

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Salinas Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46552 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for an advance directive (AD: a written instruction, such as a living will or durable power of attorney [a document that authorizes to act on behalf of resident] for healthcare when the individual is incapacitated) and completion of physician orders for life-sustaining treatment (POLST: a document that specifies the medical treatments the resident wants to receive during serious illness) form for 9 of 9 sampled residents (Residents 39, 37, 92, 43, 11, 85, 58, 91, and 78). These failures could lead to the delivery of unnecessary or inappropriate medical services against sampled resident's goals and wishes. Findings: Review of Resident 39's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 39 was admitted to facility on 7/3/2018. Review of Resident 39's POLST form dated 7/3/2018 indicated, section D for AD documented No Advance Directive. Further review of Resident 39's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 39. Review of Resident 37's FS indicated Resident 37 was admitted to facility on 7/29/2024. Review of Resident 37's POLST form dated 7/29/2024 indicated section D for AD documented No Advance Directive. Further review of Resident 37's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 37. Review of Resident 92's FS indicated Resident 92 was admitted to facility on 5/14/2024. Review of Resident 92's POLST form dated 5/14/2024 indicated section D for AD documented No Advance Directive. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 92's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 92. Review of Resident 43's FS indicated Resident 43 was admitted to facility on 8/14/2024. Review of Resident 43's POLST form dated 6/10/2024 indicated clinical section D for AD documented Advance Directive not available. Further review of Resident 43's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 43. Review of Resident 11's face sheet indicated Resident 11 was admitted to facility on 8/25/2024. Review of Resident 11's POLST form dated 8/25/2024 indicated, section D for AD documented No Advance Directive. Further review of Resident 11's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 11. Review of Resident 85's FS indicated Resident 85 was admitted to facility on 5/13/2024. Review of Resident 85's POLST form prepared on 5/13/2024 indicated, section D for AD documented No Advance Directive. Further review of Resident 85's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 85. Review of Resident 58's FS indicated Resident 58 was admitted to facility on 8/17/2024. Review of Resident 58's POLST form dated 8/15/2024 indicated section D for AD documented No Advance Directive. Further review of Resident 58's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 58. Review of Resident 91's FS indicated Resident 91 was admitted to facility on 6/4/2024. Review of Resident 91's POLST form prepared on 7/15/2024 indicated section D for AD documented No Advance Directive. Further review of Resident 91's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 91. Review of Resident 78's FS indicated Resident 78 was admitted to facility on 3/10/2023. Review of Resident 78's POLST form dated 3/25/2023 indicated section D for AD blank, uncompleted. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 78's clinical record indicated there was no documented evidence for facility discussed for AD or verified for executed AD or offered or assisted to execute AD for Resident 78. During an interview with facility's social service director (SSD) on 9/19/2024 at 9:56 a.m., SSD verified and confirmed there was no documented evidence for social service staff discussed or verified or offered or assisted to execute AD for above all 9 residents (Residents 39, 37, 92, 43, 11, 85, 58, 91, and 78). SSD stated social service staff should have verified, discussed, offered, and assisted to execute AD and documented as needed for these residents. During an interview with facility's director of nursing (DON) on 9/19/2024 at 10:30 a.m., DON stated social service staff should have discussed or verified or offered or assisted to execute AD for above residents. DON also said nursing staff should have completed all sections for POLST form for Resident 78. Review of facility's P&P titled, Advance Directive, last revised December 2016, the P&P indicated, Prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and /or his or her legal representative, about the existence of any written advance directives. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Nursing staff will document in the medical record the offer to assist and the resident's discussion to accept or decline assistance. Review of State of California law for POLST form indicated California law requires that a POLST form be followed by healthcare providers and provides immunity to those who comply in good faith. POLST must be completed by healthcare provider based on patient preferences and medical indications. Refer to WWW.caPOLST.org.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on observation, interview, and record review, the facility failed to accurately code the minimum date set (MDS, an assessment tool) for 2 of 3 sample residents (Resident 39 and 78) when their MDS assessments did not reflect the current status of the residents. This failure had the potential to affect inappropriate care and interventions. Findings: During an initial tour observation on 9/17/2024 at 9:26 a.m., Resident 39 had tracheostomy with mask on. Further observation indicated mask tube attached to cool mist humidifier (a medical device to add moisture to the air). Review of Resident 39's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident was admitted to facility on 7/3/2018, with diagnoses including tracheostomy (a tube placed in to the hole made by surgery the front of the neck and into the windpipe (the tube in the body that carries air that has been breathed in from the upper end of the throat to the lungs [a pair of organs in the chest that perform gas exchange allowing to breath and supply to body] to keep it open for breathing), anoxic brain damage (brain damage from lack of oxygen [colorless, odorless and tasteless gas essential for living organisms] supply), and acute and chronic respiratory failure (a sudden or develop slowly condition in which lungs have a hard time loading blood with oxygen). Further review of Resident 39's FS indicated Resident 39 was readmitted to facility on 1/7/2024. Review of Resident 39's physician orders dated 1/8/2024 indicated, Shiley (a type of tracheostomy product) # 6 cuffless tracheostomy with DIC (disposable inner cannula) , and another order dated 7/3/2024 indicated Trach care once a day and PRN (as needed) when soiled. Review of Resident 39's MDS assessment section O for Special Treatments, Procedures, and Programs dated 6/14/2024 did not indicate tracheostomy care. During an interview with the respiratory therapist (RT: a healthcare professional who specializes in treatment of breathing and lung disorders) on 9/18/2024 at 10:55 a.m., the RT confirmed Resident 39 admitted to facility with tracheostomy. RT also stated tracheostomy weaning attempts failed due to increased secretions (mucus or sputum from lungs) and currently Resident 39 needing frequent suctioning (a medical procedure that uses a device to remove secretions) through tracheostomy. During a concurrent record review of MDS assessment dated [DATE] for Resident 39 and interview with MDS coordinator F (MDSC F) on 9/19/2024 at 1:36 p.m., MDSC F confirmed tracheostomy care was not coded for Resident 39. MDSC F stated assessment for tracheostomy should have been completed and coded accurately for MDS assessment for Resident 39. During an observation on 9/17/2024 at 9:40 a.m., noted Resident 78 with no tracheostomy. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 78's FS indicated Resident 78 was admitted to facility on 3/10/2023 with diagnoses including acute and chronic respiratory failure, and tracheostomy. Further review of FS indicated Resident 78 was readmitted to facility on 2/7/2024. Review of health status note dated 11/20/2023 at 15:55 indicated, MD (medical doctor) order carried out by a writer with license nurse at bed side to assist. At approximately 1505 resident successfully decannulated (removed) without any adverse reactions or respiratory distress. Review of Resident 78's MDS assessment section O dated 7/5/2024 indicated tracheostomy care. During an interview with RT on 9/18/2024 at 10:55 a.m., RT confirmed there was currently no tracheostomy for Resident 78. RT stated Resident 78 was able to tolerate tracheostomy weaning attempts and tracheostomy was removed approximately 9 months ago. During an interview with MDSC F on 9/19/2024 at 1:31 p.m., MDSC F confirmed MDS assessment for Resident 78 for tracheostomy care was coded wrong. MDSC F stated MDS staff should have assessed and coded accurately for tracheostomy care for Resident 78. During an interview with Director of nursing (DON) on 9/19/2024 at 2:00 p.m., DON stated MDS staff should have assessed and coded MDS assessments accurately to reflect resident's clinical status. Review of facility's policy and procedure (P&P) titled, MDS Completion and Submission, revised July 2017, the P&P indicated, MDS assessments are completed based on the current published RAI (resident assessment instrument: helps nursing home staff in gathering definitive information on resident's strengths and needs) manual guideline. Review of Center for Medicare and Medicaid Services (CMS, a federal agency) RAI 3.0 Version 1.17, section 0, E1 indicated to code if resident received tracheostomy care.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46552 Based on interview and record review the facility failed to ensure the pre-admission screening and resident review (PASRR- screening for residents with a mental disorder and residents with intellectual disability) screening was completed and submitted for two of three sample residents (Resident 43 and 85). This failure had the potential for the mentally ill sample residents to not specialized health care and services. Findings: Review of Resident 43 face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 43 admitted to facility on 8/14/2024. Resident FS also indicated Resident 43 admitted with diagnoses included psychosis (a serious mental disorder characterized by a disconnect from reality), anxiety (excessive and persistent worry and fear of everyday situations), obsessive-compulsive disorder (uncontrollable, recurring thoughts and engages in repetitive behaviors), and adult personality disorder (a disorder of thinking, feeling, behaving, and relating to others in a way that is different to the average person). Review of Resident 43's PASRR dated 4/22/2024 facility name indicated not the current nursing facility name. Level 1 screening completed for another nursing facility name which located 21 miles away from this facility. Review of Resident 85's FS indicated Resident 85 admitted to facility on 5/13/2024 and residing currently residing in the facility. Resident 85's FS also indicated Resident 85 admitted with diagnoses included psychosis (mental disorder) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 85's PASRR dated 2/1/2024 under, Reason Code: 30 Day Exempted Hospital Discharge. Review of letter from California Department of Health Care services (DHCS: state agency responsible for financing and administering health care services delivery programs) dated 2/1/2024 for Resident 85 indicated If the individual remains in the NF (nursing facility) longer than 30 days, the facility should resubmit a new Level 1 Screening as a Resident Review on the 31st day. During record review for Residents 43 and 85 and interview with medical record assistant (MRDA) on 9/18/2024 at 4:15 p.m., MRDA confirmed Level 1 PASRR was not completed for Resident 43 after Resident 43 admitted to this facility and for Resident 85 on 31st day of admission to this facility on 5/13/2024. MRDA stated there was no PASRR completed for both residents after they admitted to this facility. