STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 Based on observation, interview, and record review, the facility failed to ensure nurses were trained and demonstrated competency in testing the functionality of the Wander Management Transmitters (wander guard, a device placed on a resident's wrist, ankle, or wheelchair that alarms to notify the staff if a resident tries to leave the facility) used for 9 of 9 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, and 9). This failure had the potential to result in transmitter equipment failure or system failure and resident elopement (to leave a health facility without notification or permission). Findings: Review of Resident 1's face sheet indicated she was admitted to the facility with diagnoses including dementia (decline in mental capacity affecting daily function) and type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar). Review of Resident 1's Elopement Risk Observation/Assessment, dated [DATE], indicated her elopement risk score was 12 (If the score was 10 or greater, the resident would be considered to be at risk for elopement). Review of Resident 1's Order Summary Report, dated [DATE] indicated she had a physician order to check function and placement of wander guard every shift, dated [DATE]. The report also indicated Resident 1 had a physician order for Wander Guard on wheelchair for safety, dated [DATE]. Review of Resident 1's elopement care plan, dated [DATE] indicated Wander Alert: Check function and placement per orders. Review of Resident 2's face sheet indicated she was admitted to the facility with diagnoses including hypertension (high blood pressure) and dementia. Review of Resident 2's Elopement Risk Observation/Assessment, dated [DATE], indicated her elopement risk score was 12. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 2's Order Summary Report, dated [DATE] indicated she had a physician order for Wander guard right wrist verify function every evening shift every Wednesday and Saturday, dated [DATE]. The report also indicated Resident 2 had a physician order for Wander Guard right wrist check placement every shift, dated [DATE]. Review of Resident 2's elopement care plan, dated [DATE] indicated Wander Alert: check placement and functioning per orders. Review of Resident 3's face sheet indicated she was admitted to the facility with diagnoses including syncope (fainting)/collapse and dementia. Review of Resident 3's Elopement Risk Observation/Assessment, dated [DATE], indicated her elopement risk score was 20. Review of Resident 3's Order Summary Report, dated [DATE] indicated she had a physician order Wander Guard For Safety applied to the right wrist every shift, dated [DATE]. Review of Resident 3's elopement care plan, dated [DATE] indicated Equip with device that alarms when the resident wanders. Check for proper functioning of the device and alarms every shift. Review of Resident 4's face sheet indicated she was admitted to the facility with diagnoses including parkinsonism (a term for brain conditions that cause slowed movements, rigidity [stiffness] and tremors) and dementia. Review of Resident 4's Elopement Risk Observation/Assessment, dated [DATE], indicated her elopement risk score was 24. Review of Resident 4's Order Summary Report, dated [DATE] indicated she had a physician order for Wander guard on right wrist for exit seeking, Check placement and function every shift, dated [DATE]. Review of Resident 4's elopement care plan, dated [DATE] indicated wander guard to be worn at all times related to poor safety awareness. Review of Resident 5's face sheet indicated he was admitted to the facility with diagnoses including diabetes and dementia. Review of Resident 5's Elopement Risk Observation/Assessment, dated [DATE], indicated his elopement risk score was 14. Review of Resident 5's Order Summary Report, dated [DATE] indicated he had a physician order for Wanderguard on the right wrist check placement daily, dated [DATE]. Review of Resident 5's elopement care plan, dated [DATE] indicated resident has episode of wandering. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 6's face sheet indicated he was admitted to the facility with diagnoses including paranoid schizophrenia (a serious mental health condition that affects a person's ability to think, feel, and behave clearly) and autistic disorder (a developmental disorder that impairs the ability to communicate and interact). Review of Resident 6's Order Summary Report, dated [DATE] indicated he had a physician order for Wander guard to prevent elopement on left wrist every shift, dated [DATE]. The Report also indicated Resident 6 had a physician order to check functioning and placement of wander guard twice a week, every Tuesday and Saturday evening shift, dated [DATE]. Review of Resident 7's face sheet indicated she was admitted to the facility with diagnoses including aphasia (a disorder that affects the ability to communicate due to a brain injury) and diabetes. Review of Resident 7's Order Summary Report, dated [DATE] indicated she had a physician order for Wander guard on left wrist check function every Wednesday and Saturday evening shift, dated [DATE]. Review of Resident 7's elopement care plan, dated [DATE] indicated wander guard check placement and function. Review of Resident 8's face sheet indicated she was admitted to the facility with diagnoses including hemiplegia and hemiparesis (complete paralysis, partial paralysis or muscle weakness on one side of the body) and dementia. Review of Resident 8's Order Summary Report, dated [DATE] indicated she had a physician order for Wander guard apply to walker, check placement and function every shift, dated [DATE]. Review of Resident 8's elopement care plan, dated [DATE] indicated wander guard (on walker) at all times related to poor safety awareness. Review of Resident 9's face sheet indicated she was admitted to the facility with diagnoses including dementia and difficulty walking. Review of Resident 9's Order Summary Report, dated [DATE] indicated she had a physician order for Wander guard apply for safety, check placement and function every shift, dated [DATE]. During an interview on [DATE] at 1:16 p.m. licensed vocational nurse A (LVN A) stated she had multiple residents who had a wander guard. When asked how to check whether the wander guard was working, LVN A stated to bring the resident to the door because there is a sensor on each exit door in the facility. LVN A did not mention the use of a tester. During an observation and interview on [DATE] at 1:20 p.m., LVN A stated Resident 1 had a wander guard on her left wrist. LVN A attempted to bring Resident 1 to a side exit door but she did not want to go outside. During an observation on [DATE] at 1:25 p.m., LVN A brought Resident 2 to a side exit door and the alarm sounded. