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	06/25/2024

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 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** 46001 Based on interview and record review, the facility failed to ensure supervision and assistance were provided for one of three sampled residents (Resident 1), who was dependent on staff for transferring, when Resident1 was left sitting in her wheelchair in her room and fell on the floor on 2/19/2024 without staff watching and/or supervising her. This failure resulted in Resident 1 falling on the floor and sustaining a laceration (a deep cut or tear in skin) on her forehead that required hospital transfer on 2/19/2024 where she had 18 stitches (a way doctors can close certain types of cuts). Findings: A review of Resident 1's face sheet (a document that gives a resident's information) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a range of?neurological conditions affecting the brain including loss of the ability to think, remember, and reason to levels that affect daily life and activities), difficulty in walking, muscle weakness, and history of falling. A review of Resident 1's Fall Risk assessment, dated 11/21/2023, indicated a score of 22 (score of 16-42 indicates high risk of falling), Resident 1 was at high risk of falling. A review of Resident 1's care plan, initiated on 3/2/2023, indicated Resident 1 had an Activities of daily living (ADLs, a person's daily self-care activities) self-care performance deficit related to impaired balance and limited mobility . TRANSFER The resident has [sic] requires staff participation with transfers. A review of Resident 1's admission minimum data set (MDS, an assessment tool) dated 11/21/2023 indicated a brief interview for mental status (BIMS, cognition [includes memory, problem-solving, and thinking skills] level) score of 8 (score of 8-12 indicates moderate cognitive impairment). A review of Resident 1's MDS section GG, dated 11/21/2023, indicated Resident 1's level of performance was coded 1 which indicated Resident 1 was dependent, and helpers did all of the effort, the resident did none of the effort to complete the activities; and Resident 1 required assistance of 2 or more helpers to complete the activities of bed mobility, transfer, and toileting. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Interdisciplinary Team's (IDT, team composed of members from different departments involved in resident's care) Fall Follow up notes dated 2/20/2024, indicated, the resident was found lying on her right side next to her wheelchair in her room, bleeding from right forehead and hand noted . Several minutes prior to the incident, the resident participated in group activities and was assisted back to her room via wheelchair . resident was sent to the hospital via 911 per physician's order for further evaluation and treatment as indicated .the resident's previous fall incident was about a month ago with no injury noted . The staff had been providing redirection and assistance with ADLs .Resident appeared to have tried to self-transfer without staff assistance and lost balance . Prior Intervention(s) : Preventive measures prior to event: frequent checks for needs, assistance with ADLs and re-direction as needed . Resident returned on the same day with sutures to scalp. A review of Resident 1's clinical records from the hospital, titled emergency room (ED) Physician Report, dated 2/19/2024, indicated that .patient (Resident 1) was presenting to the ED via ambulance after an unwitnessed fall .Patient (Resident 1) was found on the ground after she had fallen out of her wheelchair. The patient was noted to have a large laceration to her forehead and scalp. No other injuries were noted . During an interview with the MDS coordinator (MDSC) on 6/13/24 at 10:30 a.m., the MDSC reviewed Resident 1's MDS section GG, and she confirmed Resident 1 was dependent, required helpers (staff) to do all of the effort, the resident did none of the effort to complete the activities. Resident 1 required the assistance of 2 or more helpers(staff) to complete the activities of bed mobility, transfer, and toileting. During an interview with the Activity Director (AD) on 6/13/24 at 2:42 p.m., the AD confirmed the concerned activity staff C (AS C) who brought Resident 1 back to her room no longer work in the facility. The AD stated the activity staff should not leave residents alone in their room without notifying nursing staff. During a phone interview with Registered Nurse (RN) A on 6/13/24 at 3:04 p.m., RN A recalled Resident 1 falling inside her room on 2/19/2024 around noon time. RN A stated the AS C brought Resident 1 back to her room without notifying the nursing staff. RN A confirmed that Resident 1's MDS and ADL care plan indicated Resident 1 needed helpers to help with the transfer. RN A further stated Resident 1 was at risk of falling and should not have been left alone in her room. she also stated Resident 1 returned from the hospital on the same day (2/19/2024) with 18 stitches on her forehead. During a phone interview with CNA B on 6/13/24 at 3:57 p.m., CNA B confirmed she was the assigned CNA for Resident 1 on 2/19/2024. CNA B confirmed that Resident 1 cannot transfer by herself and required staff help during wheelchair-to-bed transfer. CNA B stated AS C brought Resident 1 back to her room without informing her. When CNA B came to Resident 1' room to answer the call light, Resident 1 already fell on the floor. CNA B further stated that the AS C should not have left Resident 1 alone in her room. During an interview with the Director of Nursing (DON) on 6/13/24 at 4:11 p.m., the DON reviewed Resident 1's MDS and ADL care plan. The DON confirmed that Resident 1 was a high risk for falling and needed help with the wheelchair to bed transfer. The DON stated that the AS C should have stayed with Resident 1 and notified the CNAs and/or nurses that Resident 1 was back in her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Review of the facility's undated policy and procedure (P&P) titled Falls and Fall risk, Managing, the P&P indicated, .several possible interventions may be identified considering resident fall risks, and the staff may prioritize certain interventions based on the circumstances .