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with minimum data set (MDS: resident assessment tool) coordinator G (MDSC G) on 9/18/2024 at 4:20 pm., MDSC G confirmed there was no Level 1 PASRR screening for Resident 43 for this facility after Resident 43 admitted to this facility from another nursing facility on 8/14/2024. MDSC G stated new Level 1 PASRR screening and resubmission to DHCS were not done on 31st day for Resident 85. MDSC G stated no documentation for PASRR Level 1 screening for both above residents, she completed and submitted to DHCS for Resident 43 and 85 after it was requested the PASRR copies for both residents. During an interview with director of nursing (DON) on 9/19/2024 at 11:00 a.m., DON confirmed Level 1 screening and submission completed on 9/18/2024 for Resident 43, and 85 after (HFEN) requested copies. DON stated nursing staff responsible to complete Level 1 screening and submit to DHCS. DON also stated nursing staff should have completed and submitted Level 1 PASRR screening for above both residents after these residents admitted to this facility to receive mental health care and services as needed for these two residents. Review of facility's policy and procedure (P&P) titled, Admission Criteria, undated, the P&P indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid (a public health insurance program which provides needed health care services for low-income individuals) Pre-Admission Screening and Resident Review (PASARR) process.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview and record review, the facility failed to maintain a safe and secure environment for three sampled residents (48, 74, and 91) when: 1. Resident 48 and 74 Wander Guard (a device that activates an alarm when a resident attempts to leave a safe area) devices were not checked for proper functioning; 2. The interdisciplinary team (IDT: a group of healthcare professionals with various areas of expertise who work together toward the goals of resident's care) 's reommendation and care plan intervetrnion was not followed for Resident 91 after a fall; 3. Cleaning supplies were left in a shared bathroom used by multiple residents. These failures had the potential for elopement (leave a facility without staff knowledge) and compromise the residents safety of the residents. Findings: During an observation on 9/19/24 at 4:20 p.m., Resident 48 was dressed in street clothes and laying on top of her bed sleeping. There was a Wander Guard on her right ankle. Review of Resident 48's physician order dated 9/18/24 indicated Monitor placement of wander guard q shift. During an interview with registered nurse A (RN A) on 9/19/24 at 4:30 p.m., she was asked if the staff document functionality of Resident 48's Wander Guard. RN A stated, If the resident goes near an exit door, the alarm would turn off. RN A stated she did not chart regarding the checking or placement of the Wander Guard every shift. During an observation on 9/16/24 at 1:05 p.m., Resident 74 was dressed in street clothes and ambulating behind his wheelchair. There was a Wander Guard on his right wrist. Review of Resident 74's physician order dated 9/18/24 indicated Monitor placement of wander guard every shift. During an interview with licensed vocational nurse J (LVN J) on 9/18/24 at 2:29 p.m., she was asked if staff document the functionality of Resident 74's Wander Guard. LVN J stated, We don't check the function, only the placement. LVN J further stated He has wandering behavior and ambulates all over the building and when he goes to the exit doors it would beep/sound the alarm. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the director of nursing (DON) on 9/18/24 at 3:00 p.m., he confirmed that Residents 48 and 74 were wearing Wander Guards. The DON was questioned about the staff's responsibility for monitoring those residents in the facility who are wearing Wander Guards. The DON stated there should be a physician's order to check the placement and function of all Wander Guards worn by any resident in the facility. The DON reviewed the physician orders for Resident 48 and 74 and confirmed there were no physician orders to check the functioning of the Wander Guards for these two residents prior to 9/18/24. The DON stated, The staff know the Wander Guards are working because the door alarms when the resident is near the door. When asked if staff are documenting the functionality of the Wander Guards in the clinical record, the DON confirmed there was no documentation that the Wander Guards of Residents 48 and 74 were checked daily for functionality. the DON stated there should be physician orders in place so that the Wander Guards can be assessed, at least daily, for proper functioning. Review of the facility's policy titled Wander Guard System, revised March 2019, indicated Each Wander Guard bracelet used by a resident will be tested for its placement and functionality by staff at least once day. 46552 2. During an observation on 9/17/2024 at 11:20 a.m., noted Resident 91's wheelchair (w/c: a assistive device used for mobility when walking difficult or impossible to do) next to Resident 91's bed with both footrests (used to provide support and stability for user's feet for w/c) were attached to w/c. During a second observation on 9/18/2024 at 3:40 pm., noted Resident 91's w/c with both footrests were attached to w/c. During an interview with Resident 91 on 9/18/2024 at 3:40 pm., Resident 91 stated he has been using a wheelchair with footrests since he was admitted to the facility. Resident 91 also stated nursing staff did not remove the footrests from his wheelchair after his fall on 9/16/2024. Review of Resident 91's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 91 was admitted to facility on 6/4/2024 with diagnoses including anemia (not enough healthy red blood cells [part of blood cells, transport oxygen to body tissues] in body), hypotension (force of the blood pushing against the vessel walls too low) and depression (a mood disorder causes persistent feeling of sadness and loss of interest). Further review of FS also indicated Resident 91 self-responsible for daily decision making. Review of Resident 91's minimum data set (MDS: clinical assessment tool) assessment dated [DATE] indicated Resident's 91's brief interview for mental status (BIMS) score of 13/15 (score range- 00-07: severe impaired cognition, 08-12: moderately impaired cognition, 13-15: intact cognition). Review of Resident 91's change in condition evaluation (a sudden, clinically important change from baseline in physical, cognitive, behavioral, or functional status that requires a change in plan of care) dated 9/16/2024 indicated Resident 91 had a fall when Resident 91 tipped on the wheelchair's footrest while trying to reach over coffee mug. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 91's interdisciplinary team (IDT: a group of healthcare professionals with various areas of expertise who work together toward the goals of resident's care)'s note dated 9/17/2024 indicated recommended interventions included remove w/c footrests as indicated for Resident 91's fall on 9/16/2024. Review of Resident's care plan fall on 9/16/2024 indicated interventions included remove wheelchair footrests as indicated. During an interview with registered nurse M (RN M) on 9/18/2024 at 4:07 pm., RN M confirmed the wheelchair footrests were attached to the wheelchair for Resident 91. RN M stated IDT recommendation for removal of the footrest had not been communicated to nursing staff. RN M also stated nursing should have removed footrests as indicated plan of care to prevent future falls for Resident 91. During an interview with director of nursing (DON) on 9/20/2024 at 12:25 pm., DON stated nursing staff should have removed the wheelchair footrests as indicated recommended by IDT's plan of care to prevent future falls for Resident 91. During review of facility's policy and procedure (P&P) titled, Assessing Falls and Their Causes, undated, the P&P indicated, Appropriate interventions taken to prevent future falls. Review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised December 2016, the P&P indicated, The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 3. During an observation in Resident room [ROOM NUMBER]'s bathroom on 9/16/2024 at 10:40 a.m., noted 2 containers of multi-purpose cleaners with blue color liquid inside with a safety lock cap and 2 cans of disinfectant spray (chemical liquid used to destroy germs) appeared both were in use left on floor next to sink. Review of instructions given on back of multi-purpose cleaner bottles and disinfectant spray cans indicated keep away from children. If Swallowed: Rinse mouth, and then drink 1-2 glasses of water. Contact a poison control center or a doctor immediately. During an interview with certified nursing assistant H (CNA H) on 9/16/2024 at 11:46 a.m., CNA H confirmed above bottles of cleaners and disinfectant spray cans were left on floor in bathroom in Resident room [ROOM NUMBER]. CNA H stated cleaning supplies should not have left in bathroom to prevent accidental drinking by confused residents in the facility. During an interview with RN A on 9/16/2024 at 1:00 pm., RN A stated cleaning products should not be left in resident's access area. RN A also stated cleaning supplies should have kept in a locked storage area for safety. During an interview with facility's infection preventionist (IP) on 9/19/2024 at 4:15 p.m., IP stated all cleaning products should have stored in a locked area for resident's safety. Review of facility's P&P titled, Storage Areas, Environmental Services, revised December 2009, the P&P indicated, Cleaning supplies, etc., shall be stored in areas separate from food storage rooms and shall be stored as instructed on the labels of such products.