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	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Grove Post Acute	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 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. Based on interview and record review, the facility failed to properly perform and document discharge planning for one of six residents (Resident 1), when there was no documented discharge plan on the interdisciplinary team (IDT, a group of healthcare professionals from different fields that work together towards common goal for a patient) meeting notes. This failure resulted in Resident 1 being discharged without a definitive plan documented. Findings:A review of Resident 1's electronic record indicated that he was admitted with diagnoses which included sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage), atherosclerosis of aorta (a progressive buildup of plaque in the largest artery in your body, called your aorta), emphysema (a progressive lung disease making breathing difficult due to decreased lung surface area and trapped air).During an interview with the case manager (CM) on 7/22/25 at 11:47 a.m., she stated she had not documented a discharge plan for Resident 1. During an interview with the director of nursing (DON) on 7/22/25 at 1:09 p.m., she stated Resident 1 was discharged to a motel for two nights.During an interview with CM on 8/21/25 at 12:30 p.m., she stated she was not care planning at that time, she was writing progress notes.During a review of Resident 1's IDT Care Conference note (IDTCC), dated 7/2/25, the IDTCC indicated a check box for a discharge plan, and failed to indicate the discharge plan.During a telephone interview with the administrator (ADM) on 9/17/25 at 4:18 p.m., when asked about the lack of a documented discharge plan on the IDTCC, he pointed out other notes which indicated the facility was attempting to connect to Resident 1 with some county resources which Resident 1 had refused.During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, revised October 2022, the P&P indicated.3. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan.4. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes: a. where the individual plans to reside;b. arrangements that have been made for follow-up care and services;c. a description of the resident's stated discharge goals;d. the degree of caregiver/support person availability, capacity and capability to perform required care;e. how the IDT will support the resident or representative in the transition to post-discharge care;f. what factors may make the resident vulnerable to preventable readmission; andg. how those factors will be addressed.5. The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge. 6. The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan.

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