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	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068 Based on interview and record review, the facility failed to provide and/or communicate the appropriate information to the receiving facility for one of two residents (Resident 3) regarding the pending laboratory workup. This failure had the potential to negatively affect the continuity of care and may jeopardize Resident 3's health and safety. Findings: Review of Resident 3's medical record indicated she was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included overactive bladder (a problem with bladder function that causes the sudden need to urinate) and urinary tract infection (UTI, infection in any part of urinary system). She was discharged to another facility on 9/28/24. Review of Resident 3's medical record indicated, she received of Cephalexin (antibiotic) 500 milligram (mg, unit of measurement) capsule orally every eight hours for 7 days as ordered by her physician on 9/10/24 for UTI. Review of Resident 3's laboratory workups report indicated, a urine specimen was collected on 9/26/24 for urinalysis (test of urine for presence of infection) and culture and sensitivity (C&S, a lab procedures that identifies the cause of an infection and the best treatment) if indicated. It also indicated the urine specimen was received by laboratory on 9/27/24 with preliminary result on 9/30/24 of gram-negative bacilli (bacteria that can cause infection) with colony count (estimate number of bacteria) more than 100,000 and identification and sensitivity test to follow. Further review of Resident 3's final laboratory urine cultures results dated 10/1/24 indicated presence of pseudomonas aeruginosa (bacteria that can cause disease in humans) and enterococcus faecalis (bacteria that can cause disease in humans) in the urine. During a review of Resident 3's transfer and discharge report dated 9/24/24 indicated she was discharged on [DATE] at 12:30 p.m. There was no written information on the report that Resident 3 had a pending urinalysis exam in the laboratory being done since 9/27/24. During a review of Resident 3's medical record indicated there was no evidence of documentation that the Licensed Vocational Nurse A (LVN A) who discharged Resident 3 provided or communicated to the receiving facility that Resident 3 had a pending urine exams in the laboratory. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 12/26/24 at 12:29 p.m., he stated he did not know that Resident 3 had a pending urine exam in the laboratory. LVN A confirmed he did not communicate or provide information to the receiving facility that Resident 3 had a pending urine exam in the laboratory. LVN A acknowledged he should have communicated that Resident 3 had a pending urine exam to the receiving facility and also to Resident 3 and her RP on the day of discharged on [DATE] to facilitate effective and safe continuity of care. During a concurrent interview and record review with the Director of Nursing (DON) on 12/26/24 at 1:35 p.m., she confirmed there was no evidence of documentation that the pending urinalysis exam was communicated to the receiving facility nor to Resident 3 and her RP. The DON acknowledged LVN A should have communicated or provided information that Resident 3 had a pending urine exam in the laboratory to the receiving facility for Resident 3's safe continuity of care. Review of facility's revised policy and procedures dated 10/2022 titled Transfer or Discharge, Facility-Initiated: Information Conveyed to The Receiving Provider indicated, Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: All information necessary to meet the resident's needs, including but not limited to . (5) most recent labs, other diagnostic test, .(7) any other documentation, as applicable, to ensure a safe and effective transition of care. Review of the facility's policy and procedures dated 11/2018 Job Description: LPN/LVN indicated Periodically review the resident's written discharge plan. Participate in the updating of the resident's written discharge plan as required. Assist in planning the nursing services portion of the resident's discharge plan as necessary. Admit, transfer, and discharge resident as required. Review of the facility's policy and procedures dated 9/2018 Job Description: Registered Nurse (RN) indicated Periodically review the resident's written discharge plan. Participate in the updating of the resident's written discharge plan as required. Assist the Director in planning the nursing services portion of the 's discharge plan as necessary. Admit, transfer, and discharge resident as required. Assist in the overall supervision of and management of the nursing staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068 Based on interview and record review, the facility failed to provide approriate and necessary services in accordance with professional standard of practice for three out of three residents (Residents 1, 2, & 3) when: 1. a) For Resident 1, the skin and wound assessment was incomplete and Nursing Care Plan (NCP a detailed document that outlines a patient's specific healthcare needs, identifying potential problems, setting goals, and detailing the nursing interventions required to address those needs) was not specific to wound status and b) Facilitys' Licensed Nurses (LNs) did not recheck and notify the physician for abnormal low blood pressures (the pressure of blood circulating against the walls of the blood vessels) measurements. 