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	04/14/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure the result of the investigation of an alleged resident-to-resident altercation that occurred 2/2/26 was reported to the State Survey Agency (SSA) within the required timeframe for two of three sampled residents (Residents 2 and 3). This failure had the potential to delay the State Survey Agency's review of the investigation results. Findings:Review of Resident 2's clinical records indicated resident with diagnoses including vascular dementia (decline in thinking, memory, and reasoning caused by reduced blood flow to the brain) major depressive disorder (mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities).Review of Resident 2's Health Status Note dated 2/2/26 indicated staff heard Resident 2 yell out from his room. The Certified Nursing Assistant (CNA) immediately responded and saw Resident 3 standing next to Resident 2's bed, holding Resident 2's chest with one hand and hitting Resident 2 in the face. The CNA intervened and separated the residents.Review of Resident 3's clinical records indicated resident with diagnoses including cerebral infarction (stroke), dementia, anxiety disorder (mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life), and major depressive disorder.Review of Resident 3's Health Status Note dated 2/2/26 indicated the CNA observed Resident 3 standing next to his roommate's bed, holding his roommate's chest, and hitting him in the face.On 4/16/26, further review of the facility's documents received there was no 5-day investigation report on file submitted within the required timeframe.During an interview with the Administrator (ADM) on 4/16/26 at 2:18 p.m., the ADM stated the 5-day investigation report was completed but was not emailed or faxed to the Department. The ADM stated he was not sure why it was not sent and stated the facility usually emails investigation reports within five days.Review of the undated facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating indicated All reports of resident abuse.are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** Based on interview and record review, the facility failed to ensure adequate supervision and implement fall prevention interventions for one of three sampled residents (Resident 1) when Resident 1 had repeated attempts to stand on 1/17/26 and staff did not provide extra activity to keep Resident 1 occupied during attempts of standing up unassisted. This failure resulted in Resident 1 sustaining a 5-centimeter (cm, unit of measurement) x 2 cm head laceration (wound on the skin, typically caused by blunt trauma) that required hospitalization and 13 staples (specialized metal or plastic used in medical procedure to close deep wound).Findings:Review of Resident 1's face sheet (summary page of a patient's important information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition that is marked by hallucinations [something that does not exist in reality] and delusions [not based on reality], and mood disorder symptoms, bipolar disorder (mental health condition that causes extreme mood swings) vascular dementia (changes to memory, thinking, behavior resulting from conditions that affect the blood vessels in the brain, muscle weakness, and repeated falls.Review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool), Section C, dated 1/12/26, indicated Resident 1 had impaired short-term and long-term memory and was coded as severely impaired for daily decision making. Resident 1 was unable to recall items under memory/recall ability.Review of Resident 1's MDS, Section GG (function and mobility assessment), dated 1/12/26, indicated Resident 1 was coded as dependent for sit-to-stand and transfers, toileting, and requiring staff to provide full assistance for mobility.Review of Resident 1's Fall risk Observation/assessment dated [DATE] indicated Resident 1 had a high fall risk score of 20 (high risk). The assessment form indicated multiple risk factors including impaired vision, unsteady gait, impaired mobility, and multiple underlying health conditions.Review of Resident 1's Comprehensive Fall Risk Care plan initiated 4/19/23 indicated Resident 1 was at risk for falls related to impaired cognition, wandering (moving from place to place), psychoactive (affecting the mind or mood or other mental processes) medication use, and gait/balance problems. Interventions included monitoring the resident's whereabouts, assisting with toileting, ensuring a safe environment, and providing activities to keep the resident occupied to reduce the risk of standing without assistance.Review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, an assessment tool used to facilitate prompt and appropriate communication of a problem) dated 