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48935 Based on observation, interview and record review, the facility failed to provide care according to facility policy and procedures for one of 23 sampled residents (Resident 20) when a registered nurse (RN A) did not check gastrostomy tube (G-tube, a tube that goes directly into the stomach [part of digestive system] and used for giving tube feeding formula and medications) placement (by injecting air and listening to the stomach with a stethoscope) before tube feeding administration. This failure had the potential for enteral feeding complications that could cause harm to this resident. Findings: During a concurrent observation and interview on 9/18/24 at 12:20 p.m., RN A stated she gave a water flush in Resident 20's G-tube without checking the placement in the stomach and the tube feeding was running continuously for some time that why she did not check the placement. During an interview with the director of nursing (DON) on 9/18/24 at 3:50 p.m., the DON stated I expect the nursing staff to check placement by injecting an air bolus, listening to gurgling sounds in the stomach, and check the residual before giving the water flush. Review of facility policy titled Administering Medications through an Enteral Tube, last revision date unknown, indicated to have the staff verify placement of the tube before giving any medication or water flush.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Salinas Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 637 East Romie Lane Salinas, CA 93901	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 38087 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with professional standards of practice for five sampled residents (5, 11, 32, 58, and 92) when: 1. For Resident 5 and 32, the facility administered oxygen with no physician order; 2. For Residents 58 and 92, the oxygen tubing was undated and uncovered when not in use. 3. For Resident 11, the facility administered oxygen without physician order and the oxygen tubing was undated. These failures had the potential to affect the residents' care and could jeopardize their health and well-being. Findings: 1. Review of Resident 5's clinical record indicated she had diagnoses including chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe) and respiratory disorders. During an observation on 9/16/24 at 10:33 a.m., Resident 5 was lying in bed receiving oxygen through a nasal cannula (NC, plastic tubing inserted into the nostrils and attached to an oxygen source). The oxygen concentrator (device used to deliver oxygen) was set at four liters per minutes (LPM, the amount of oxygen being delivered to the resident). Resident 5 stated I use oxygen all the time, and I need it. During an interview and concurrent record review with licensed vocational nurse J (LVN J) on 9/17/24 at 12:30 p.m., she stated Resident 5 uses oxygen continuously. LVN J further stated, She receives oxygen at 4 LPM, I don't see any physician orders for the oxygen, we need a physician order. Review of Resident 32's clinical record indicated she had diagnoses including chronic respiratory failure with hypoxia (inability to keep oxygen and carbon dioxide at normal levels), congestive heart failure (heart works less efficiently and can lead to buildup of fluid in the lungs and shortness of breath), and chronic obstructive pulmonary disease. During an observation on 9/16/24 at 10:33 a.m., Resident 32 was sitting in bed receiving oxygen through NC. The oxygen concentrator was set at 2.5 LPM. During an interview and concurrent record review with licensed vocational nurse J (LVN J) on 9/17/24 at 12:30 p.m., she stated Resident 32 use oxygen continuously. LVN J further stated, She receives oxygen at 2.5LPM, and I don't see any physician orders for the oxyge. When asked if staff documents Resident 32's use of oxygen in the clinical record, LVN J stated We are not documenting it anywhere. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/17/24 at 12:40 p.m., with the director of nursing (DON), the oxygen concentrator settings for Resident 5 and Resident 32 were verified in their respective rooms. The DON confirmed Resident 5 was receiving oxygen via NC at a concentrator setting of 4 LPM and Resident 32 was receiving oxygen via NC at a concentrator setting of 2.5 LPM. During a record review and concurrent interview with the DON on 9/17/24 at 12:50 p.m., he looked through Resident 5's and Resident 32's clinical records and confirmed they did not have a physician's order for the administration of oxygen. The DON acknowledged there should have been an order for oxygen administration for Resident 5 and Resident 32, and the orders should have specified how much oxygen the residents were supposed to receive. Review of facility policy titled Oxygen Administration, last revision date unknown, indicated Verify that there is a physician's order for this procedure. Review the physician's orders . for oxygen administration. 46552 2. During an observation on 9/16/2024 at 11:06 a.m., observed Resident 58's nasal cannula (NC: a plastic medical device tube that provides supplemental O2 through nose) one end hanging on right bed side rail and other end attached to room air concentrator (RAC: a medical device that takes in air from the room and filter out nitrogen [colorless, odorless, tasteless gas, excess in the air can impair ability to breath for humans] to provides higher amounts of oxygen[O2: colorless, odorless, tasteless gas essential for human life]) in Resident 58's room when O2 not in use. Further observation noted NC was undated. Review of Resident 58's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 58 was admitted to facility on 8/17/2024 with diagnoses included interstitial pulmonary disease (a group of conditions that cause scarring in lungs [primary organ responsible for allowing to breath]). Review of Resident 58's physician orders dated 9/15/2024 indicated Oxygen via nasal cannula as needed for low oxygen on RA (room air) maintain 93-95% oxygen. During an interview with Licensed Vocational Nurse I (LVN I) on 9/16/2024 at 11:20 a.m., LVN I confirmed NC tubing was hanging on bed side rail and undated. LVN I stated respiratory therapist staff should have dated NC when changed and nursing staff should have kept NC in a plastic bag when O2 not in use for infection control. During an interview with respiratory therapist (RT: a healthcare professional who specializes in treatment of breathing and lung disorders) on 9/18/2024 at 10:35 a.m., RT stated nursing staff should have kept NC tubing in a bag when O2 not in use. RT also stated RT staff should have dated when changed NC tube weekly. During an observation on 9/17/2024 at 10:10 a.m., noted O2 in use via NC for Resident 92. Further observation indicated O2 rate was set at 2LPM, and NC was undated. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 92's FS indicated Resident 92 was admitted to facility on 5/14/2024 with diagnoses including acute respiratory failure, and chronic obstructive pulmonary disease (a common lung disease that causes breathing problems and restricted airflow). Review of Resident 92's O2 order dated 5/14/2024 indicated Oxygen at 2L/M via nasal cannula; OK to titrate to keep O2 above 90% every shift. During an interview with license vocational nurse L (LVN L) on 9/17/2024 at 10:36 a.m., LVN L confirmed NC tube not labeled with date when changed by RT on weekly basis. LVN L stated RT staff should have labeled NC tube with date when changed for infection control. During an interview with RT on 9/18/2024 at 11:10 a.m., RT stated NC should be labeled with date to know when it was changed. RT also stated RT staff should have dated NC tube when changed on weekly basis for residents. During an interview with facility's infection preventionist (IP) on 9/19/2024 at 4:25 pm., IP stated RT staff should have dated NC tube when changed and nursing staff should have kept NC in a plastic bag when O2 not in use for standard infection control practices. 3. During an observation on 9/16/2024 at 11:51 a.m., noted Resident 11's O2 rate was set at 3 liters per minute (LPM: measurement of oxygen flow rate) O2 to deliver via NC for Resident 11. Further observation noted NC was undated. Review of Resident 11's FS indicated Resident 11 admitted to facility on 8/25/2024. Review of Resident's admission diagnoses including acute respiratory failure (lungs [primary organ responsible for allowing to breath] can't release enough oxygen into the blood), respiratory disorder (lung disease), and obstructive sleep apnea (breathing stops involuntarily for brief periods of times during sleep). Review of Resident 11s physician orders indicated there was no O2 administration order for Resident 11. During an interview with Registered Nurse A (RN A) on 9/16/2024 at 12:12 p.m., RN A confirmed Resident 11's RAC O2 rate indicator was set at 3 LPM, and NC tube not labeled with date when changed. RN A stated RT staff change NC once a week for Resident 11. During an interview with RT on 9/18/2024 at 11:15 a.m., RT stated O2 considered a medical gas, nursing should have obtained an order for O2 before stated administering O2 to Resident 11. RT also stated RT staff should have labeled NC tube when changed weekly for residents. During an interview with director of nursing (DON) on 9/19/2024 at 12:16 p.m., DON stated nursing should have received an order for O2 prior to oxygen administration for Resident 11. Review of facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, undated, the P&P indicated, Change the oxygen cannulae and tubing every seven (7) days, or as needed. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use. Store the circuit in platic bag, marked with date and resident's name, between uses.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935 Based on observation, interview and record review, the facility failed to ensure the proper use of side rails for six (Residents 303, 304, 91, 44, 75, and 12) of 30 residents when: 1. For Residents 303 and 304, there were no signed informed consents for the use of side rails by the resident or the responsible party for either resident. 2. For Resident 91, the informed consent on file was missing a signature from the resident or responsible party. 3. For Residents 44, 75 and 12, there were no care plans for the use of side rails for any of the three residents These failures had the potential to compromise the resident's rights to fully make informed decisions on the use of side rails, and had the potential to put residents at risk for entrapment or serious injury. Findings: 1. During an observation on 9/16/24 at 10:11 AM, Resident 303 was observed lying in bed, with two siderails up in the upright position. Review of Resident 303's facesheet indicated she was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis (partial paralysis and blindness) following cerebral infarction (a brain attack, also known as a stroke) affecting right dominant side, systemic lupus erythematosus (a disease of the immune system that attacks the body), and right humerus fracture. Review of Resident 303's record indicated there was no signed informed consent for the use of side rails signed by either the Resident or the Responsible Party (RP) During an observation on 9/17/24 at 9:08 AM, Resident 304 was observed lying in bed, with two side rails up in the upright position. Review of Resident 304's facesheet indicated she was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease, type 2 diabetes mellitus (a disorder that affects regulation of blood sugar levels), and cardiomyopathy (enlarged heart). Review of Resident 304's record indicated there was no signed informed consent for the use of side rails signed by either the Resident or the responsible party. