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	07/31/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on observation, interview, and record review, the facility failed to honor two of three residents' (Residents 2 and 3) requests for showers. This failure resulted in the resident's request and preference not being honored. Findings: 1. Review of Resident 2's clinical record indicated Resident 2 was admitted on [DATE] and had diagnoses including acquired absence of right leg above knee (a surgical amputation [the loss or removal of a body part]), obesity (a disorder that has too much body fat), and difficulty in walking. Review of Resident 2's Minimum Data Set (MDS, an assessment tool), dated 6/11/24, indicated she had a brief interview for mental status (BIMS, a structured cognitive [relating to the mental process involved in knowing, learning, and understanding things] test) score of 15 (cognitively intact). During an interview on 7/26/24 at 1:20 p.m. with Resident 2, she was lying in bed and stated she missed showers on her scheduled shower days. Resident 2 stated she asked for a bed bath on her scheduled shower days, and the facility staff said they were too busy and did not have time. Review of the facility's shower schedule indicated Resident 2's scheduled shower days were Tuesdays and Fridays. Review of Resident 2's bathing task records indicated there was no documentation indicating the staff provided or offered a shower or bed bath to Resident 2 on 7/09/24, 7/16/24, 7/26/24, and 7/30/24. 2. Review of Resident 3's clinical record indicated Resident 3 was admitted on [DATE] and had diagnoses including osteomyelitis of vertebra (a spinal [back bone] infection), type 2 diabetes (high blood sugar), and difficulty in walking. Review of Resident 3's MDS, dated [DATE], indicated she had a BIMS score of 15. During an interview on 7/26/24 at 1:40 p.m. with Resident 3, she was lying in bed and stated she missed showers on some Saturdays. Resident 3 stated she asked for a shower on her scheduled shower days, and the facility staff said they were too busy and did not have time for a shower. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's shower schedule indicated Resident 3's scheduled shower days were Wednesdays and Saturdays. Review of Resident 3's bathing task records indicated there was no documentation indicating the staff provided or offered a shower or bed bath to Resident 3 on 7/03/24, 7/13/24, 7/20/24, 7/24/24 and 7/27/24. During an interview and record review on 7/31/24 at 2:15 p.m. with the minimum data set coordinator (MDSC) A, she confirmed the above record review of Resident 2 and 3. The MDSC A stated staff should have provide or offer showers or bed baths as scheduled and document them. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 2/2021, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: e. self-determination. During a review of the facility's policy and procedure (P&P) titled Bath, Shower/Tub, revised 2/2018, the P&P indicated, Purpose: The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: if the resident refused the shower/tub bath, the reason(s).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview, and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for one of two residents when it did not follow the physician's order to provide 1:1 monitoring for Resident 1. This failure had the potential to compromise residents' safety and health in the facility. Findings: Review of Resident 1's clinical record indicated Resident 1 was admitted on [DATE] and had diagnoses including dementia (a decline in mental capacity affecting daily function), neurosyphilis (an infection of the brain or spinal cord), and unsteadiness on feet. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 4/30/24, indicated he had a brief interview for mental status (BIMS, a structured cognitive [relating to the mental process involved in knowing, learning, and understanding things] test) score of 03 (severe cognitive impairment). Review of Resident 1's care plan for episodes of altercation with another resident initiated on 5/01/24 included an intervention of temporary 1:1 initiated. Review of Resident 1's care plan involving him as the aggressor in resident to resident incident on 5/01/24 initiated on 5/02/24 included the goal that resident will be monitored 1:1 to ensure other residents' safety. Review of Resident 1's physician's order, dated 5/01/24, indicated 1:1 monitoring every shift. 