1/17/26 indicated Resident 1 was found on the floor in room A by the door on 1/17/26, approximately 2100 with a laceration to the back of the head measuring approximately 3 cm. The SBAR indicated Resident 1 had been sitting in the hallway for approximately two hours prior to the fall, and staff were assisting another resident at the time of the incident. The SBAR further indicated the aide was approximately 5 feet away from her when Resident 1 was found on the floor.Review of Resident 1's Progress notes (Health Status Note) dated 1/17/26 indicated Resident 1 was sitting in a hallway chair for approximately two hours prior to the fall and had been attempting to stand up and walk prior to the fall. At approximately 2100, staff heard a loud sound and found Resident 1 on the floor in room A next to the doorway with a laceration to the back of the head and significant bleeding. Emergency medical services were contacted, and Resident 1 was transferred to the hospital.Review of Resident 1's Hospital Discharge summary dated [DATE] indicated Resident 1 was hospitalized following a fall and sustained a head laceration. The discharge summary also indicated Resident 1 required close supervision as evidenced by recent fall while unsupervised.Review of Resident 1's Comprehensive Skin Evaluation/assessment dated [DATE] indicated Resident 1 had a laceration to the back of the head measuring 5 cm x 2 cm and 13 staples at laceration site.Review of Resident 1's Interdisciplinary Team (IDT, staff from different disciplines who work together to plan and provide care) note dated 2/5/26, late entry for 1/20/26 indicated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1 had a history of impulsive behaviors, including sudden standing and rapid ambulation (ability to walk), requiring supervision. The IDT note indicated interventions included continued supervision by nursing and activity staff. The IDT note indicated that at the time of the fall on 1/17/26, approximately 9:00 p.m., another resident required assistance, which caused the CNA A to turn away, and a loud sound was heard shortly after.Review of Resident 1's clinical record indicated the following:2/14/25 - witnessed fall with no injury3/5/25 - unwitnessed fall with left brow swelling3/6/25 - witnessed fall with no injury5/14/25 - witnessed fall with left knee discoloration5/25/25 - unwitnessed fall with right wrist swelling6/4/25 - witnessed fall with right forearm discoloration6/23/25 - unwitnessed fall with no injury8/8/25 - witnessed fall with no injury8/30/25 - assisted to the floor with no injuryReview of Resident 1's Rehab-Status Post Fall Screen document dated 8/12/25 indicated Resident 1 was at a high risk for falls due to cognitive deficit and impulsivity in movement (acting on urges without thinking) patterns. The document recommended continued 24/7 (twenty-four hours a day, seven days a week) supervision.During a phone interview on 3/13/26 at 9:10 a.m., Certified Nursing Assistant A (CNA A) stated that she was the only CNA supervising approximately 15 residents in the hallway on 1/17/26 at approximately 2100, while two other CNAs were assisting residents in their rooms. CNA A stated Resident 1 had been attempting to stand multiple times, and CNA A reminded Resident 1 to sit back down. CNA A stated she turned to assist another resident and did not see Resident 1 get up, then heard a loud sound and found Resident 1 on the floor.During a phone interview on 3/13/26 at 2:16 p.m., Licensed Vocational Nurse B (LVN B) stated Resident 1 was a high fall risk and had a history of attempting to stand and ambulate without assistance. LVN B stated that when Resident 1 attempted to stand, staff would provide snacks and redirect Resident 1 to sit back in the chair; however, at the time of the fall, CNA A was assisting another resident. During a phone interview with the Director of Nursing (DON) on 4/3/26 at 10:31 a.m., the DON stated Resident 1 was very impulsive and a high risk for falls. The DON stated Resident 1 was not left unattended; however, CNA A missed it when CNA A turned away to assist another resident. The DON stated staff needed to be quick when responding to Resident 1's attempts to stand.During a follow up interview with the DON on 4/14/26 at 12:58 p.m., DON stated Resident 1 required one-to-one supervision, especially after dinner, due to impulsive behavior and attempts to stand. The DON stated that providing activities to keep Resident 1 occupied was an intervention to prevent falls. The DON further stated there were no activities provided at the time of the fall.Review of the undated facility's policy Falls - Clinical Protocol indicated .staff will try various relevant interventions, based on assessment of the nature or category, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).