

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Redwood Grove Post Acute		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)		
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 observation, interview, and record review, the facility failed to ensure residents were free of accidents and hazards for two of three sampled residents (Residents 1 and 2) when staff did not: 1. accurately assess for fall risk and implement interventions to prevent further fall on 6/20/26 for Resident 1; and, 2. implement interventions to prevent further falls for Resident 2. These failures led to Resident 1's unwitnessed fall on 6/20/26 which resulted in a left humerus fracture (broken upper arm bone) and Resident 2's unwitnessed fall on 6/29/26 which resulted in a cervical spine fracture (broken neck bone). Findings: 1. Review of Resident 1's Face Sheet (summary of a Resident's basic information) indicated Resident 1 was admitted on [DATE] and had diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness or limited movement) following cerebral infarction (when a blocked or narrowed blood vessel disrupts blood flow to an area of the brain), muscle weakness, and reduced mobility. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 6/10/26, indicated a brief interview for mental status (BIMS, a structured cognitive test) score of 15 (a score of 15 means cognitively intact). The MDS also indicated Resident 1 had impairment of the upper extremity (shoulder, elbow, wrist, and hand) on one side. Review of Resident 1's Nurses Notes contained a Fall SBAR (a communication format with sections for documenting the Situation, Background, Assessment, and Recommendations), dated 6/9/26, which indicated, At approximately 7:35 a.m. during shift change resident was noted by certified nurse assistant [CNA] to have unwitnessed fall. Intervention: Toileting schedule. Review of Resident 1's Fall Risk Assessment, dated 6/9/26 at 3:14 p.m., indicated a score of 5 out of a scale of 10 (A score of 5 out of a possible 10 indicates the patient has recognizable fall risk factors). A History of falls section of this assessment had No falls in past 3 months marked as a response. Review of Resident 1's care plans contained an item dated 6/9/26 that indicated, Resident has had an actual fall, which included toileting schedule as an intervention. Review of Resident 1's Occupational Therapy Treatment Encounter Notes, dated 6/18/26, indicated, Toilet transfer = Supervision or touching assistance, walk 10 feet = Supervision or touching assistance, Toilet/Commode Transfers = Supervision or touching assistance. Review of Resident 1's interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) notes, dated 6/10/26, indicated Resident Fall Investigation and Intervention. A new intervention has been implemented to place a bedside commode (a portable chair-like toilet for people with mobility issues) within reach to help reduce the need for unsupervised transfers and decrease fall risks. Review of Resident 1's medical records lacked documentation to indicate implementation of a toileting schedule and/or bedside commode to prevent further falls after Resident 1's fall on 6/9/26. Review of Resident 1's Fall SBAR, dated 6/21/26, indicated, Resident (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055017
		If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	had an unwitnessed fall when getting assistance to the bathroom. While providing care, CNA stepped out of the room. while CNA was out of the room, Resident got out of the bathroom and, as she was leaving the bathroom, she collapsed and fell on the floor. Review of Resident 1's left shoulder X-ray (a radiation imaging test) report, dated 6/23/26, indicated Impression: Displaced fracture [when a bone snaps into two or more parts] of proximal humerus [the upper arm bone near the shoulder joint]. Review of Resident 1's Fall SBAR, dated 6/24/26, indicated, Resident 1 had a fall on 6/20/26, and an x-ray on 6/23/26 showed fracture, and the resident was transferred to emergency department (ED). During an interview and observation with Resident 1 in the bedroom on 7/1/26 at 12:30 p.m., Resident 1 sat up in her wheelchair and wore a left arm sling (a fabric support to immobilize and protect arm, shoulder, or elbow after surgery or injury). There was no bedside commode present. Resident 1 stated she fell a couple of weeks ago and broke her arm. Resident 1 stated a CNA assisted her to the bathroom and left. Resident 1 stated while trying to come out from the bathroom, her legs got loose, and she fell. Resident 1 stated there was no commode to use. During an interview and record review with the director of nursing (DON) on 7/1/26 at 2:10 p.m., she reviewed Resident 1's Fall Risk assessment dated [DATE] and confirmed the resident was not accurately assessed, because Resident 1 had a fall prior to the assessment on 6/9/26. The DON reviewed Resident 1's medical record and confirmed there was no documentation to indicate implementation of a toileting schedule and/or bedside commode to prevent further fall after Resident 1's fall on 6/9/26. The DON acknowledged the interventions were lacking for a toileting schedule and/or bedside commode and should have been implemented to prevent further falls. The DON stated the CNA should not have left Resident 1 alone in the bathroom because the resident required assistance for ambulation. During an interview and record review with licensed vocational nurse (LVN) A on 7/1/26 at 2:30 p.m., she confirmed she completed Resident 1's Fall Risk assessment dated [DATE], and that Resident 1 had a fall prior to the assessment on 6/9/26. LVN A acknowledged Resident 1 was not accurately assessed for the Fall Risk Assessment. During a phone interview with LVN B on 7/1/26 at 4:05 p.m., she confirmed she was assigned to Resident 1 on 6/20/26, and the CNA left the resident alone in the bathroom. LVN B stated the CNA told her leaving the resident alone in the bathroom was okay. LVN B stated she educated the CNA to not leave the resident alone after assisting the resident to the bathroom. LVN B stated Resident 1 did not have bedside commode in her room. During a phone interview with the director of rehabilitation (DOR) on 7/15/26 at 10:35 a.m., she confirmed the OT (occupational therapy) Treatment Encounter Note(s), dated 6/18/26, indicated Resident 1 required supervision for touching assistance with ambulation and/or toileting. 