

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/02/2024
NAME OF PROVIDER OR SUPPLIER  Santa Cruz Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590</b></p> <p>Based on interview and record review, the facility failed to develop a care plan (identifies residents' concerns and outlines the care and services needed to meet their needs) to address foley catheter for two of four sampled residents (Resident 1 and 2). This failure had the potential to result in the inability to identify the residents' individualized care issues and implement a person-centered care.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record, indicated, Resident 1 was admitted on [DATE] with diagnoses including hypertensive heart disease with heart failure (heart problems that occur because of high blood pressure that is present over a long time), acute on chronic diastolic congestive heart failure (heart works less efficiently and can lead to buildup of fluid in the lungs and shortness of breath), acute respiratory failure with hypoxia (A condition where not enough oxygen in the body. A condition in which the lungs have a hard time loading the blood with oxygen or removing carbon dioxide. Lungs cannot release enough oxygen into the blood), obstructive and reflux uropathy (obstruction in the urinary tract that prevents urine from flowing normally).</p> <p>Review of Resident 1's clinical record indicated he had a physician's order, dated 9/17/23, to insert foley catheter. There was no care plan developed to address the foley catheter.</p> <p>During a concurrent interview and record review on 8/2/24 at 3:29 p.m., with the Director of Nursing (DON), the DON acknowledged there was no care plan developed for foley catheter. The DON stated the care plan was needed so the staff would know how to take care of the foley catheter.</p> <p>During a concurrent interview and record review on 8/7/24 at 1:54 pm., with the Assistant Director of Nursing (ADON), the ADON acknowledged there was no care plan developed for the foley catheter. The ADON stated there should be one.</p> <p>Review of Resident 2's clinical record, indicated, Resident 2 was admitted on [DATE] with diagnoses including fusion of spine cervical region (surgery to permanently join together two or more bones in the spine), essential hypertension (high blood pressure that does not have a known cause), muscle wasting (the loss of muscle tissue, strength, and mass) and atrophy (the partial or complete wasting away of a body part or tissue), dysphagia (difficulty swallowing).</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's nursing progress notes indicated he had a foley catheter inserted on 6/10/24. There was no care plan developed to address foley catheter.</p> <p>During a concurrent interview and record review on 8/2/24 at 1:04 p.m., with the Nursing Supervisor (NS), the NS confirmed there was no care plan developed addressing foley catheter.</p> <p>During a concurrent interview and record review on 8/7/24 at 12:39 p.m., with the Assistant Director of Nursing (ADON), the ADON confirmed there was no care plan developed addressing the foley catheter. The ADON stated there should be one.</p> <p>During a review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, dated 3/22, indicated The comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48590</p> <p>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 (Resident 2) when:</p> <ol style="list-style-type: none"> <li>1. Discharge wound care order from acute hospital to skilled nursing facility was not transcribed, and</li> <li>2. No physician order to insert foley catheter.</li> </ol> <p>This failure had the potential to negatively affect Resident 2's health and well-being.</p> <p>Findings:</p> <p>1. Review of Resident 2's clinical record, indicated, Resident 2 was admitted on [DATE] with diagnoses including fusion of spine cervical region (surgery to permanently join together two or more bones in the spine), essential hypertension (high blood pressure that does not have a known cause), muscle wasting (the loss of muscle tissue, strength, and mass) and atrophy (the partial or complete wasting away of a body part or tissue), dysphagia (difficulty swallowing).</p> <p>Review of Resident 2's Interagency Discharge Summary and Order from acute hospital, dated 6/6/24, indicated Resident 2 had PSF (posterior spinal fusion, a surgical procedure used to correct problems with the small bones in the spine) and decompression (a treatment that relieves pressure on the spinal cord) on 5/31/24.</p> <p>Review of Resident 2's discharge wound care from acute hospital, dated 6/6/24, indicated sutures or staples must be removed in 7-10 days.</p> <p>Review of Resident 2's clinical record, indicated Resident 2 has a physician order to remove sutures to cervical spine, dated 6/27/24.</p> <p>During a concurrent interview and record review on 8/2/24 at 11:41 a.m., with the Wound Nurse (WN) A, the WN A stated half of the sutures were removed on 6/28/24. WN A stated the remaining sutures will be removed by the wound doctor.</p> <p>During a concurrent interview and record review on 8/2/24 at 12:28 p.m., with the Nursing Supervisor (NS), the NS stated the surgical wound was not checked if sutures were removed. The NS stated there was no documentation that the surgical wound on the back of the neck was checked. The NS confirmed the sutures were removed on 6/28/24. The NS stated the sutures should have been removed within 7-10 days based on the acute hospital discharge instructions.</p> <p>During a concurrent interview and record review on 8/2/24 at 4:39 p.m., with the Director of Nursing (DON), the DON stated the facility follow the discharge summary instruction from acute hospital. The DON stated the sutures should have been removed within 7-10 days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 8/7/24 at 11:02 a.m., with WN B, WN B confirmed that half of the sutures were removed on 6/28/24. The WN B stated there was no documentation that the remaining sutures were removed.</p> <p>During a concurrent interview and record review on 8/7/24 at 11:33 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility follows the discharge summary instructions and orders from acute care hospital and will be transcribed in the physician order. The ADON confirmed the wound care order from acute hospital to remove the sutures within 7-10 days was not transferred as an order on 6/6/24.</p> <p>During a review of the facility's policy and procedure titled, Admission Criteria, undated, indicated Prior to or at time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders at least: .c. routine care orders to maintain or improve the resident's function .</p> <p>2. Review of Resident 2's progress notes, indicated foley catheter was inserted on 6/10/24.</p> <p>During a concurrent interview and record review on 8/2/24 at 12:28 p.m., with the NS, the NS confirmed there was no order to insert the foley catheter. The NS stated there should be an order to insert the foley catheter.</p> <p>During a concurrent interview and record review on 8/7/24 at 12:33 p.m., with the ADON, the ADON confirmed foley catheter was inserted on 6/10/24 and there was no physician order.</p> <p>During a review of the facility's policy and procedure titled, Indwelling (Foley) Catheter Insertion, Male Resident, dated 2001, indicated Verify that there is a physician's order for this procedure.</p>		