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	02/13/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 Based on observation, interview, and record review the facility failed to ensure resident's care needs were accommodated for one of four sampled residents (Resident 99) when Resident 99's call light button (a cord with a button used by residents to request assistance) was not within reach to use. This failure had the potential to result in the delay of care and treatments for the resident. Findings: Review of Resident 99's clinical record titled, Admission Record, indicated Resident 99 was admitted to the facility with diagnoses including heart failure (the heart is unable to pump enough blood to the rest of the body), gout (painful tenderness and swelling of one or more joints of the body), osteomyelitis (infection of the bone), and muscle weakness. The quarterly Minimum Data Set (MDS, an assessment tool), dated 1/27/25, indicated Resident 99 had impaired functional use of both sides of his lower extremities. The quarterly MDS, dated [DATE], indicated a score of 4 out of 15 on a Brief Interview for Mental Status (BIMS) indicating Resident 99 had severe memory problems. During an observation and concurrent interview on 2/10/25 at 9:20 a.m., Resident 99 was awake and sitting up in bed. Resident 99 stated, I can't find my call button. Certified Nursing Assistant B (CNA B) located the call light button at the head of Resident 99's bed tucked between the bed frame and mattress. Resident 99 tried to reach for the call light button, but he could not reach it. During an interview on 2/10/25 at 9:25 a.m. with CNA B, CNA B stated the call light button should have been within reach for Resident 99. During an interview on 2/11/25 at 10:15 a.m. with the Director of Nursing (DON), the DON stated, The call light button should have been within reach at all times. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, undated, the P&P indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure service provided met professional standards when: 1. Resident 64 received ferrous sulfate (an iron supplement used to treat or prevent low blood levels of iron) and calcium-vitamin D (a medication used to prevent or treat low blood calcium levels) at the same time; and 2. A medication was not administered correctly for Resident 98. This failure resulted in Resident 64 and Resident 98 not getting the full dose and desired effect of the prescribed medications. Findings: 1. Review of Resident 64's Admission Record indicated she was admitted to the facility on [DATE] with anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells) diagnosis. Review of Resident 64's clinical record indicated, she had physician orders for ferrous sulfate 325 milligrams (mg, a metric unit of mass) every other day at 9 a.m., starting on 9/13/24, and for calcium-vitamin D 500-200 mg-unit every day at 9 a.m. and 5 p.m., starting on 2/14/24. Thus, since 9/13/24, ferrous sulfate and calcium-vitamin D were given at the same time at 9 a.m. every other day. During an interview with the director of nursing (DON) on 2/13/25 at 4:08 p.m., she reviewed Resident 64's clinical record and confirmed ferrous sulfate and calcium-vitamin D were given to Resident 64 at the same time at 9 a.m. every other day since 9/13/24. The DON stated ferrous sulfate and calcium-vitamin D should not be administered at the same time due to drug-to-drug interaction, and she would change the administration time so that ferrous sulfate and calcium-vitamin D would be given separately to Resident 64. According to Lexicomp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of calcium and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of the DDI was that the calcium may decrease the absorption of oral preparations of iron salts. It indicated the iron absorption was decreased an average of 60% when given as ferrous sulfate and co-administered with calcium. Lexicomp also indicated to separate the administrations of these medications so it may minimize the potential for significant interaction. 49345 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation of medication administration on 2/9/25 at 11:26 a.m. with Licensed Vocational Nurse (LVN) A, LVN A prepared medications for Resident 98 which included Fluticasone (an oral inhalation medication used to prevent difficulty in breathing, chest tightness, wheezing and coughing) 230 mcg (microgram, a unit of measurement)/21 mcg inhaler. Prior to giving the medication, LVN A shook the inhaler and asked Resident 98 to open his mouth. LVN A then placed the mouthpiece into Resident 98's mouth, administered one puff of the medication, and removed the mouthpiece from the patient's mouth. Resident 98 had his mouth slightly open after the first puff. LVN A waited for a few seconds and asked Resident 98 to open his mouth again and administered a second puff to Resident 98. Resident had his mouth slight open after the second puff. During an interview on 2/9/25 at 12:19 p.m. with LVN A, LVN A verified she did not provide instructions to Resident 98 to effectively administer the Fluticasone Inhaler. LVN A stated, They should not hold their breath, they just hold the medication. LVN A also stated, I should have asked him to inhale before giving the medication. During an interview on 2/12/25 at 11:50 a.m. with the DON, the DON stated, For inhaler medication administration, the nurse should have ask the resident to hold his breath for five or more seconds after giving a puff and then exhale after. Then, the resident must be instructed to rinse his mouth with water. A review of Resident 98's medical record indicated a diagnosis including Chronic Obstructive Pulmonary Disease (COPD, a lung disease that makes it difficult to breathe). A review of Resident 98's Active Physician Orders indicated, (Fluticasone-Salmeterol) 2 puffs inhale orally two times a day for COPD (Rinse mouth & spit after use). A review of facility's policy and procedure (P&P) titled, Administering Medications through a Metered Dose Inhaler dated October 2010, the P&P indicated, .14. Administer medication: .d. Ask the resident to inhale and exhale deeply for a few breath cycles. On the last cycle, instruct the resident to exhale deeply. e. Place the mouthpiece in the mouth and instruct resident to close his or her lips to form a seal around the mouthpiece. f. Firmly depress the mouthpiece against the medication canister to administer medication. g. Instruct the resident to inhale deeply and hold for several seconds. h. Remove the mouthpiece from the mouth and instruct the resident to exhale slowly through pursed lips. 15. Repeat inhalation, if ordered. Allow at least one (1) minute between inhalations of the same mediation . 16. Rinse the mouthpiece with warm water to remove medication residue .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure one of 29 sampled residents (86) was served with the appropriate diet texture. This failure had the potential to result in choking for the resident. Findings: Review of Resident 86's Admission Record indicated she was admitted to the facility on [DATE] with a dysphagia (difficulty swallowing) diagnosis. During a tray line observation and concurrent record review with the dietary director (DD) on 2/11/25 at 1 p.m. , Resident 86's lunch ticket indicated her diet texture was mechanical soft (a modified diet that consists of soft, easy-to-chew foods that require minimal chewing or grinding; it is designed for individuals who have difficulty swallowing or chewing due to condition such as dysphagia) and ground meats. Chopped meats was served for Resident 86's lunch. During a concurrent interview with the DD, he confirmed that Resident 86's diet texture was mechanical soft/ground meats, but chopped meats was served for her. The DD stated mechanical soft texture with ground meats meal should have been served to Resident 86.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to provide meals with food items according to preferences for four of 144 residents (34, 36, 58, and 117). This failure had the potential to result in meal dissatisfaction, decreased intake, and leading to compromised nutritional and medical status for the residents. Findings: Review of Resident 36's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 58's Admission Record indicated she was admitted to the facility on [DATE]. During a tray line observation with the dietary director (DD) on 2/11/25 at 12:15 p.m., Resident 58's lunch ticket indicated she preferred to have low-fat milk, but whole milk was served for her. During a tray line observation with the dietary director (DD) on 2/11/25 at 12:50 p.m., Resident 36's lunch ticket indicated he preferred to have yogurt, but yogurt was not served for him. During a concurrent interview with the DD, he confirmed that Resident 58's lunch ticket indicated she preferred to have low-fat milk, but whole milk was served for her; and Resident 36's lunch ticket indicated he preferred to have yogurt, but yogurt was not served for him. The DD stated meals should have been served according to the residents' preferences. 36623 During an interview on 2/9/25 at 12:20 p.m. Resident 117 stated she was allergic to melon, but she got served melon. Resident 117 stated she requested fruit and she was served strawberries with cantaloupe. Review of Resident 117's tray card indicated she was allergic to bell pepper, cucumber, melon, and peanuts. The tray card also indicated melon as one of her dislikes. During a resident council meeting on 2/11/25 at 10:30 a.m., Resident 34 stated the facility kitchen does not follow her preferences. Resident 34 stated she does not like honey dew melon and it was listed in her tray card. She stated she still gets honey dew melon on her tray. Review of the facility's 2023 policy, Food Preferences, indicated, Resident's food preferences will be adhered to within reason.

