

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
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	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819</p> <p>Based on the observation, interview, and record review, the facility failed to adequately monitor and supervise one of three sampled residents (Resident 1) to prevent him from entering other female residents' rooms. This failure resulted to Resident 1 entering Residen 2 and Resident 3's room and could compromised the residents' rights to a safe environment in the facility.</p> <p>Findings:</p> <p>Review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery (blockage or narrowing in a cerebral artery. This leads to a stroke); abnormalities of gait and mobility.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/8/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 5 indicating severe cognition (mental process of thinking, learning, and understanding) impairment. The MDS indicated that Resident 1 needed supervision for mobility and transfers. Resident 1 uses a wheelchair, and once seated in the wheelchair, Resident was able to wheel at least 150 feet in a corridor independently.</p> <p>Review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 8/27/23, indicated Resident 1 was found inappropriately touching himself in front of another female resident (Resident 3).</p> <p>Review of Resident 1's Interdisciplinary (IDT, a group of health care professionals with different areas of expertise who work together toward the goals of the patients) Risk Management Meeting Notes, dated 8/28/23 indicated Resident 1 was found by a certified nursing assistant (CNA) in female residents' room inappropriately touching himself. The CNA escorted Resident 1 from the room and Resident 1 was placed on every 1-hour monitoring following the incident, and a stop sign was placed outside female residents' room to deter Resident 1 from returning. The IDT Risk Management Meeting Notes further indicated Resident 1 had behavior of constantly cleaning hallways and doors.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055017
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's SBAR, dated 9/3/24, indicated Resident 1 was inappropriately touching Resident 2 and was witnessed by CNA A (Certified nursing Assistant A). CNA A saw Resident 1 in Resident 2's room rubbing Resident 2's legs with lotion.</p> <p>Review of Resident 1's IDT Risk Management Meeting Notes, dated 9/3/24 indicated, Resident 1 was witnessed with his hand between Resident 2's legs rubbing lotion onto Resident 2. Resident 1 had behavior of wandering. The IDT recommended a psychiatric evaluation for Resident 1's behavior of constantly cleaning walls around facility to the point of exhaustion. Resident 1 was started on every 1-hour safety checks following the incident for 1 week.</p> <p>Review of Resident 1's Behavior Care Plan on inappropriately touching another resident initiated on 9/3/24. The interventions included to monitor resident going into another resident's room, safety check every 1 hour.</p> <p>During an observation on 9/4/24 at 12:10 p.m., Resident 1 was seen seated in a wheelchair, moving independently through the hallway, and wiping the siderails and walls along the corridor. The CNA's were observed delivering meal trays to other resident rooms.</p> <p>During an interview with Licensed Vocational Nurse B (LVN B) on 9/4/24 at 12:15 p.m. LVN B stated that Resident 1 was being monitored every hour for safety checks for one week. When asked how the safety checks were being implemented, LVN B showed the surveyor the Medication Administration Record (MAR) and stated that staff were required to check Resident 1's whereabouts every hour and then nursing will document it in the MAR.</p> <p>During an interview with Certified Nursing Assistant (CNA) A on 9/4/24 at 2:01 p.m., CNA A stated that she witnessed Resident 1 in Resident 2's room, rubbing lotion between Resident 2's legs. CNA A further stated that Resident 1 frequently enters female residents' rooms.</p> <p>Review of Resident 1's SBAR, dated 9/21/24 indicated Resident 1 was found in female resident's (3) room. Resident 1 allegedly started touching Resident 3 inappropriately.</p> <p>Review of Resident 1's IDT Risk Management Meeting Notes, dated 9/23/24, indicated that IDT discussed the claim that Resident 1 entered female residents' room (Resident 3) and licked Resident 3's thigh. Resident 1 was removed from Resident 3's room. Resident 1 was placed on every 1-hour safety checks for 30 days following the claim. Resident 1 will remain on every hour safety checks until the behavior is stable and monitor the effectiveness of the medication.</p> <p>During an observation on 9/24/24 at 12:05 p.m., Resident 1 was seen seated in a wheelchair, moving independently through the hallway, and wiping the siderails and walls along the corridor. At the same time, the CNA's were observed delivering meal trays to other resident rooms.</p> <p>During a phone interview with CNA C on 9/25/24 at 11:37 a.m., CNA C stated on 9/21/24 he heard a scream coming from Resident 3's room. CNA C further stated he saw Resident 1 near Resident 3's bed and Resident 1 was about to wheel himself out of the room. CNA C confirmed he did not see Resident 1 entering Resident 3's room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview and concurrent record review with the Director of Nursing (DON) on 10/9/24 at 11:57 a.m., the DON reviewed the three incidents involving Resident 1's inappropriate sexual behavior, including entering Residents 2 and 3's rooms. Despite these incidents, the DON stated that the one-hour safety checks were appropriate for monitoring Resident 1's behavior.</p> <p>Review of facility's policy, titled Resident Rights, revised on 2/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: be treated with respect, kindness, and dignity .</p>