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) note included New interventions: Monitoring initiated for agitation. Patient currently on 1:1. Review of Resident 1's medication administration record (MAR) from May 2024 to July 2024 on 7/26/24 indicated Resident 1 had a physician's order for 1:1 monitoring every shift from 5/01/24 to present. There was documentation in the MAR indicating staff provided 1:1 monitoring every shift for Resident 1 from 5/01/24 to 7/25/24. Review of the facility's 1:1 monitoring assignment for Resident 1 from May 2024 to July 2024 indicated there was no staff assignment to provide 1:1 monitoring at night shift from 6/09/24 to present. During an interview and facility document review on 7/26/24 at 12:40 p.m. with the staffing coordinator (SC), she confirmed the above assignment. The SC stated that there was no 1:1 monitoring assignment for the night shift from 6/09/24 to the present because Resident 1 slept at night. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 7/26/24 at 12:50 p.m. with the administrator (ADM), he confirmed Resident 1's physician's order of 1:1 monitoring every shift was current and active, and there was no 1:1 monitoring assignment for night shift from 6/09/24 to the present. The ADM stated there was no documentation indicating the facility evaluated Resident 1's behavior and communicated with his physician to change his 1:1 monitoring schedule. The ADM agreed the facility should have done the resident evaluation and communicated with his physician before changing the monitoring schedule. During a telephone interview on 8/01/24 at 10:30 a.m. with the director of nursing (DON), she confirmed Resident 1's physician's order of 1:1 monitoring every shift was current and active. The DON agreed the facility should have done the resident's evaluation for any behavior change, communicated with his physician, and received an order to change the monitoring schedule. During a review of the facility's policy and procedure (P&P) titled Behavioral Assessment, Intervention and Monitoring, revised 3/2019, the P&P indicated, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44733 Based on observation, interview, and record review, the facility failed to follow their bed rails (adjustable rigid bars attached to the side of a bed: side rails, safety rails, and grab/assist bars) policy for one of three residents (Resident 4). The facility failed to follow their bed rail policy when: 1. There was no documentation that alternatives were attempted prior to installing bed rails; 2. There was no documentation that the risks and benefits were explained to the residents or responsible parties (RP, individuals designated to make decisions on behalf of the residents) prior to installing bed rails; 3. There was no informed consent obtained prior to installing bed rails; 4. There was no documentation that the facility assessed for risk of entrapment (becoming trapped between the bed rail and mattress) prior to installing bed rails; and 5. There was no documentation that the facility assessed the bed dimensions to ensure they were appropriate for the residents' size and weight. These failures resulted in the resident and the resident's RPs not being fully informed on the risks of the use of bed rails and had the potential to place the resident at risk of entrapment and serious injury. Findings: During an observation on 7/26/24 at 2:00 p.m., the bed of Resident 4 was inspected. The bed had upper partial bed rails bilaterally (on both sides). Review of Resident 4's physician's order, dated 7/05/24, indicated she may have bilateral upper repositioning bars up every shift to assist the resident in bed mobility (movement). Review of Resident 4's clinical record indicated there was no documentation that the facility attempted alternatives, explained risks and benefits, obtained informed consent, assessed for risk of entrapment, and assessed the bed dimensions prior to installing bed rails. During an interview on 7/31/24 at 1:35 p.m., minimum data set coordinator (MDSC) A stated that the facility should attempt alternatives, explain risks and benefits, obtain informed consent, assess for risk of entrapment, and assess the bed dimensions prior to installing bed rails. During a concurrent observation and interview on 7/31/24 at 1:50 p.m. with MDSC A in Resident 4's room, bilateral upper partial bed rails were in an upright position on Resident 4's bed. MDSC A confirmed the observation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview and record review on 7/31/24 at 2:00 p.m., MDSC A confirmed there was no documentation indicating the facility attempted alternatives, explained risks and benefits, obtained informed consent, assessed for risk of entrapment, or assessed the bed dimensions prior to installing bed rails. During a review of the facility's policy and procedure (P&P) titled Bed Safety and Bed Rails, revised 8/2022, the P&P indicated, Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. The resident assessment to determine risk of entrapment includes, but is not limited to: medical diagnosis, conditions, symptoms; size and weight; sleep habits; medication(s) .Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.