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	555090	A. Building B. Wing	02/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and policy review, the facility failed to ensure food was stored, prepared, and served in accordance with professional standards for food safety when: 1. Undated food items, food past their use by date, expired food, and rotten vegetables were found in the refrigerator, the freezer, and on the shelves in the kitchen; 2. Dietary Aid E (DA E) and the maintenance director (MD) did not wash their hands when entering the kitchen; and 3. Juice temperature was higher than acceptable delivery temperature. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness and cross-contaminated food for the 144 residents receiving food at the facility. Findings: 1. On [DATE], at 9:30 a.m., during an observation of the kitchen's storage shelves, in the freezer, and the refrigerator, with cook D (CK D) and the dietary director (DD), the following were observed: a. Opened three-gallons containers of apple base, iced tea, apple raspberry, thicken water with no open date and no use by date b. One 20-pound box of frozen sugar cookie dough with no use by date and no expiration date c. One box of cherry twin pops with no use by date d. Five pounds of sour cream with an expiration date of [DATE] e. One lime jello container with an expiration date of [DATE] f. A container of rotten chopped salad g. Two cups of lime jello with no cover and undated h. Two bowls of chopped salad with no date i. Five and a half trays of glasses of punch (32 glasses per tray) had no date j. Eleven glasses of milk and seven glasses of juice had no date k. One honey thick water with an expiration date of [DATE] (continued on next page)