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:50 a.m., the director of staff development (DSD) stated since he has been a DSD, he has not given a wander guard training. The DSD stated he would check to see whether one has been given. During an interview on [DATE] at 10:54 a.m., registered nurse B (RN B) stated she was normally worked during the day shift (working hours from 7 a.m. to 3 p.m.) and was assigned to at least one resident with a wander guard. When asked how to check whether the wander guard was working, RN B stated there is a device used to check the wander guard function at the nurse's station. She stated she was not sure where it was because it was the night shift's (working hours from 11 p.m. to 7 a.m.) responsibility to check it. During an interview on [DATE] at 10:56 a.m., licensed vocational nurse C (LVN C) stated he was assigned to a resident with a wander guard. When asked how to check whether the wander guard was working, LVN C stated prior to putting a wander guard on a resident, staff should put it near one of the doors. LVN C stated staff can take the residents near a door to make sure the wander guard is working. During an interview on [DATE] at 11:01 a.m. licensed vocational nurse D (LVN D) stated she was not assigned to any residents with a wander guard. During an interview on [DATE] at 11:20 a.m., with the DSD and nurse supervisor (NS), the DSD stated he has been taking the residents to the front door to check whether their wander guard was working. The NS took the tester to Resident 1 to test Resident 1's wander guard. The NS pressed the button on the tester and the tester indicator light turned green and beeped. After the tester indicator light turned green, the NS released the button. The NS did not hold the button to wait for the indicator light to continue blinking. During an interview on [DATE] at 11:38 a.m., licensed vocational nurse E (LVN E) stated she was assigned to residents with a wander guard. She stated the day shift nurses just check to make sure the wander guard is in place. LVN E stated the night shift used a device shaped like a box to check the functionality. LVN E checked three drawers and the medication cart to locate the device and was not able to locate it. During an interview and concurrent record review on [DATE] at 12:14 p.m., the DSD provided a facility in-service, Wandering and Elopements, dated [DATE]. The in-service training indicated it addressed elopement assessment, care plans, and resident elopement. The DSD stated he did not know if there was any in-service about how to use the wander guard tester. He stated he did not even know that a wander guard tester existed. During an concurrent observation and interview on [DATE] at 1:36 p.m. LVN D was asked whether Resident 3 had a wander guard. LVN D confirmed she was assigned to Resident 3 and Resident 3 had a wander guard on her right wrist. LVN D stated she only checked to see that the wander guard was on the resident. LVN D stated she did not check the functionality of Resident 3's wander guard. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and concurrent record review on [DATE] at 3:45 p.m. the director of nursing (DON) stated she was familiar with the wander guard system. She stated nurses should be checking the placement of the wander guard on the residents. The DON stated that there should be a little device to check the functionality of the wander guard every shift. She stated bringing the resident to the doors to test the wander guard was not the accurate way to do it. The DON stated it was not only the night shift's responsibility. She reviewed the facility's Wander Management Transmitters User Guide, dated ,d+[DATE] and verified that users should have adequate training on how to use the wander guard system and that the wander guards should be tested using the device tester. The DON also confirmed that the User Guide indicated not to bring the residents to the exit doors to test their wander guard. During an interview on [DATE] 2:17 p.m., the DON stated it was the responsibility of the DON and DSD to train nurses regarding the use of the wander guard. Review of the facility's policy, Wandering and Elopements, dated ,d+[DATE] indicated, If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety . nursing assessment is initiated to determine if a resident is at risk for elopement and is eligible for a wander guard alert device . A care plan is added and daily check ins for wander guard placement. Review of the Wander Management Transmitters User Guide, dated ,d+[DATE] indicated the following: - Only users who have received adequate training on the use of the system, outlined in this manual, should use the system. It is the responsibility of the facility to ensure all users have been trained. Failure to adequately train employees may cause system failure due to user error. In addition, incorrect use of the equipment may also result in system failure . - You must test all transmitters prior to use to verify proper operation. This includes every time that the band is replaced. Failure to test the transmitters before use can result in system failure and/or an elopement. - Operation: Test the operation of the transmitter using the Transmitter Tester. The transmitter tester will detect whether or not a transmitter is emitting a signal, but cannot indicate the strength of the signal. 1. Place the transmitter tester directly on the transmitter. 2. Press and hold the button on the left side of the transmitter tester. 3. The device beeps once when you initially press the button. 4. While holding the button in, the indicator light flashes and a tone sounds once per second. Wait for at least 3 flashes of the indicator light and 3 tones from the transmitter tester to verify that the transmitter is functioning correctly . - Weekly Testing: The following testing is required for all transmitters in use on residents. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Test the operation of transmitters using the transmitter tester. NOTE: Never take a resident to a door to test their transmitter . Verify that the warranty expiration date stamped on the transmitter has not expired. If the warranty period has expired, discard and replace the transmitter immediately.