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/18/24 at 3:50 PM with the director of nursing (DON), the DON confirmed there were no signed informed consents for the use of side rails for both resident 303 and Resident 304. The DON also stated he expects they should have an informed consent for the use of side rails, for residents that use side rails. Review of facility policy titled Bed Safety and Bed Rails, last revision date unknown, indicated Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. 46552 2. During an observation on 9/17/2024 at 10:38 a.m., Resident 91's bed had 1/4 bed rails up both sides at the head of the bed. Review of Resident 91's FS indicated Resident 91 was admitted to facility on 6/4/2024. Resident 91's FS also indicated resident 91 was self-responsible for decision making. Review of resident 91's minimum data set (MDS: clinical assessment tool) dated 9/4/2024 indicated Resident 91's brief interview for mental status (BIMS) score of 13/15 (score of 00-07: severely impaired cognition, 08-12: moderately impaired cognition, 13-15: intact cognition). During an interview with Resident 91 on 9/17/2024 at 10:38 a.m., Resident 91 stated did not recall given consent or not to facility for use bed side [NAME]. Review of Resident 91's physician orders dated 8/14/2024 indicated, Bilateral upper side rails for bed mobility/positioning and /or transfer. Review of Resident 91's clinical document for bed rail and entrapment risk observation/assessment dated [DATE] indicated no signature by Resident 91 for informed consent given for bed side rails use. During record review and interview with facility's director of nursing (DON) on 9/19/2024 at 10:54 a.m., DON reviewed 91's no signature for informed consent for Resident 91. DON stated nursing staff should have completed and taken signature for informed consent from Resident 91 before started using bed side [NAME] for Resident 91. 38087 3. During an observation on 9/17/24 at 8:48 a.m., in Resident 12's room, Resident 12 had 1/4 bed rails up, bilaterally. Review of Resident 12's physician order, dated 6/7/24 indicated he had an order for Bilateral upper side rails for bed mobility/positioning and/or transfer. During a review of Resident 12's Bed Rail Observation/Assessment, dated 6/7/24, indicated bed rails are recommended at all times when resident is in bed to enhance mobility. During an observation on 9/16/24 at 11:08 a.m., in Resident 44's room, Resident 44 had 1/4 bed rails up, bilaterally. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 44's physician order, dated 11/2/23 indicated he had an order for Bilateral upper side rails for bed mobility/positioning and/or transfer. During a review of Resident 44's Bed Rail Observation/Assessment, dated 1/10/24, indicated bed rails are recommended at all times when resident was in bed to enhance mobility. During an observation on 9/16/24 at 9:28 a.m., in Resident 75's room, Resident 75 had 1/4 bed rails up, bilaterally. Review of Resident 75's physician order, dated 11/17/23 indicated he had an order for Bilateral upper side rails for bed mobility/positioning and/or transfer. During a review of Resident 75's Bed Rail Observation/Assessment, dated 11/17/23, indicated bed rails are recommended at all times when resident was in bed to enhance mobility. Review of residents 12, 44, and 75, care plan documents indicated the residents did not have bed or side rails care plans. During an interview and concurrent record review with the director of nursing (DON) on 9/17/24 at 3:15 p.m., he confirmed Residents 12, 44, and 75 were using side rails on their beds, and did not have care plans addressing the use of the side rails. The DON further stated residents who had bed rails in use should have a care plan in place. Review of the facility's policy titled Care Planning - Interdisciplinary Team, revised March 2022, indicated The interdisciplinary team is responsible for the development of resident care plans . Comprehensive person-centered care plans are based on resident assessments and developed by an interdisciplinary team.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 27000 Based on observation, interview, and record review, the facility failed to ensure safe use and disposition of medications, and accurate accountability of controlled drugs (those with high potential for abuse and addiction), when: 1. There were discrepancies between the controlled drug record (CDR, an inventory/accountability sheet) and the medication administration record (MAR) for 2 out of 4 residents (Residents 34 and 83). The failure had the potential for abuse or misuse of controlled drugs; 2. The pharmacy failed to label 3 insulin pens in accordance with the current standards of practice to prevent mix-ups or administration errors; and 3. There was no process in place for the disposition of hazardous drugs (HDs, medications capable of toxic effects on humans) in accordance with the current standards of practice (See United States Pharmacopeia 800 or USP 800, a scientific non-profit organization that sets standards for safe handling of HDs to minimize the risk of exposure to healthcare personnel, patients, and the environment). This deficiency had the potential for exposing healthcare workers, residents, and the environment to dangerous hazardous medications. Findings: 1. During the survey, the CDR (or count sheet) for four residents receiving PRN (as-needed) controlled medications was requested for review. During an interview with the Director of Nursing (DON) on 9/18/24 at 9:15 a.m., he stated any time a resident requests for a PRN (as-needed) controlled medication, the nurse assesses the resident; reviews the physician's order, and if it's time to give the medication, removes the medication from the medication cart; signs it out of the count sheet; administers the medication to the resident; and documents the administration on the resident's MAR. a. A review of Resident 83's clinical record indicated a physician's order, dated 8/12/24, for oxycodone (a potent narcotic for pain) 5 milligrams (mg, unit of measure) every 4 hours as needed for severe pain. During a concurrent interview and record with the DON on 9/18/24 at 9:20 a.m., a review of Resident 83's CDR for oxycodone and the August and September 2024 MARs indicated, on 4 occasions, the nursing staff signed out of the count sheet but did not document on the MAR to show it was administered to the resident, as follows: - 8/14/24 at 1700 (5 p.m.) - 8/21/24 at 6:50 a.m. - 9/7/24 at 10:20 a.m. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/14/24 at 1800 (6 p.m.) During this interview and record review, the DON confirmed the above finding. He also reviewed Resident 83's progress notes and stated he could not find documented evidence to show the medication was administered to the resident. b. A review of Resident 34's clinical record indicated a physician's order for hydrocodone/acetaminophen (brand name Norco, a potent narcotic for pain) 5/325 mg 1 tablet every 4 hours PRN pain, dated 7/31/2024. During a concurrent interview and record review with the DON on 09/18/24 at 9:31 a.m., a review of Resident 34's CDR for hydrocodone/acetaminophen 5/325 mg and the September 2023 indicated Resident 34 had 9 instances where Norco 1 tablet was signed out of the count sheet but not documented on the MAR. They were as follows: - 9/12/24 at 1600 (4 p.m.), 2000 (8 p.m.), 2359 (11:59 p.m.) - 9/13/24 at 1600, 2000, and 2359 - 9/14/24 at 1545, 2000, and 2359 The DON confirmed the above finding and stated the same nurse (RN M) removed the medication each of those 9 times. During a concurrent interview and record review with RN M on 9/18/24 at 3:51 p.m., he verified he had removed the Norco for Resident 34 each of the above 9 occasions but failed to document the administration on the MAR. He stated he was supposed to document each time but sometimes I forget. A review of the facility's policy and procedures (P&P) titled Administering Medications, dated 4/2019, indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. A review of the facility's P&P titled Controlled Substances, dated 11/2022, indicated in part, The system of reconciling the . dispensing .of controlled substances includes the following . a. Records of personnel access and usage; b. Medication administration records . 2. During the inspection of the Station 4 Medication Cart with Licensed Vocational Nurse (LVN) L on 9/17/24 at 11:17 a.m., an insulin pen (a pre-filled pen containing insulin - to lower blood sugar) was identified with the pharmacy label on the cap (not the body) of the pen. LVN L confirmed this finding. On 9/17/24 at 11:30 a.m., an inspection of the Station 2 Medication Cart with RN A identified an insulin pen with the pharmacy label on the cap, not on its body. The cap of the pen was found loosely re-capped and could become loose during movement/shuffling. RN A confirmed this finding and acknowledged that the pen cap labeling had the potential for mix-ups when multiple pen caps become loose when not tightly capped. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 12:11 p.m., an inspection of the Station 3 Medication Cart with LVN J identified an insulin pen with the pharmacy label on the pen cap. LVN J confirmed this finding. A review of the Institute for Safe Medication Practices' (ISMP, a non-profit patient safety organization with recognized national expertise in medication error prevention) Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults, 2017, indicated A patient-specific label is affixed on the body of the insulin pen (not on the removable cap), without obscuring important information on manufacturer labeling or the dose counter/dose window. It further indicated, Insulin pen mix-ups between patients have been reported to ISMP when patient-specific labels were stuck to (or placed on) the pen caps rather than to the barrel of the pen and the caps of two different pens were inadvertently switched. Thus, patients were at high risk for receiving insulin from another patient's pen device as well as exposure to bloodborne pathogens or even the wrong insulin. All patient-specific labels should be applied to the barrel of the pen in a manner as not to obstruct manufacturer drug information. 3. During a medication pass observation on 9/16/24 at 9:36 a.m., RN A was observed preparing 10 medications for Resident 40. One of the medications called Junel 1/20 (a birth control pill) was observed inside a plastic bag with large yellow imprint on the outside: CAUTION HAZARDOUS DRUG. During a visit to the Station 3 Medication Room (main medication room) with the DON on 9/17/24 at 10:46 a. m., five blue-lidded pharmaceutical bins were identified inside the room. The DON stated the discharged and unused medications were discarded in these bins. When asked if there was a separate bin for hazardous drugs (HD), he stated he will get back to the surveyor. During a follow-up interview on 9/18/24 at 9:12 a.m., the DON stated, We are using the blue lidded container for wasting of all the meds. We don't have a separate one [for hazardous drugs]. He confirmed the facility is supposed to have one for HD disposition. On 9/19/24 at 12:15 p.m., the DON provided a copy of the National Institute for Occupational Safety and Health (NIOSH) List of Antineoplastic (cancer treating)] and Other Hazardous Drugs in Healthcare Settings, 2016. A review of 2016 NIOSH List revealed it included commonly used medications in skilled nursing facilities such as colchicine (medication for gout), finasteride (for enlarged prostate), topiramate (an anticonvulsant), fluconazole (an antifungal), warfarin (an anticlotting medication), etc. A review of the current USP 800, effective 11/1/2023, indicated the following under LIST OF HAZARDOUS DRUGS, The National Institute for Occupational Safety and Health (NIOSH) maintains a list of antineoplastic and other HDs used in healthcare. Further review of the USP 800 indicated: (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This chapter describes practice and quality standards for handling hazardous drugs (HDs) to promote patient safety, worker safety and environmental protection. Handling HDs includes .receipt, storage . administration, and disposal of sterile and nonsterile products and preparations. This chapter applies to all healthcare personnel who handle HD preparations and all entities that store, prepare, transport, or administer HDs (e.g., pharmacies .healthcare institutions .). Personnel who may potentially be exposed to HDs include . nurses . Entities that handle HDs must incorporate the standards in this chapter into their occupational safety plan. The entity's health and safety management system must, at a minimum, include: A list of HDs . Safe work practices . Policies for HD waste segregation and disposal.		