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	555090	A. Building B. Wing	02/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	l. One 20-pound case of zucchini with a use by date of [DATE] m. Fifteen tomatoes with no use by date n. Three stacks of celery with a use by date of [DATE] o. Eleven cantaloupes, one watermelon, and four honeydews with a use by date of [DATE] p. Thirty-three rotten iceberg lettuce with a use by date of [DATE] q. Twenty-two oranges with no open date and no use by date r. One 8-pound pork loin with a use by date of [DATE] s. Ten pounds of bacon received on [DATE] t. Three rotten romaine heads with a use by date of [DATE] u. Four heavy creams with an expiration date of [DATE] v. One open and undated half and half creamer w. A container of cherry jello with a use by date of [DATE] x. Five five-pound shredded cheese with no use by date y. Five five-pound cheese with no use by date and no expiration date z. One open liquid egg with no open date and no use by date aa. Ten pounds of breaded pork patties with no use by date bb. Three pounds of cheese ravioli with no open date and no use by date cc. One hundred and thirty dinner rolls with no open date dd. One pumpkin pie with a use by date of [DATE] ee. Fifty cheese and bean burritos with no open date and no use by date ff. Four pounds of corn tortillas with no open date and no used by date gg. Four two-pound broccoli florets with no open date and no use by date hh. Fifteen pounds of diced carrots with no open date and no use by date ii. Eight pizzas with no open date and no use by date (continued on next page)

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	555090	A. Building B. Wing	02/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	jj. Ground chorizo with no open date and no use by date kk. Twelve beef and pepper patties with a use by date of [DATE] ll. Five pounds of ground beef patties with no open date and no use by date mm. Twelve and a half pounds of asparagus with no received date, no open date, and no use by date nn. Opened box of six bags of tortillas (24-count) with no open date oo. Four pounds of chicken breast with rib meat with no open date and no use by date pp. Eight ounces of non-dairy powdered cream received on [DATE] qq. One gallon of lemon juice with an expiration date of [DATE] rr. Four open bags of cereal with no open dates. ss. Two pounds of pecans with an expiration date of [DATE] tt. Two pounds of almonds with an expiration date of [DATE] uu. One fourth pounds of pecans with a use by date of [DATE] vv. One pound of saline crackers with no received date and no use by date ww. One container of bread crumbs with no date. During a concurrent interview with the DD, he stated the bacon should have been used in three days, and they were expired; non-dairy powdered cream was good for one month, and it was expired; the above mentioned food and drink items should have an open date and use by date; expired food and food past their use by date should have been discarded. Review of the facility's 2023 policy, Labeling and Dating of Foods, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered to facility needs to be marked with a received date . Newly opened food items will need to be closed and labeled with an open date and use by date . All prepared foods need to be covered, labeled, and dated. Review of the facility's policy, Food Receiving and Storage, dated ,d+[DATE], indicated, . Dry Food Storage: . 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date) . Refrigerated/Frozen Storage: 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Review of the facility's policy, Refrigerators and Freezers, dated ,d+[DATE], indicated, . 9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. (continued on next page)

