

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

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No. 0938-0391

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 07/23/2026
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 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** Based on observation, interview and record review, the facility failed to ensure, infection control prevention was maintained, to one of twenty-nine residents affected with coronavirus disease 2019 (COVID-19, contagious disease caused by the severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2), (Resident 1), when Resident 1 was allowed to go to his medical appointment without informing the receiving healthcare facility in advance that Resident 1 had a pending COVID-19 testing result. This failure affected the way the receiving healthcare facility handled Resident 1 who eventually tested positive for COVID-19, and this could potentially spread to the staffs and patients of the receiving healthcare facility. Findings:Review of Resident 1's clinical records indicated, Resident 1 was admitted to the facility on [DATE] with the principal diagnosis of chronic obstructive pulmonary disease (COPD, long-term lung condition that blocks airflow and makes it hard to breathe) with acute exacerbation (sudden, sharp worsening of symptoms for a chronic health condition). Resident 1 was tested for COVID-19 for exposure to the disease on 7/15/26 and the specimen was sent to the laboratory. Further review of Resident 1's clinical records indicated, he went for his medical appointment to an outside healthcare facility (OHCF) on 7/16/26. His COVID-19 testing result was not received yet when he went out. After the facility got Resident 1's positive COVID-19 testing result, they then notified Resident 1's receiving outside healthcare facility (OHCF) about the result. The receiving outside healthcare facility (OHCF) was never informed of Resident 1's COVID-19 testing prior to the appointment and the pending result. During the interview with the infection preventionist (IP), on 7/23/26 at 2:20 p.m., IP verified that the facility nurse or staff should have informed, Resident 1's receiving healthcare facility (OHCF) that he was tested for COVID-19 for exposure and the result was still pending, so they would be aware and the necessary preventions would be implemented to prevent the spread of infection to the staffs and patients at the outside facility. During the interview with registered nurse A (RN A), on 7/23/26 at 3:15 p.m., RN A confirmed that she was not able to inform Resident 1's receiving healthcare facility prior to his appointment and before going there that he was tested for COVID-19 for exposure and would not do it next time to prevent the possible spread of infection. RN A further confirmed that Resident 1 tested positive for COVID-19 when the result came back. During the interview with the director of nursing (DON), on 7/23/26 at 4:30 p.m., DON acknowledged that the facility should have informed the receiving healthcare facility of Resident 1 prior to his medical appointment that he was tested for COVID-19 for exposure and that, he actually was positive when his result came back, to prevent spreading the infection. DON further acknowledged that she would remind staffs about this incident. Review of the facility's policy titled, Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents, revised September 2022 indicated, .Resident Placement.Information about residents with suspected or confirmed SARS-CoV-2 infection is communicated to appropriate personnel before transferring them.to other healthcare facilities.		

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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