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on interview, and record review, the facility failed to ensure the consultant pharmacist (CP) identified irregularities and make recommendations to the facility during the monthly medication regimen review (MRR) for 4 of 23 sampled residents (Residents 72, 40, 44 and 2). This failure had the potential for unsafe medication use and/or residents not achieving highest therapeutic outcomes. Findings: 1. A review of Resident 72's medical record indicated he was an elderly resident admitted to the facility with diagnoses including Parkinson's disease with dyskinesia (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), unspecified dementia (a condition characterized by memory loss) unspecified severity, without behavioral disturbance, mood disturbance, and anxiety, unspecified psychosis (condition that affect the mind, where there has been some loss of contact with reality), depression unspecified and anxiety disorder, unspecified. A review of Resident 72's physician's orders indicated the following: a. Pimavanserin (medication for hallucinations and delusion) 34 milligrams (mg, unit of measure) by mouth at bedtime for Parkinson's, dated 1/11/24. b. Seroquel (medication for mental disorder) 25 mg, give 1 tablet by mouth at bedtime for psychosis (hallucinations and delusions) for seeing things that doesn't exist, dated 1/11/2024. A review of Lexi-comp online (www.[NAME].com), a nationally recognized drug information resource, indicates pimavanserin is used for treatment of Parkinson disease psychosis. For Seroquel, Lexi-comp indicated it can cause increase in the blood lipids and to monitor lipid panel 4 months after initiation and annually. A review of Resident 72's clinical record indicated there had been no identification of and monitoring for specific targeted behaviors; no side effect monitoring; no developed care plan with specific behavioral symptoms, goals, and interventions; no quarterly review by the interdisciplinary team; and no evidence of informed consent for pimavanserin. Also, there was no lipid panel monitoring for the use of Seroquel. During an interview and record review on 09/18/24 at 3:25 p.m. with the Director of Nursing (DON), the DON stated residents receiving psychotropic medications are monitored for behavior(s) and side effects. The DON verified pimavanserin's use for hallucinations and thoughts that happen with Parkinson's disease. He verified there were no documentation of any specific hallucinations and delusions associated with Parkinson's disease psychosis and no care planning specific to Resident 72's symptom of hallucinations. The DON also confirmed there was no informed consent, no quarterly review for this medication, and no documentation of a cholesterol panel for the use of Seroquel. A review of the medication regimen review (MRR) dated January to September 2024 for Resident 72 did not indicate recommendations for pimavanserin from the Consultant Pharmacist (CP). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Salinas Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 637 East Romie Lane Salinas, CA 93901	
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 9/19/24 at 11:00 a. m. with the CP, the CP stated he should have made the recommendations for target behaviors, side effect monitoring, psychotropic review, and informed consent for Resident 72's pimavanserin use. Regarding the lipid panel monitoring, the CP confirmed Resident 72 was receiving Seroquel there should have been a recommendation for a lipid panel monitoring, but he did not make the recommendation. Review of the facility's policy, titled, Medication Regimen Reviews, dated May 2019, indicated the CP performs a medication regimen review, at least monthly, to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. It also indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems medication errors and other irregularities . A review of the facility's policy titled, Pharmacy Services- Role of the Consultant Pharmacist, dated 4/2019, indicated, The Consultant Pharmacist will provide specific activities related to medication regimen review including . Providing the facility with written and electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. 38087 2. Review of Resident 44's medical record indicated Resident 44 had a physician's order dated 7/11/24, for pantoprazole sodium (medication used to treat too much acid in the stomach) 40 milligrams (mg, unit of dose measurement) one time a day for GERD (a chronic digestive disorder in which stomach acid irritates the food pipe lining). Review of Resident 44's document titled Nursing Recommendations, written by the CP and dated 6/9/24, indicated: Pantoprazole is recommended to be administered 30 minutes before the morning meal. The document had initials written in the column marked Follow-Through. Review of Resident 44's medication administration record (MAR) for July, August, and September of 2024 indicated pantoprazole sodium was administered at 9 a.m. beginning on 7/12/24 through 9/19/24. During an interview and concurrent record review with the director of nursing (DON) on 9/19/24 at 2:05 p.m., he stated the initials on the document were his own. The DON further stated that he followed through with the pharmacist's recommendations and adjusted the administration time of the pantoprazole sodium to be one half hour before breakfast. The DON reviewed Resident 44's medication administration record for July, August, and September of 2024. The DON confirmed the licensed nurses were documenting an administration time of 9 a.m. for the pantoprazole sodium. The DON stated I don't know how the administration time got switched back to 9 a.m., I followed the pharmacist's recommendation and changed it to be 6:30 a.m. The DON confirmed the pantoprazole should be administered one half hour before breakfast. 46552 3. Review of Resident 40's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 40 was admitted to facility on 12/11/2020. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 40's current physician medication orders indicated, Acidophilus Capsule (used to help maintain the number of healthy bacteria in stomach (body organ part of digestive system) (Lactobacillus [also called acidophilus]) give 2 capsules two times a day, dated 12/15/2020. Another order dated 4/1/2022 indicated diphenhydramine (used to relieve symptoms of allergy and common cold) 50 mg (milligram: unit of mass equals a thousandth of a gram) at bedtime, dated 4/1/2022. Other order indicated, Ondansetron (used to prevent nausea and vomiting) 8 mg three times a day, dated 11/26/2023. Review of medication administration record for September/2024 indicated, Resident 40 receiving all three medications as ordered above. Review of Resident 40's CP recommendations dated 6/4/2024 indicated, In order to prevent polypharmacy (multiple medications) and unnecessary medication use, may we consider discontinuing the following medications? Ondansetron Acidophilus Diphenhydramine. During a telephone interview with CP on 9/20/2024 at 12:30 p.m., CP confirmed he provided recommendations to the facility to discontinue above three medications for Resident 40. CP stated facility was responsible to follow up with MD (medical doctor) for CP's recommendations for residents as needed. During a concurrent record review of CP recommendations for Resident 40 dated 6/4/2024 and interview with director of nursing (DON) on 9/20/2024 at 1:01 p.m., DON confirmed received CP recommendations for Resident 40, and not been followed up with MD to discontinue above three medications for Resident 40. DON also confirmed Resident 40 currently receiving above three medications as ordered. DON stated nursing staff should have been followed up with MD regarding CP's recommendations to discontinue to prevent use of unnecessary medications for Resident 40. Review of facility's policy titled, CONSULTANT PHARMACIST REPORTS, undated, the P&P indicated, Recommendations are acted upon and documented by the facility staff and/or the prescriber. 48935 4. Review of Resident 2's face sheet indicated he was admitted to the facility on [DATE] with a diagnosis of paraplegia, neuromuscular dysfunction of bladder (a disorder of control of the urinary bladder) and history of COVID-19 (a respiratory illness). Review of Resident 2's physician orders indicated an order for Keflex (antibiotic medications) 250 mg one tablet by mouth in the morning for presence of indwelling catheter & chronic UTI prophylaxis x indefinite, with a start date of 1/31/23. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication regimen review (MRR) binder, which contains the CP's recommendations from January to September 2024, reflected no recommendations from the current CP or previous CP for reviewing the Keflex order with the physician. During a telephone interview with the CP on 9/19/24 at 10:57 AM, the CP stated antibiotics was a part of the MRR review. When asked about Resident 20's physician order for Keflex, the CP stated I do not recall prior review of this resident's Keflex order and Typically we don't recommend keeping someone on Keflex indefinitely.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on interviews and record review, the facility failed to ensure two of 23 sampled residents (Residents 72 and 91) were free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications when: 1. Resident 72 received pimavanserin (an antipsychotic medication to treat hallucinations and delusions associated with Parkinson's disease psychosis) without specific target behaviors, side effect monitoring, quarterly psychotropic review, care plan, and evidence of informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for over 8 months. Also, Resident 72 did not receive periodic monitoring of the blood lipids while being on Seroquel (antipsychotic medication) that would affect the blood lipids). 