was developed after one fall; and4. Resident 1's Responsible Party was not notified after 2 falls. These failures had the potential for Resident 1 to develop ill effects from a fall, to result in future falls and injury, and for Resident 1's responsible party being uninformed and unaware of his condition.A review of Resident 1's clinical record indicated he was admitted on [DATE] and had diagnoses including unspecified fall, muscle weakness, abnormalities of gait and mobility, and cellulitis (bacterial infection of the skin) of the left lower limb. A review of Resident 1's admission Fall Risk Observation/Assessment, dated 3/12/25, indicated his fall risk score was 16 which indicated a high risk for falls. Review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] and was discharged on 6/2/25. Resident 1 had 5 unwitnessed falls during his stay in the facility. Review of Resident 1's clinical record indicated he had unwitnessed falls on 4/1/25, 5/2/25, 5/19/25, 5/24/25, and 5/29/25. There was no documentation in the progress notes that licensed nurses were monitoring Resident 1 every shift after these falls for any ill effects from the falls for a 72 period. During an interview and concurrent record review with the director of nursing (DON) on 7/2/25 at 2:00 p.m., he stated licensed nurses should monitor a resident for 72 hours after a fall and record the resident's post-fall status in the progress notes every shift. The DON confirmed documentation by licensed nurses every shift for 72 hours was not done after Resident 1's 5 falls on the above dates. Review of Resident 1's clinical record indicated three of Resident 1's 5 falls, on 5/19/25, 5/24/25, 5/29/25, had no documented evidence that the facility's interdisciplinary team (IDT, team members from different departments involved in a resident's care) met to discuss Resident 1's falls. During an interview and concurrent record review with the DON on 7/2/25 at 2:00 p.m., he stated the IDT should meet after every fall to discuss the cause of the fall and to develop a plan to prevent further falls, and revise and/or update the care plan based on the IDT's decision. The DON confirmed there was no evidence the IDT met after Resident 1's 3 falls on 5/19/25, 5/24/25. and 5/29/25. Review of Resident 1's clinical record indicated Resident 1 had an unwitnessed fall on 4/1/25. This was the first fall in the facility since Resident 1's admission on [DATE]. There was no care plan developed for Resident 1's actual fall on 4/1/25. During an interview and concurrent record review with the DON on 7/2/25 at 2:00 p.m., he confirmed there was no care plan developed for Resident 1's fall on 4/1/25. The DON stated there should be a care plan created after a fall with interventions identified to prevent further falls. A review of Resident 1's Change of Condition Evaluation, dated 5/2/25, indicated Resident 1 had an unwitnessed fall. The section titled Resident Representative Notification indicated notification was done on 5/2/25 at 2:00 p.m., and Resident 1 was self-responsible party. Another Change of Condition Evaluation, dated 5/19/25, indicated Resident 1 had an unwitnessed fall. The section titled Resident Representative Notification indicated notification was done on 5/19/25 at 4:00 p.m., and Resident 1 was self-responsible. A review of Resident 1's face sheet (a document summarizing key information about a resident) indicated Resident 1's son was the responsible party (RP, a person designated to make health care decisions for a resident). During an interview and concurrent record review with the DON on 7/2/25 at 2:00 p.m., he stated Resident 1 was not identified as being self-responsible and confirmed the son was listed as the RP. The DON confirmed the son was not notified of Resident 1's falls on 5/2/25 and 5/19/25, and stated the son should have been informed of the falls. Review of the facility's policy titled Change in a Resident's Condition or Status, revised February 2021, indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Review of the facility's policy titled Care Plans - comprehensive Person Centered, dated 2001, indicated the interdisciplinary team develops and implements a comprehensive, person-centered care plan for each resident. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the residents' condition.