| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056065 | A. Building<br>B. Wing | 08/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Santa Cruz Post Acute | 1115 Capitola Road<br>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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>36623<br><br>Based on interview and record review, the facility failed to provide appropriate care and services for an indwelling catheter (flexible tube inserted and left in the bladder to drain urine) for one of three residents when Resident 1 did not have a physician's order for an indwelling catheter, there was no care plan for an indwelling catheter, and there was no documentation of the assessment of urine output and whether catheter care was completed. Also, the facility staff did not document the number of times Resident 1 voided per physician's order. These failures had the potential to result in health complications for the resident.<br><br>Findings:<br><br>Review of Resident 1's face sheet indicated she was admitted to the facility with diagnoses including displaced (out of alignment) intertrochanteric fracture of right femur (broken hip).<br><br>Review of Resident 1's Minimum Data Set (MDS, assessment tool), dated 6/20/24 indicated the resident had an indwelling catheter.<br><br>Review of Resident 1's care plans indicated she did not have a urinary catheter care plan.<br><br>Review of Resident 1's medical record indicated there was no documented evidence that urinary catheter care was performed. There was no documentation regarding urine output and urine assessment.<br><br>Review of Resident 1's physician orders indicated she had an order, dated 7/11/24, Bladder training. Make sure patient is voiding. If bladder discomfort or no voiding do bladder scan and call MD every shift for 5 Days Document # [number] times patient voids.<br><br>There was no documentation in Resident 1's medical record that indicated staff documented the number of times Resident 1 voided every shift for five days.<br><br>During an interview on 8/6/24 at 2:15 p.m., the director of nursing (DON) confirmed Resident 1 was admitted to the facility with an indwelling catheter. The DON stated Resident 1 did not have a physician's order for an indwelling catheter. She confirmed Resident 1 did not have a catheter care plan and there was no documentation regarding urine output, urine color, catheter care. The DON also confirmed there was no documentation of the number of time Resident 1 voided after the indwelling catheter was removed.<br><br>(continued on next page) |



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

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy, Goals and Objectives, Care Plans, indicated, Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment.<br><br>Review of the facility's policy and procedure (P&P), Urinary Catheter Care, revised 8/2022, indicated to use soap and water or bathing wipes for routine daily hygiene. The P&P also indicated, The following information should be recorded in the resident's medical record:<br><br>1. The date and time that catheter care was given.<br><br>2. The name and title of the individual(s) giving the catheter care.<br><br>3. All assessment data obtained when giving catheter care.<br><br>4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.<br><br>5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain .<br><br>Review of the facility's policy, Behavioral Programs and Toileting Plans for Urinary Incontinence, revised 10/2010 indicated the staff will document the results of toileting trial in the resident's medical record.<br><br>Based on interview and record review, the facility failed to provide appropriate care and services for an indwelling catheter (flexible tube inserted and left in the bladder to drain urine) for one of three residents when Resident 1 did not have a physician's order for an indwelling catheter, there was no care plan for an indwelling catheter, and there was no documentation of the assessment of urine output and whether catheter care was completed. Also, the facility staff did not document the number of times Resident 1 voided per physician's order. These failures had the potential to result in health complications for the resident.<br><br>Findings:<br><br>Review of Resident 1's face sheet indicated she was admitted to the facility with diagnoses including displaced (out of alignment) intertrochanteric fracture of right femur (broken hip).<br><br>Review of Resident 1's Minimum Data Set (MDS, assessment tool), dated 6/20/24 indicated the resident had an indwelling catheter.<br><br>Review of Resident 1's care plans indicated she did not have a urinary catheter care plan.<br><br>Review of Resident 1's medical record indicated there was no documented evidence that urinary catheter care was performed. There was no documentation regarding urine output and urine assessment.<br><br>Review of Resident 1's physician orders indicated she had an order, dated 7/11/24, Bladder training. Make sure patient is voiding. If bladder discomfort or no voiding do bladder scan and call MD every shift for 5 Days Document # [number] times patient voids.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | There was no documentation in Resident 1's medical record that indicated staff documented the number of times Resident 1 voided every shift for five days.<br><br>During an interview on 8/6/24 at 2:15 p.m., the director of nursing (DON) confirmed Resident 1 was admitted to the facility with an indwelling catheter. The DON stated Resident 1 did not have a physician's order for an indwelling catheter. She confirmed Resident 1 did not have a catheter care plan and there was no documentation regarding urine output, urine color, catheter care. The DON also confirmed there was no documentation of the number of time Resident 1 voided after the indwelling catheter was removed.<br><br>Review of the facility's policy, Goals and Objectives, Care Plans, indicated, Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment.<br><br>Review of the facility's policy and procedure (P&P), Urinary Catheter Care, revised 8/2022, indicated to use soap and water or bathing wipes for routine daily hygiene. The P&P also indicated, The following information should be recorded in the resident's medical record:<br><br>1. The date and time that catheter care was given.<br><br>2. The name and title of the individual(s) giving the catheter care.<br><br>3. All assessment data obtained when giving catheter care.<br><br>4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.<br><br>5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain .<br><br>Review of the facility's policy, Behavioral Programs and Toileting Plans for Urinary Incontinence, revised 10/2010 indicated the staff will document the results of toileting trial in the resident's medical record. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623<br><br>Based on interview and record review, the facility failed to ensure nurses documented the admission for one of three residents (Resident 1). This failure resulted in an incomplete medical record for Resident 1.<br><br>Findings:<br><br>Review of Resident 1's face sheet indicated she was admitted to the facility on [DATE] with diagnoses including displaced (out of alignment) intertrochanteric fracture of right femur (broken hip).<br><br>Review of Resident 1's medical record indicated there was no admission assessment or narrative admission notes when the resident was admitted on [DATE].<br><br>During an interview on 8/6/24 at 2:15 p.m., the director of nursing (DON) confirmed Resident 1 did not have an admission assessment or admission notes when the resident was admitted on [DATE]. The DON stated the admission notes should be one of the most detailed notes in order to paint the picture of how the resident got to the facility.<br><br>Review of the facility's policy, Admission Notes, revised 9/2012 indicated, When a reident is admitted to the nursing unit, the admitting nurse must document the following information . The date and time of the resident's admission . From where the resident was admitted (i.e., hospital, home, other facility) . The general condition of the resident upon admission . This initial information-gathering precedes the complete history and physical assessment that also accompanies the resident admission process.<br><br>Based on interview and record review, the facility failed to ensure nurses documented the admission for one of three residents (Resident 1). This failure resulted in an incomplete medical record for Resident 1.<br><br>Findings:<br><br>Review of Resident 1's face sheet indicated she was admitted to the facility on [DATE] with diagnoses including displaced (out of alignment) intertrochanteric fracture of right femur (broken hip).<br><br>Review of Resident 1's medical record indicated there was no admission assessment or narrative admission notes when the resident was admitted on [DATE].<br><br>During an interview on 8/6/24 at 2:15 p.m., the director of nursing (DON) confirmed Resident 1 did not have an admission assessment or admission notes when the resident was admitted on [DATE]. The DON stated the admission notes should be one of the most detailed notes in order to paint the picture of how the resident got to the facility.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy, Admission Notes, revised 9/2012 indicated, When a reident is admitted to the nursing unit, the admitting nurse must document the following information . The date and time of the resident's admission . From where the resident was admitted (i.e., hospital, home, other facility) . The general condition of the resident upon admission . This initial information-gathering precedes the complete history and physical assessment that also accompanies the resident admission process. |