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	555090	A. Building B. Wing	02/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on [DATE] at 9:40 a.m., dietary aid E (DA E) came in the kitchen, did not wash her hands, and started working. During a concurrent interview with DA E, she stated she should have washed her hands when she entered the kitchen before starting to work. During an observation of the ice machine in the kitchen with the maintenance director (MD) on [DATE] at 3:15 p.m., the MD came in the kitchen, put on beard net, but did not wash his hands. During a concurrent interview with the MD, he acknowledged that he should have washed his hands when he entered the kitchen. During an interview with the director of staff development/infection preventionist (DSD/IP) on [DATE] at 4:35 p.m., she stated when staff goes beyond the red line on the kitchen floor, the staff should have wash their hands. Review of the facility's undated policy, Kitchen - Employee Hygiene and Sanitary Practices, indicated, . 6. Employees must wash their hands: . c. Whenever entering or re-entering the kitchen; . 3. During a test tray observation with the dietary director (DD) on [DATE] at 1:10 p.m., the temperature of the juice in the glass was 66.6 degrees Fahrenheit (F). During a concurrent interview with the DD, he confirmed the temperature of the juice was high at 66.6 degrees, and he would check on the acceptable delivery temperature of the juice. Review of the facility's undated Room Test Tray Evaluation, indicated the acceptable delivery temperature for a cold beverage was 40 degrees F to 55 degrees F.

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	555090	A. Building B. Wing	02/13/2025

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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** 36623 Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices when: 1. A nurse did not perform hand hygiene after removing gloves during Resident 61's wound dressing change; 2. The tips of the feeding tubing was left uncovered for two residents (Residents 137 and 128); 3. Oxygen tubing was undated, touching, and lying on the floor for Resident 41, Resident 71, and Resident 134; and 4. Certified nursing assistant H (CNA H) and certified nursing assistant I (CNA I) walked out of Resident 106's room and Resident 107's room with gloves on. These failures had the potential to result in transmission and spread of infection in the facility. Findings: 1. Review of Resident 61's clinical record indicated she was admitted to the facility with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection) and stage 4 pressure ulcer (pressure-related damage to skin resulting in full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During an observation and concurrent interview on 2/12/25 at 11:28 a.m. with the treatment nurse (TN), she stated Resident 61 had a Stage 4 pressure ulcer and required a dressing change every day. She prepared supplies to perform a dressing change. The TN washed her hands before removing Resident 61's wound dressing, then she removed her gloves, washed her hands, and donned new gloves. After cleansing Resident 61's wound with with normal saline, the TN removed her gloves and put on new gloves without washing her hands or performing hand hygiene. The TN placed a dressing on Resident 61's wound, removed her gloves and put on new gloves without washing her hands or performing hand hygiene. The TN confirmed she did not perform hand hygiene when she changed her gloves. During an interview on 2/12/25 at 12:28 p.m., the Director of Staff Development/Infection Preventionist (DSD/IP) stated the expectation is to perform hand hygiene in between glove changes. Review of the facility's policy, Handwashing/Hand Hygiene, dated 2001 indicated hand hygiene is indicated immediately after glove removal. 2a. Review of Resident 137's clinical record indicated Resident 137 was admitted to the facility with diagnoses including hemiplegia and hemiparesis (complete paralysis, partial paralysis or muscle weakness on one side of the body), dysphagia (difficulty swallowing food or liquids), aphasia (loss of ability to understand or express speech), dysarthria and anarthria (inability to produce clear and understandable speech) and heart failure (inability of the heart to pump enough blood to the rest of the body). (continued on next page)

