STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555090	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Coast Post Acute	720 East Romie Lane Salinas, CA 93901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the discharge planning for one of three sampled residents (Resident 1) when there was no final discharge date and no documented place of discharge for Resident 1.These failures resulted in incomplete discharge planning and had the potential for Resident 1's needs to be unmet after leaving the facility on 6/7/25.Findings:Review of Resident 1's face sheet (a document that gives a resident's information) indicated, Resident 1 was admitted [DATE] with diagnoses including hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die), orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a sitting or lying position.)Review of Resident 1's Social History assessment dated [DATE] indicated resident was homeless prior to hospitalization and had resided at a shelter.Review of Resident 1's Discharge Care Plan (initiated 3/6/25, revised 6/11/25) indicated goals for discharge to an appropriate placement that would meet individualized needs and a safe move to the community. Interventions included: Assess resident/family preference regarding discharge resources and coordinates DME (durable medical equipment), pharmacy, home health, and/or in-home support services.Review of Resident 1's Social Service Note dated 5/21/25 (late entry, created 6/21/25) indicated the SSD informed the resident and son of a 5/30/25 discharge date . The document did not show that the date was updated. Review of Resident 1's Social Service Note dated 5/28/25 (late entry, created 6/21/25) indicated the son requested an extension, which was approved by the IDT (Interdisciplinary Team, consists of professionals from different disciplines who collaborate to provide comprehensive and coordinated care to patients), but there was no specific date when Resident 1 will be discharged .Review of Resident 1's Social Service Note dated 6/4/25 (late entry, created 6/21/25) indicated the son asked about discharge. The SSD explained therapy days had ended but did not confirm a discharge date .Review of Resident 1's Health Status Note dated 6/7/25 (late entry, created 6/13/25) indicated: Resident discharged today.bags packed.received two small bags of medications.Resident was picked up by son at 1200.Review of Resident 1's Social Service Note dated 6/7/25 (late entry, created 6/21/25) indicated the discharge as unplanned.During an interview with the Social Service Director (SSD) on 6/11/25 at 10:30 a.m., the SSD stated that Resident 1 was not scheduled for discharge on [DATE]. The SSD stated she was not aware Resident 1 was leaving that day and she had no social services note for that day because the IDT had not finalized the discharge date .During an interview with the Director of Nursing (DON) on 6/11/25 at 1:30 p.m., the DON stated that discharge planning begins on admission and being updated during resident's stay. The DON stated that for homeless residents, the SSD assist in finding a shelter, and once a discharge date was set, the facility obtains a physician's order and needed equipment.During a follow-up phone call with the DON on 6/20/25 at 3:30 p.m., the DON stated Resident 1 wanted to go home on 6/7/25. On 6/23/25, the DON emailed Social Service notes and wrote: The discharge was planned for a future date, however, it turned unplanned on June 7, 2025 when Resident 1 informed the nurse that he will be going home on that day, June 7, 2025 and was picked up by his son. The documents provided by the DON did not show documentation that Resident 1 requested to be discharged on 6/7/25.During an interview with the SSD on 9/11/25 at 3:28 p.m., SSD stated her practice was to document the name of the shelter or destination in the progress notes prior to a resident's discharge. The SSD acknowledged there was no documented place of discharge for Resident 1 on 6/7/25 because the discharge happened on a Saturday when she was not on site. The SSD further stated that Resident 1 was not supposed to be discharged on 6/7/25 and that the discharge happened due to a miscommunication with the resident.Review of the undated facility's policy titled Discharge Summary and Plan indicated When a resident's discharge is anticipated, a discharge summary is created and the discharge plan is finalized to assist the resident with plans for care after discharge.7) A member of the IDT reviews the final discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 8) The final discharge plan of care shows what arrangements have been made for the resident regarding: a.) where the resident will live after leaving the facility.