2. Resident 91 received Remeron (anti-depressant medication) without monitoring for potential side effects of the medication. The failures resulted in unnecessary medications for the residents and had the potential for medication interactions, adverse reactions, and increased risks associated with the use of psychotropic medications that included, but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, and memory loss. Findings: 1. A review of Resident 72's medical record indicated he was an elderly resident admitted to the facility with diagnoses including Parkinson's disease with dyskinesia (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), unspecified dementia (a condition characterized by memory loss) unspecified severity, without behavioral disturbance, mood disturbance, and anxiety, unspecified psychosis (condition that affect the mind, where there has been some loss of contact with reality), depression unspecified and anxiety disorder, unspecified. A record review of Resident 72's physician's orders indicated the following: a. Pimavanserin 34 milligrams (mg, unit of measure) by mouth at bedtime for Parkinson's, dated 1/11/24. b. Seroquel 25 mg, give 1 tablet by mouth at bedtime for psychosis for seeing things that doesn't exist, dated 1/11/2024. A review of Lexi-comp online (www.[NAME].com), a nationally recognized drug information resource, indicates pimavanserin is used for treatment of Parkinson disease psychosis. For Seroquel, Lexi-comp indicated it can cause increase in the blood lipids and to monitor lipid panel 4 months after initiation and annually. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 9/18/24 at 9:00 a.m., Resident 72 was observed in his room speaking and answering questions in a hard-to-understand manner of speech. Resident 72 was observed to be a bit confused but had a pleasant demeanor. No behaviors were noted. A telephone interview was conducted on 9/18/24 at 2:07 p.m. with Resident 72's responsible party (RP1). RP1 stated the pimavanserin was prescribed by Resident 72's neurologist (doctor who diagnoses, treats, and manages disorders of the brain and nervous system) for Parkinson's symptoms such as seeing cats in the house, seeing someone sitting on the chair, or children playing outside when they were not there. A review of Resident 72's clinical record indicated there had been no identification of and monitoring for specific targeted behaviors; no side effect monitoring; no developed care plan with specific behavioral symptoms, goals, and interventions; no quarterly review by the interdisciplinary team; and no evidence of informed consent for pimavanserin. Also, there was no lipid panel monitoring for the use of Seroquel. During an interview and record review on 09/18/24 at 3:25 p.m. with the Director of Nursing (DON), the DON stated residents receiving psychotropic medications are monitored for behavior(s) and side effects. The DON verified pimavanserin's use for hallucinations and thoughts that happen with Parkinson's disease. He verified there were no documentation of any specific hallucinations and delusions associated with Parkinson's disease psychosis and no care planning specific to Resident 72's symptom of hallucinations. The DON also confirmed there was no informed consent, no quarterly review for this medication, and no documentation of a cholesterol panel for the use of Seroquel. 2. A review of Resident 91's medical record indicated he was an elderly resident admitted to the facility with diagnoses including unspecified depression. A review of Resident 91's order summary report indicated a physician's order for Remeron 7.5 mg, 1 tablet by mouth at bedtime for depression for poor meal intake, dated 8/14/2024. A review of Resident 91's medical record indicated there was no monitoring for adverse effects of Remeron. Lexi-comp, a nationally recognized drug information resource, indicated Remeron can produce marked sedation in the elderly and Older patients with depression being treated with an antidepressant should have been closely monitored for response and adverse effects. An interview and record review on 9/19/24 at 10:03 a.m. with the DON, the DON stated when a resident is on psychotropic medication, the staff monitors the target behaviors and side effects on the medication administration record (MAR). He stated there should have been an order for it. After looking on the electronic health record, he stated When Resident 91 was sent to the hospital the order was discontinued, and when he returned on 8/14/24, we did not renew the order but, the order should have been renewed at that time. The DON verified the side effects for Remeron had not been monitored for over one month. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Salinas Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 637 East Romie Lane Salinas, CA 93901	
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated policy and procedures titled Psychoactive/Psychotropic Medication Use, indicated, Residents will only receive psychotropic medications when necessary to treat a specifically diagnosed condition that is documented in the medical record. The attending physician and other staff will gather and document information to clarify, as possible, the resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. Prior to administration of a psychotropic, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative, and document the consent in the medical record. Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication, dose, duration, and adequate monitoring for efficacy and adverse consequences and Staff will monitor for potential adverse consequences such as iii. Metabolic: increase in total cholesterol and triglycerides .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview, and record review, the facility had a medication error rate of 11.11% when four (5) medication errors occurred out of 45 opportunities during the medication administration for four out of nine residents (Resident 3, 38, 45, and 78). The deficient practice resulted in medications not given in accordance with the prescriber's orders and/or manufacturer's specifications, which resulted in residents not receiving the full therapeutic effect of the medications and may cause preventable side effects for the residents. Findings: 1. During the medication pass observation on 9/16/24 at 9:15 a.m., registered nurse (RN) A was observed preparing and administering 6 medications to Resident 45. The medications included 1 tablet of calcium acetate (a phosphate binder, medication to control high blood levels of phosphorus, a mineral found in food, in people with kidney disease who are on dialysis) 667 milligrams (mg, unit of measurement) and 1 tablet of carvedilol (medication to control high blood pressure) 3.125 mg. Resident 45 took her medications with water. There was no food offered to the resident with the administration of his medications. During the medication pass observation, RN A stated the resident had her breakfast at 8 a.m. that morning. During an interview on 9/16/24 at 9:15 a.m. with Resident 45, Resident 45 stated she ate breakfast at 8 a.m. A review of Resident 45's physician's order, dated 9/13/24, indicated: a. Calcium Acetate 667 mg (Phosphate Binder) give 1 tablet by mouth with meals for ESRD (end-stage renal disease) /on hemodialysis, dated 9/13/2024. b. Carvedilol, order dated 9/1/24, 3.125 mg give 1 tablet by mouth two times a day for high blood pressure. During an interview on 9/16/24 at 10:00 a.m. with RN A, RN A stated breakfast was served between 8:15 a. m. and 8:30 a.m. She stated she got behind in time giving four residents their insulin with their meals and three residents requesting pain medications is the reason the calcium acetate was given late. During an interview and observation on 9/16/24 at 2:51 p.m. with RN A, when asked whether carvedilol should have been given with food, RN A stated she did not know how to look up the information. A review of Lexicomp (a nationally recognized drug information resource) with RN A indicated to give the medication with food. RN A stated she did not know carvedilol was supposed to be given with food. She acknowledged the resident ate around 8 a.m. and the medications were given at 9:30 a.m. (one hour past meal consumption). (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Lexi-comp indicated to give carvedilol with food to minimize the risk of orthostatic hypotension (sudden drop in blood pressure when you stand from a seated or lying down position). For Calcium Acetate, Lexi-comp indicated, the medication must be administered with meals to be effective. 2. During a medication administration observation on 9/16/24 at 10:20 a.m., licensed vocational nurse (LVN) L was observed administering 13 medications to Resident 78 and stated she was holding chlorhexidine (an antiseptic and disinfectant for oral hygiene). Review of Resident 78's clinical record indicated a physician's order for chlorhexidine solution give 15 milliliters (unit of liquid) by mouth two times a day for oral care swab and suction, dated 2/7/24. During an interview with LVN L on 9/16/24 at 4:12 p.m., she stated the reason she held the chlorohexidine was because we ran out and I ordered it. She stated that she wrote in the progress notes of the resident that it was not available. LVN L confirmed the medication was due for oral care for the resident. A review of Resident 78's September 2024 Medication Administration Record (MAR) indicated the facility scheduled chlorhexidine gluconate solution to be administered at 9 a.m.; and that LVN L documented a 9 (meaning to see progress notes) in the 9/16/24 entry. A review of resident 78's Nursing Progress Notes, dated 9/16/2024 at 10:27 a.m. LVN L wrote the chlorhexidine was on order. 3. During a medication administration observation on 9/16/24 at 11:48 a.m. with LVN I, LVN I administered seven medications to Resident 38. Included in the medications was one tablet of vitamin D (used for weak bone prevention)1000 IU (international unit; internationally accepted amount of a substance). On 9/16/24, a review of Resident 38's physician's order dated 9/23/23, indicated Cholecalciferol Tablet 1000 Unit give 5 tablets by mouth one time a day for supplement. During an interview and record review on 9/16/24 at 2:50 p.m., LVN I confirmed she gave 1 tablet of vitamin D to Resident 38 and should have given 5 tablets, as ordered. 4. During a medication administration observation on 9/16/24 at 12:55 p.m. with LVN I. LVN I prepared an Insulin Lispro) KwikPen (a pre-filled pen containing (a fast acting insulin to lower blood sugar level) for Resident 3. She stated the resident's blood sugar was 226 and was going to give 2 units of Lispro. LVN I placed the new needle on the KwikPen and turned the dose dial to 2 units. LVN I did not prime the pen before turning the dose dial. On 9/16/24 at 12:55 p.m. LVN I injected the Lispro into the resident's abdomen right side and held it in place for a few seconds. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16/24 at 1:02 p.m. with LVN I, she was asked to explain the preparation process of the Insulin Lispro KwikPen before injection. She stated she typically does not wipe down the tip of the pen after removing the cap. She then puts on the needle, checks the physician's order then twists the pen to the number of units based on the order then gives it SQ (subcutaneous; injection given in the fatty tissue just under the skin). LVN I confirmed she did not prime the needle and stated she was not aware of priming the pen before use. During a follow-up interview on 9/16/24 at 2:47 p.m. with LVN I, she stated she learned that insulin pens have to be primed with 2 units before each injection. During a review of [NAME]-Comp, it indicated for prefilled Insulin lispro pens, prime the needle before each injection with 2 units of insulin. Once injected, hold the needle in the skin for ?? ten seconds after the dose dial has returned to 0 units before removing the needle to ensure the full dose has been administered. A review of the facility's policy and procedure (P&P) titled Administering Medications, dated 4/2019, indicated, Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication . Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . A review of the facility's P&P titled Insulin Administration, dated 2001, indicated, The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview, and record review, the facility failed to ensure proper medication storage as per facility's policy and procedures (P&P) and/or manufacturer's specifications, and expired medications were removed from active stock. Inspection of two of two medication refrigerators and three of four medication carts identified: 1. Four medications were not stored as in accordance with the manufacturer's guidance, and a discontinued medication for a resident was not discarded to prevent medication errors; 2. An insulin pen without visible resident's name on it. This had potential for it to be given to the wrong resident; and 3. One opened inhaler and four eye drop medications did not have an open date; and eight eye medications were used past their respective discard date. The failure had the potential for medication errors and/or medications being ineffective for the residents. Findings: 1. During a visit to the Medication room [ROOM NUMBER] with the Director of Nursing (DON) on 9/17/24 at 10:26 a.m., the medication refrigerator was identified. It contained four syringes of Lovenox (medication used to treat and prevent harmful blood clots) 40mg/0.4ml for Resident 43. The manufacturer's label on the Lovenox indicated to store at 59 F (degrees Fahrenheit) to 86 F (room temperature). During this visit, the DON stated the Lovenox belonged to Resident 43 who was already discharged on [DATE] (19 days ago). He confirmed the Lovenox syringes should not have been stored in the refrigerator and removed when the resident was discharged . 1b. During a visit to the Medication room [ROOM NUMBER] with the DON on 9/17/24 at 10:46 a.m., the medication refrigerator was identified. It contained two bottles of brimonidine (medication that lowers pressure in the eyes) 0.2% eye drops. A review of the the manufacturer's label with the DON indicated for brimonidine to store at 59 F to 77 F. 1c. During an inspection of the Medication Cart # 2 with RN A on 9/17/24 at 11:29 a.m., a tuberculin vial was identified stored at room temperature and not labeled with an open date. The manufacturer's label on the tuberculin carton box indicated, Discard opened product after 30 days. RN A stated it should have been stored in the refrigerator and have an open date. A review of Lexicomp (a nationally recognized drug information resource) indicated: Store tuberculin vials at 2 C to 8 C (36 F to 46 F). Open vials should be discarded after 30 days. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Storage of Medications, dated 2020, indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed and Medication requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. 2. During an inspection of Medication Cart #2 on 9/17/24 at 11:30 a.m. with RN A, an insulin pen (a pre-filled pen containing insulin to lower blood sugar) was identified with pharmacy label on its' cap. However, the label was not readable. RN A confirmed she could not tell which resident the pen belonged to and had the potential for it to be given to the wrong resident. A review of the facility's P&P titled Administering Medications, dated April 2019 indicated: Insulin pens are clearly labeled with the resident's name and other identifying information. 3. During the inspection of Medication Cart #4 on 9/17/24 at 11:51 a.m. with LVN L, an opened Serevent Diskus inhaler (medication to treat breathing problems) was identified without an open date. A review of the manufacturer's labeling with LVN L indicated to Discard SEREVENT DISKUS 6 weeks after opening. LVN L confirmed this finding and that it should have an open date. During an inspection of the Medication Cart #2 with RN A on 9/17/24 at 11:29 a.m., a bottle of latanoprost (medication to treat glaucoma) eye drops with no open date. The pharmacy label on the latanoprost indicated it was good for 6 weeks after opening. During an inspection of the Medication Cart # 3 with LVN J on 9/17/24 at 12:11 p.m., the following were identified: a. Four opened bottles of eye drops without open dates. b. Eight bottles of eye drops past due date; four of which were latanoprost eye drops which had the following open dates 7/2/24, 7/6/24, 7/20/24, and 7/30/24. The pharmacy label on each indicated to discard 6 weeks after opening. During this inspection, LVN J confirmed the findings. She stated opened eye drops were good for 28 days after opening and should have open date so they are not used beyond the 28 days; and those latanoprost eye drops were being used past their 6-week expiration date. During an interview with the DON on 9/17/24 at 1:23 p.m., he stated eye drops are good for 30 days unless manufacturer says longer. A review of Lexicomp indicated the following for latanoprost ophthalmic solution: Once opened, the container may be stored at room temperature up to 25 C (77 F) for 6 weeks. A review of the facility's policy and procedure (P&P) titled, Medication Storage and Labeling for Single dose/Multidose Container, dated 4/2019, indicated, When opening a multi-dose container, the date opened is recorded on the container.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46552 Based on observation, interview, and record review, the facility failed to accommodate food preferences for two of four sample residents (Resident 46 and 16). This failure had the potential for decreased meal intake, negative effect on health and well-being for the residents. Findings: Review of Resident 46's lunch tray card for 9/16/2024 indicated, Notes and Alert: Ground Meat. Review of facility's lunch menu cycle 4 2023 indicated for Monday, Polish Sausage During lunch meal observation on 9/16/2024 at 12:45 p.m., noted Resident 46 served lunch plate with bite size cut meat pieces along with other menu food items. During an interview with certified nursing assistant B (CNA B) on 9/16/2024 at 12:50 p.m., CNA B confirmed Resident 46 received bite size cut polish sausage for lunch meal. CNA B also reviewed and confirmed Resident 46's lunch tray card indicated ground meat under notes and alerts. CNA B stated kitchen staff should have served ground meat to Resident 46 instead of bite size cut sausage pieces. CNA B took Resident 46's lunch plate to kitchen, came back with another lunch plate with ground meat for Resident 46. Review of Resident 16's lunch tray card for 9/16/2024 indicated, Notes: Extra sauce on meats. During an observation on 9/16/2024 at 12:57 p.m., noted Resident 16's lunch plate with bite size cut meat pieces with no sauce on. During an interview with CNA C on 9/16/2024 at 1:05 p.m., CNA C confirmed Resident 16 received meat with no sauce on for lunch meal. CNA C also reviewed and confirmed Resident 16's lunch tray card indicated extra sauce on meats under notes. CNA C stated dietary staff should have prepared lunch plate with extra sauce on meat for Resident 16. During an interview with cook D (CD) on 9/18/2024 at 1:45 p.m., CD stated dietary staff should have read resident's tray cards for notes, alerts for food preferences, and prepared lunch plate according to food preferences for Resident 46 and 16 on 9/16/2024. During an interview with dietary supervisor (DS) on 9/19/2024 at 9:19 a.m., DS stated dietary staff should have read Resident 46's and 16's lunch tray card for alerts and notes for food preferences and served lunch to accommodate both resident's food preferences on 9/16/2024. During an interview with facility's registered dietitian (RD) on 9/20/2024 at 2:00 p.m., RD stated notes and alerts for resident's meal tray card indicate resident's food preferences. RD also stated dietary staff should have read meal try card's notes, alerts, and prepared meal tray to accommodate each resident's food preferences during tray line for each meal. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy and procedure (P&P) titled, Serving Foods, revised January 2013, the P&P indicated, Use diet tray cards to ensure tray accuracy, and that resident preferences are provided.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46552 Based on observation, interview, and record review, the facility failed to ensure sanitary practices in the kitchen and foods were stored under sanitary conditions when: 1. The kitchen floor and corner were seen with dark black areas; 2. Kitchen cleaning cloths were found in the sink and on a food storage container; 3. A container with sliced cheese had no opened date; 4. A food blender was seen with dry and dark brown particles. These failures had the potential to result in food borne illnesses among residents in the facility. Findings: 1. During a concurrent initial kitchen tour and interview with facility's registered dietitian (RD: a health care professional who had special training in nutrition and food) on 9/16/2024 at 9:26 a.m., dark black areas were noted on the kitchen floor near food preparation, cooking stove, front and under refrigerators 1,2, and 3, under stream table, 3-way sink (used to clean and sanitize [removing germs after cleaning] dishes), vegetable washing sink areas, on chemical stand (place to store sanitizing solution[used to sanitize dishes]) located next to 3 way sink, and all corners of kitchen floor. During an interview RD confirmed dark black areas in kitchen and stated dark black areas were from collection of dust and grease build up. RD also stated old building, kitchen floor should have been replaced. RD further stated dietary staff should have cleaned kitchen as scheduled to maintain clean and sanitary practices in the kitchen. Review of facility provided Daily cleaning Task log dated 9/1/224 to 9/14/2024 indicated on 9/1/1024, 9/14/2024 blank, no staff's initials for the task, Sweep and mop diet aide area. No Daily Cleaning Task log available after 9/14/2024. Further review of facility provided Detail Time and Job dated 9/1/2024 to 9/12/2024 for dietary aid staff who initialed Daily Cleaning Task log on 9/2/2024, 9/3/2024, 9/9/2024 for Sweep and mop diet aide area did not work those days. Review of facility provided Deep cleaning tasks kitchen duties indicated there were no signed logs for 1st and 4th week in June 2024, 1st, and 3rd week in July/2024, and 4th week in August 2024. During an interview with dietary aid N (DA N) on 9/19/2024 at 2:40 pm., DA N confirmed he was off from work and did not sweep and mob kitchen on 9/2/24, 9/3/24, 9/9/24, and 9/13/2024. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with facility's dietary supervisor (DS) on 9/19/2024 at 2:50 p.m., DS confirmed daily kitchen sweep and mop task not done on 9/1/24, 9/2/24, 9/3/24, 9/9/24, 9/14/24, and 9/15/2024. DS stated weekly kitchen deep cleaning not completed on regular basis for last few months due to kitchen staff not available. DS also stated dietary staff should have cleaned and initialed each task after completed as assigned to keep kitchen clean and practice sanitary conditions in all kitchen areas. DS also stated he will educate kitchen staff for cleaning and document after cleaned the task as assigned daily or weekly basis. 2 .During an initial tour on 9/16/2024 at 9:43 a.m., noted wet kitchen cleaning cloth on vegetable sink. During an interview with cook D (CD) on 9/16/2024 at 9:44 a.m., CD confirmed kitchen cleaning cloth was used. CD stated she cleaned dietary food carts few minutes ago and left the kitchen cleaning cloth on the sink. CD also stated she should not have left the cleaning cloth on sink, and she should have put the cleaning cloth for cleaning. Another observation and interview along with RD and cook E (CE) on 9/16/2024 at 10:38 a.m., noted kitchen cleaning cloth on plastic container used to store dry beans under food preparation counter area. [NAME] E (CE) removed the cleaning cloth and stated not sure cleaning cloth used or unused. CE also stated dietary staff should not have left kitchen cleaning cloth on food storage container. RD stated dietary staff should have maintained clean and sanitary practices in kitchen. 3. During a kitchen observation along with RD and CE on 9/16/2024 at 10:19 a.m., noted sliced cheddar cheese stored plastic container labeled with no opened date stored inside 3 door refrigerator. During an interview with CE on 9/16/2024 at 10:28 a.m., CE confirmed no opened date written for above food storage container. CE stated dietary staff should have labeled when opened the cheese packet and store in container. During an interview with RD on 9/16/2024 at 10:31 a.m., RD stated dietary staff should have labeled all food storage containers with opened date. 4. During initial kitchen tour along with RD on 9/16/2024 at 10:40 a.m., both noted kitchen blender (used to mix, puree, and liquefy foods) with dark dry brown particles all over on main base where blender jar locks in. During an interview with RD on 9/16/224 at 10:45 a.m., RD confirmed dry dark brown particles on blender base. RD stated these particles were from dry food. RD also stated dietary staff should have cleaned blender base after used. RD further stated currently dietary staff were not using the blender and it should have been removed from kitchen when not in use. Review of facility's policy and procedure (P&P) titled, GENERAL CLEANING OF FOOD & NUTRITION SERVICES DEPARTMENT, undated, the P&P indicated, Seep the floor, pushing all debris forward. Use a dustpan to remove and dispose of debris as it accumulates. Use a mop bucket which has a mop press. Mop under and around equipment, along the walls and in corners. Wipe all splash and soil marks from baseboards and walls. Wipe up all spills as they occur. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's P&P titled, FOOD LABELING AND DATING, undated, the P&P indicated, All items when opened will be labeled with word opened and dated with month, date, and year. Food storage areas should be used only for food. Items such as bleach, soap, and other cleaning supplies should be stored in entirely separate and specific areas.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. The blood pressure cuff was not disinfected between resident use; 2. The shared glucometer (blood glucose meter to measure and display the amount of sugar (glucose) in your blood) was not sanitized and disinfected between resident use; 3. Unlabeled urinals, wash basins, and resident's care items in residents bathrooms; and 4. Resident's care items on the floor. These failures could result in cross-contamination and the spread of infection throughout the facility. Findings: 1. During a medication pass observation on 9/16/24 at 9:15 a.m., Registered Nurse (RN) A was observed giving medications to Resident 45. RN A was called away immediately to assist staff with an incident with another resident, Resident 91. RN A used the blood pressure (BP) cuff to obtain reading for Resident 91. After finished, it was put back on the BP cart outside of Resident 45's room. On 9/16/24 at 9:29 a.m., RN A was observed using the same BP cuff that was used on Resident 91 to take the BP measurement for Resident 45. She did not wipe it down before using it. During an interview on 9/16/24 at 10:00 a.m., RN A confirmed she should have sanitized the BP cuff before using on Resident 45. A review of the facility's policy and procedures titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, dated 6/2011, indicated, Reuseable items are cleaned and disinfected or sterilized between residents . 2. During a medication pass observation on 9/16/24 at 11:59 a.m., Licensed Vocational Nurse (LVN) I was observed removing the glucometer from the medication cart and obtained the blood sugar reading for Resident 38. After finished, she placed the glucometer back in the cart without disinfecting it. She stated she would return to check the reading in ten minutes because it was low. During the medication pass observation on 9/16/24 at 12:11 p.m., LVN I removed the glucometer from the cart without cleaning and disinfecting it first, obtained the blood sugar reading for Resident 3, then returned the glucometer to the cart, again without cleaning and disinfecting it. On 9/16/24 at 12:16 p.m., LVN I returned to check blood sugar reading for Resident 38. After finished, she placed the glucometer on top of the medication cart. She stated she had two more residents to check blood sugar readings. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at 12:22 p.m., LVN I sanitized her hands and put on gloves then began to obtain reading for Resident 14 without cleaning glucometer. The surveyor asked to speak with her before proceeding. During an interview on 9/16/24 at 12:22 p.m. with LVN I, she stated she should have wiped the glucometer with a disinfectant wipe after each use and that she forgot. During an interview on 9/16/24 at 1:02 p.m. with LVN I stated she was supposed to use the Sani-Cloth (a germicidal disinfectant) wipes to disinfect the glucometer to prevent the spread of infection between residents. During an interview on 9/17/24 at 1:23 p.m. with the DON, he stated the nurses are expected to clean and disinfect the glucometer with the Sani-Cloth wipes before and after each use and allow dwell time two minutes, the glucometer wet for two minutes. A review of the facility's provided Blood Sampling- Capillary (Finger Sticks) procedure, undated, indicated: Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. 46552 3. During an observation on 9/16/2024 at 11:06 a.m., noted urinal (a single resident use plastic container used to collect urine) unlabeled was left on top of the commode in the resident room [ROOM NUMBER]'s bathroom. During an interview with certified nursing assistant H (CNA H) on 9/16/2024 at 11:12 a.m., CNA H confirmed urinal in bathroom in use and unlabeled with resident's name. CNA H this bathroom been shared between 4 residents. CNA H also stated without name, risk for using urinal for unassigned residents. CNA H further stated nursing staff should have labeled urinal with resident's name before started using for infection control practice. CNA H discarded the urinal. During an observation on 9/16/2024 at 12:10 p.m., noted unlabeled urinal left on window in resident room [ROOM NUMBER]'s bathroom. During an interview with registered nurse A on 9/16/2024 at 12:12 p.m., RN A confirmed unlabeled urinal in use and left on window in resident room [ROOM NUMBER]'s bathroom and this bathroom been shared by 3 residents. RN A stated nursing staff should have labeled with resident's name before started using urinal for resident for not to use for unassigned residents. RN H discarded the urinal. During an observation on 9/17/2024 at 8:15 a.m., noted 2 unlabeled wash basins placed on top of the paper towel holder in resident room [ROOM NUMBER]'s bathroom. During an interview with CNA K on 9/17/2024 at 9:15 a.m., CNA K confirmed both wash basins (a plastic container used to provide personal hygiene for residents) were in use, unlabeled, and this bathroom been shared between 4 residents. CNA K stated nursing staff should have labeled both wash basins with resident's name before started using to prevent unassigned resident's use. CNA K discarded both wash basins. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in resident room [ROOM NUMBER]'s bathroom on 9/17/224 at 9:50 a.m., noted unlabeled urinal placed on rail next to commode. During an interview with CNA K on 9/17/2024 at 9:55 a.m., CNA K confirmed unlabeled, used urinal left on rail in resident room [ROOM NUMBER]'s bathroom and this bathroom been shared by 4 residents. CNA K stated nursing staff should have labeled with resident's name before started using urinal for resident for not to use for unassigned residents. CNA K discarded the urinal. 4. During an observation on 9/16/2024 at 10:40 a.m., noted stack of more than 10 adult briefs (used to keep clothing from being soiled by bodily excretions), and 3 folded bath towels on the floor each side next to commode in resident room [ROOM NUMBER]'s bathroom. Further observation in this bathroom indicated two unlabeled toothbrushes, and one single use razor placed on a plastic bin. During an interview with CNA H on 9/16/2024 at 10:46 a.m., CNA H confirmed all above in resident room [ROOM NUMBER]'s bathroom. CNA H stated adult briefs and towels should have not be placed on the floor and toothbrushes and razor should have been labeled with resident's name. CNA H also stated nursing staff should not have left towels and briefs on floor and labeled toothbrushes and razor with resident's name and should not left outside for infection control and resident's safety. During an interview with facility's infection preventionist (IP) on 9/19/2024 at 4:01 p.m., IP stated nursing staff should have labeled urinals with resident's name before started using for residents to prevent unassigned resident's use and for standard infection control practice. IP also stated nursing staff should have placed briefs and clean towels in a supply closet not on the floor in resident's bathroom. IP further stated resident's toothbrushes should have labeled with resident's name for infection control and discard razor after use for safety and infection control. During an interview with IP on 9/19/2024 at 4:10 pm., IP stated nursing staff responsible to label wash basins with resident's name before started using for residents. IP also stated nursing staff should have labeled wash basins with resident's name for standard infection control practice and to prevent use for unassigned residents. Review of facility's policy and procedure (P&P) titled, Laundry and Bedding, undated, the P&P indicated, Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with closing door are used to reduce the risk of accidental contamination. Review of facility's P&P titled, Cleaning ad Disinfecting Non-Critical Resident-care Items, revised June 2011, the P&P indicated, Single resident use items such as bed pans, wash basins, urinals etc. are for single resident use only. [NAME] with resident's name and/or room number and discard upon transfer or discharge.		