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	555090	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/9/25 at 11:47 a.m. inside Resident 137's room, Resident 137's enteral feeding tube (a medical device that delivers nutrition directly to the stomach or small intestine through a flexible tube) was lying on a towel on top of the bedside table. The tip of the tube was uncapped and not in use. During a concurrent observation and interview on 2/11/25 at 11:40 a.m. with Licensed Vocational Nurse C (LVN C) inside Resident 137's room, LVN C stated the tubing should have been capped with a plastic cap for infection control. 2b. Review of Resident 128's clinical record indicated Resident 128 was admitted to the facility with diagnoses including monoplegia (paralysis or weakness) of upper limb, aphasia (slight or serious difficulty with language or speech), dysphagia (difficulty swallowing food or liquids), and gastrostomy tube (GT tube, a surgical opening into the stomach for administration of nutrition and medications). During an observation on 2/9/25 at 12:16 p.m. inside Resident 128's room, Resident 128's enteral feeding tube was hanging from a pole. The tip of the tube was uncapped and not in use. During an interview on 2/12/25 at 11:20 a.m. with the DSD/IP, the DSD/IP stated the end of the feeding tube the licensed nurse should have capped the feeding tube when not connected to the patient for feedings and not left open to air or in contact with surfaces to prevent contamination. During an interview on 2/12/25 at 11:33 a.m. with the Director of Nursing (DON), the DON stated the tubing should have been stored with a cap on when not in use to prevent contamination. Review of the facility's in-service titled, Nurses Meeting, dated October 22-23, 2024, conducted by the DON, indicated material discussed, Tubings - O2, IV, GT; IV and GT- tape the cap to the tubing after use to prevent contamination of the tip. Review of the facility's Policy and Procedure titled, Infection Prevention and Control Program, dated 10/2019, indicated, .11. Prevention of Infection; a. Important facets of infection prevention include: . (3) educating staff and ensuring that they adhere to proper techniques and procedures. Review of the facility's policy and procedure (P&P) titled, Enteral Feedings-Safety Precautions, dated 2001, the P&P indicated, Preventing contamination 1. Maintain strict aseptic technique at all times when working with enteral nutrition systems . 37409 3a. Review of Resident 41's Admission Record indicated she was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD, caused by inflammation inside the airways that limits airflow into and out of the lungs). Review of Resident 41's physician order, dated 2/2/25, indicated she had an order for oxygen at 2 liters (L, a metric unit of volume) per minute every evening and night shift for shortness of breath (SOB). (continued on next page)

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	555090	A. Building B. Wing	02/13/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with licensed vocational nurse F (LVN F) on 2/9/25 at 2:25 p.m., Resident 41's oxygen tubing was lying on the floor and undated. LVN F stated Resident 41's oxygen tubing should not be on the floor and it should have been stored in a bag with date. 3b. Review of Resident 71's Admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 71's physician order, dated 1/18/25, indicated she had an order for oxygen at 3 L per minute as needed for SOB. During an observation and interview with LVN F on 2/9/25 at 2:22 p.m., Resident 71's oxygen tubing was lying on the floor and undated. LVN F stated Resident 71's oxygen tubing should not be on the floor; it should have been stored in a bag with date. 3c. Review of Resident 134's Admission Record indicated she was admitted to the facility on [DATE] with a diagnosis of COPD. Review of Resident 134's physician order, dated 11/12/24, indicated she had an order for oxygen at 2 L per minute continuously every shift for SOB. During an observation and interview with respiratory therapist G (RT G) on 2/10/25 at 10:25 a.m., Resident 134 was sitting on the wheelchair in her room. Resident 134 was on oxygen, and her oxygen tubing was hanging down and touched the floor. RT G stated Resident 134's oxygen tubing should not touch the floor, and he would fix that. During an interview with the DSD/IP on 2/13/25 at 4:31 p.m., she stated residents' oxygen tubing should not be touching or lying on the floor; it should have been stored in a bag and date. Review of the facility's undated policy, Departmental (Respiratory Therapy) - Prevention of Infection, indicated, . Infection Control Consideration Related to Oxygen Administration: . 8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use. 4a. During an observation on 2/12/25 at 3:01 p.m. certified nursing assistant H (CNA H) walked out of Resident 106's room with gloves on, walked in the hallway, and CNA H removed the gloves in the hallway. During a concurrent interview with CNA H, she stated she was helping Resident 106 with changing her brief in her room. CNA H stated she should have remove her gloves in Resident 106's room. 4b. During an observation on 2/10/25 at 10:39 a.m., certified nursing assistant I (CNA I) carried a bag of soiled brief and linen out of Resident 107's room with her gloved hands, walked in the hallway, and removed the gloves in the hallway. During a concurrent interview with CNA I, she stated she was helping another CNA to prepare and transfer Resident 107 for shower in her room. CNA I stated she should have remove her gloves in Resident 107's room. During an interview with the DSD/IP on 2/13/25 at 4:31 p.m., she stated staff should have remove gloves in the resident's room before walking out of the room and in the hallway. (continued on next page)

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	02/13/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Personal Protective Equipment - Gloves, dated 7/2009, indicated . 2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed.