STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055017	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearts & Hands, Post Acute Care & Rehab Center	2990 Soquel Avenue Santa Cruz, CA 95062

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on observation, interview, and record review, three of four sampled residents (Resident 2, 3 and 4) were not free from verbal abuse when Resident 1 cursed and threathened to harm Residents 2, 3, and 4. This failure had the potential to negatively impact the physical and mental well-being of all residents in the facility. Findings: Review of Resident 1's admission record, dated 5/22/24, indicated Resident 1 had diagnoses of cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (a stroke has occurred because a blood vessel in the brain either became blocked or narrowed), major depressive disorder (a mental health condition where a person experiences persistent feelings of sadness, hopelessness, and a lack of interest in activities). Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 7/10/24, indicated he had Brief Interview for Mental Status (BIMS, an assessment tool that helps determine a patient's cognitive understanding) score of 13 (BIMS score of 13-15 indicates cognitively intact). Review of Resident 1's Situation, Background, Assessment and Request (SBAR, a licensed staff communication tool) form, dated 5/19/24 at 18:53 [6:53 p.m.], indicated .resident was asked to move by another resident, as he is blocking the doorway .Resident got agitated, and threatened to shoot the other resident. Review of Resident 1's Interdisciplinary Team (IDT, staff from different departments who coordinate the resident's care) meeting notes, 5/20/24, The resident has verbal altercation with another male resident when he ask him to move from blocking the doorway . Resident got agitated, and threatened to shoot the other resident .The resident has hx (history) of verbal altercations due to behavior of having angry out bursts, uses F words towards staff when being redirected for safety of his and others . Review of Resident 2's admission record dated 5/22/24, indicated Resident 2 had diagnoses of cognitive communication deficit, major depressive disorder, cerebrovascular disease (condition that affects the blood vessels in the brain, leading to reduced or blocked blood flow). (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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NAME OF PROVIDER OR SUPPLIER: Hearts & Hands, Post Acute Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2990 Soquel Avenue Santa Cruz, CA 95062	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 13, indicating his cognition was intact. Review of Resident 2's Care Plan indicated, Alteration in Psychosocial well being due to res. alleged threatened to be shot by another resident on 5/19/24. The facility staff's interventions included skin assessment, monitor emotional distress x 72 hours, local law enforcement was called, notified MD and RP. Review of the facility's Investigation Report dated 5/22/24, indicated .On 5/19/24 resident 1 was heard yelling at another resident (Resident 2) in the hallway and threatened to shoot Resident 2. Nursing immediately separated both residents. Resident 1 was searched, and no weapons were found . Review of Resident 3's admission record, dated 6/27/24, indicated Resident 3 had diagnoses of epilepsy (a chronic brain disorder that causes seizures, which are bursts of abnormal electrical activity in the brain), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side (has weakness or complete paralysis on one side of the body as a result of stroke or other problem with the blood vessels in the brain), anxiety disorder (a mental health condition where a person experiences excessive worry, fear, or nervousness that can interfere with their daily life). Review of Resident 3's, MDS dated [DATE], indicated his BIMS score was 00 indicating his cognition was impaired. Review of the SBAR form, dated 6/26/24, at 10:49, indicated Per activity director (AD) activity assistant was told by the resident that he was in possession of a knife and showed activity assistant. Activity director was notified and requested resident to give up the knife. Resident was in fact in possession of the knife hidden in his L [left] shoe. Knife was confiscated .Resident had anger outburst after knife was confiscated and yelled I have another one in my room! Both knives were confiscated. Administrator called sheriffs .Resident is being monitored 1 on 1 for safety. Review of Resident 1's IDT risk management meeting notes, dated 6/26/24, indicated, IDT met to discuss resident recent threat to kill another resident with a knife at the facility. Residents were not near each other during threat and staff member was placed with resident for safety following the incident . Review of Resident 1's Care Plan, initiated on 6/26/24, indicated Resident threatening to kill another resident. The facility's interventions included notification of the MD (medical doctor), local enforcement, monitoring by CNA (certified nursing assistant) 1 on 1 for 72 hours, redirect resident, collect all utensils after meals, and resident was referred to in house NP (nurse practitioner) psychiatrist on 6/26/24 and declined. During an observation on 6/27/24 at 12:40 p.m., Resident 3 was seen in the dining area with other residents, sitting in a wheelchair and able to wheel himself. Resident 3 stated he was okay but was observed trying to touch the surveyor during interaction. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the AD on 6/27/24 at 12:47 p.m., about the incident where Resident 1 allegedly threatened to kill Resident 3 with a knife, the AD stated that an assistant informed her about Resident 1's plan to harm Resident 3.The AD took a knife from Resident 1, and Resident 1 mentioned that he had another knife in his room. After searching the room, the facility staff found the second knife and gave it to the administrator. During an observation on 6/27/24 at 12:57 p.m., Resident 1's room was checked, but the resident was not there. According to the charge nurse, Resident 1 had gone out with a family member. During a follow up phone interview with the AD on 9/9/24 at 2:42 p.m., regarding the investigation report from 6/28/24, the AD confirmed that Resident 1 told her, If resident (3) comes anywhere near me, I'm going to stab him in the neck and slit his throat. Review of Resident 4's admission record, dated 9/5/24, indicated Resident 4 had diagnoses of altered mental status (a person's thinking, awareness, or behavior has changed, it can include confusion, disorientation, memory problems, or unusual behavior); difficulty in walking; dementia, unspecified severity (group of symptoms that affect memory, thinking, and reasoning abilities). Review of Resident 4's MDS, dated [DATE], indicated, Resident 4 had a BIMS score of 8 (moderate cognitive impairment). Review of Resident 1's IDT risk management meeting notes, dated 8/28/24, indicated IDT met to discuss a reported incident that occurred on 8/27/24 when this resident was heard yelling and upon the nurse's arrival witnessed that he was making verbal threats towards another male resident and was attempting to hit him in front of the nurse's station. The CNA and licensed nurse immediately separated both residents . During a phone interview with CNA A on 9/4/24, at 2:21 p.m., CNA A confirmed witnessing Resident 1 threaten Resident 2 during the incident that occurred on 5/19/24. During a phone interview with CNA B on 9/6/24, at 10:20 a.m., CNA B confirmed hearing Resident 1 yelling in the hallway on 5/19/24 and verbally threatening Resident 2, stating, If I had a gun, I would shoot up this place. CNA B also witnessed the incident involving Resident 1 and Resident 4 on 8/27/24. CNA B reported that Resident 1 was verbally abusive, cursed at Resident 4, and attempted to punch him. CNA B also observed Resident 1 throwing towels and shoving staff members who intervened. During a phone interview with the Director of Nursing (DON) on 9/6/24 at 2:05 p.m., the DON acknowledged awareness of Resident 1's multiple verbal abuse incidents, where Resident 1 cursed and threatened to harm Residents 2, 3, and 4. The DON stated that Resident 1 was being monitored for angry outbursts and safety after each altercation, with facility staff anticipating Resident 1's needs. However, the DON stated that these interventions were not effective in preventing further verbal abuse because Resident 1 was non-compliant. Resident 1 refused a psychiatric evaluation and medications. The DON also noted that the facility met with Resident 1's family, and by mid-August, Resident 1 agreed to undergo a psychiatric evaluation and start psychiatric medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview with the Administrator (ADM) on 9/10/24 at 10:45 a.m., the ADM stated he was unsure if Resident 1's incidents of cursing and threatening to harm Residents 2, 3, and 4 constituted abuse or if they were a result of Resident 1's angry outbursts. The ADM stated that even facility staff had difficulty having conversations with Resident 1 without provoking angry outbursts. The ADM also stated that the effectiveness of interventions to prevent further outbursts from Resident 1 were limiting. Review of facility's policy, titled, Policy and Procedure on Patient Abuse and Prevention, revised on 6/26/24, indicated, The facility shall uphold resident's right to be free from any form of verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility shall establish system to prevent patient abuse including those practices and omissions, neglect and misappropriation of property that if left unchecked, may lead to abuse. Residents shall not be subjected to abuse by anyone, including, but not limited to, facility staff; other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals .Verbal Abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he or she will never be able to see her family again .Prevention: Facility shall also institute procedures that allows for identification, correction, and intervention in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Areas of identification, correction and intervention may include but not be limited to, facility environment, staffing, monitoring & supervision of staff, identification of residents with potential for behavioral symptoms and manifestations that may lead to conflict or anger through comprehensive assessment, care planning and monitoring.