2. Review of Resident 2's Face Sheet indicated Resident 2 was admitted on [DATE] and had diagnoses including chronic kidney disease (CKD, a long-term condition in which the kidneys are damaged and have lost their ability to fully function), epilepsy (an abnormal activity in the brain that may cause uncontrollable jerking movements of the arms and legs, and/or loss of consciousness), muscle weakness, and abnormalities of gait and mobility. Review of Resident 2's MDS dated [DATE], indicated his BIMS (Brief Interview Mental Status, and assessment tool) score was 15 (a score of 15, out of 15 possible, means cognitively intact). Review of Resident 2's medical record contained Fall SBAR Nurses Notes dated for 5/18/26, 6/3/26, 6/15/26, 6/16/26, 6/26/26, 6/27/26, 6/29/26, and 7/4/26 each of which indicated Resident 2 had a fall and had a coinciding Fall Care Plan that indicated, Intervention: Pharmacy consult to evaluate medications, PT [physical therapist] consult for strength and mobility. Review of Resident 2's IDT regarding Resident 2's Fall Investigation and Intervention, dated 6/29/26, indicated, Date and time of incident: 6/27/26 18:45 (military time for 6:45 PM). Analysis of the fall: Resident fell because sudden lower-extremity weakness caused the legs to give out, triggered by a (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	combination of physiological factors (muscle weakness, balance impairment, possible orthostatic hypotension [a sudden drop in blood pressure when standing up from a sitting or lying position] or neuropathy [damage or dysfunction of the nerves outside the brain and spinal cord]). New or Revised interventions: PT/OT [physical therapist/occupational therapist] to complete full mobility and strength evaluation, Nursing to monitor orthostatic [conditions, symptoms, or measurements associated with an upright posture, such as standing or sitting] BP [blood pressure] for 72 hours. Review of Resident 2's Fall SBAR Nurses Notes and communication, dated 6/30/26, indicated, unwitnessed fall. Resident unable to recall what happened, slurring speech. At 21:10 [military time for 9:10 PM], resident transferred to [hospital name]. Review of Resident 2's computed tomography (CT, diagnostic imaging) results, dated 6/30/26, indicated, Impression: Fracture involving the anterior aspect of C1 (first cervical vertebra, a neck bone). Review of Resident 2's IDT notes for fall investigation and intervention, dated 6/30/26, indicated, Describe if out of normal range: BP (Blood Pressure) 93/62 (values for readings of blood pressure; systolic over diastolic; systolic is the top number, measuring the pressure when your heart beats. diastolic is the bottom number, measuring the pressure when your heart rests between beats). Review of Resident 2's care plan Pt [patient] is s/p [status post = afterwards] unwitnessed fall, initiated on 7/2/26, included intervention of, Resident on 1:1 [one staff assigned to continuously monitor one resident] for safety tracking and monitoring. During observations on 7/9/26 from 11:16 a.m. to 11:22 a.m., Resident 2 was sitting in a chair alone in his room, and there was no staff providing 1:1. During an interview with LVN C on 7/9/26 at 11:26 a.m., she stated Resident 2 was placed on 1:1 sitter [a designated monitoring staff] because he had multiple falls. During an observation and interview with LVN C on 7/9/26 at 11:32 a.m. in Resident 2's room, LVN C confirmed there was no staff to provide 1:1 to Resident 2. LVN C stated a 1:1 sitter should be with Resident 2, and she did not know why the 1:1 sitter was not with the resident. During an interview with the director of staff development (DSD) on 7/9/26 at 11:55 a.m., she stated a CNA who was assigned as the 1:1 sitter for Resident 2 went on lunch break without informing LVN C. The DSD stated the CNA should have informed LVN C about taking her break to continue the 1:1 monitoring. During an interview and record review with the DON on 7/9/26 at 1:02 p.m., the DON reviewed Resident 2's medical records and confirmed there was no documentation to indicate the interventions of pharmacy consult and/or checking orthostatic BP to prevent further falls were ever implemented; and that, there was no record of PT/OT consultation documentation until after the fall on 6/16/26. The DON acknowledged these interventions should have been implemented and done so timely. During a phone interview with the DOR on 7/15/26 at 10:25 a.m., she confirmed Resident 2 had multiple falls in June 2026 and PT consultations were not timely performed as an intervention for the falls on 6/3/2026, 6/15/2026, 6/26/2026, and 6/27/2026. Review of the facility policy and procedure (P&P) titled Fall Risk assessment, revised 3/2018, indicated, The nursing staff. will seek to identify and document risk factors for falls and establish a resident centered falls prevention plan based on relevant assessment information. The nursing staff will ask the resident and/or his/her family about any history of the resident falling. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors. Review of the facility P&P titled Falls and Fall Risk, Managing, revised 3/2018, indicated, The staff. will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling. Review of the facility P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022, indicated, The intradisciplinary team (IDT). develops and implements a comprehensive, person-centered care plan for each resident.		