2.) For Resident 2, there was no evidence of documentation that physician was notified and treatment order was obtained for right gluteus (buttock) abrasion (a superficial rub or wearing off of the skin, usually caused by a scrape).; there was no evidence of documentation that treatment was provided for Resident 2's right gluteus abrasion the day after wound assessment on 11/1/24 until resident was discharged on [DATE]; and no NCP was developed for Resident 2's right gluteus abrasion. 3.) For Resident 3, there was no evidence of documentation regarding what happened on the fall incident on 9/16/24, and Interdisciplinary Team's (IDT, a group of healthcare professionals from differrent disciplines who collaborate to develop and manage a patient comprehensive care plan, considering all aspect of their health needs) post fall notes was incomplete. These failures had the potential to jeopardize Residents 1, 2, & 3's health and safety. Findings: 1. a) Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] with diagnoses that included dislocation of right shoulder, multiple fractures right ribs, dementia (a progressive state of decline in mental abilities), and difficulty walking. Review of Resident 1's Braden Scale (a risk assessment tool that predicts a patient's likelihood of developing pressure ulcers) dated 10/25/2023 indicated he had a score of 17 which means he was at risk for developing pressure ulcer (localized, pressure-related damage to skin and/or underlying tissue usually over a bony prominence area). Review of Resident 1's skin and wound assessment dated [DATE] which was conducted by Assistant Director of Nursing/Licensed Vocational Nurse (ADON/LVN) who is no longer work at the facility, indicated Resident 1 had moisture associated skin damage (MASD, moisture associated skin damage caused from prolonged exposure to moisture), but no entries were selected for the categories of location of the wound, evidence of infection, exudate (fluid that leaks out of blood vessels into the nearby tissues), periwounds (the skin and tissue that surrounds a wound), induration (thickening and hardening of soft tissues), edema (swelling caused by fluid buildup in the body's tissues), periwound temperature, pain scale, goal of care, and treatments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's NCP dated 10/26/23 indicated Resident 1 has potential/actual impairment to skin integrity related to fragile skin. It did not indicate the location and actual status of the skin alteration condition. During an interview with the Treatment Nurse B (TN B) on 12/24/24 at 10:06 a.m., she stated the skin and wound assessment should have been filled up by ADON/LVN completely including the location of the wound, evidence of infection, exudate, peri wounds, induration, edema, peri wound temperature, pain scale, goal of care, and treatments. During a concurrent interview and record review with the Director of Nursing (DON) on 12/26/24 at 2:27 p.m., she confirmed Resident 1's skin and wound assessment conducted by ADON/LVN on 10/27/23 was incomplete. The DON also confirmed the NCP was not specific to Resident 1's skin alteration. The DON acknowledged every category in the skin and wound assessment form should have been filled up completely by ADON/LVN, and the specific NCP should have been developed by facility's Licensed Nurses (LNs) for Resident 1's skin alteration on coccyx area. Review of the revised facility's policy and procedures dated 3/2014 titled Pressure Ulcer/Skin Breakdown -Clinical Protocol indicated, The Nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, ., presence of exudates or necrotic tissue. b. Pain assessment .d. Current Treatments, including support surfaces . Review of the facility's policy and procedures dated 10/2016 titled Job Description: Treatment Nurse RN/LVN/LPN indicated, Accurately observe and assess wounds and pressure sores . Review of the facility's policy and procedures dated 3/2022 titled Care Plans-Baseline indicated, The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care . Review of the facility's policy and procedures dated 11/2018 titled Job Description: LPN/LVN indicated, Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Review of the facility's policy and procedures dated 9/2018 titled Job Description: Registered Nurse (RN) indicated, Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Assist in overall supervision of and management of the nursing staff. b) Review of Resident 1's medical record he was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeat), presence of cardiac pacemaker (a small, battery powered device that surgically implanted in the chest or abdomen to regulate abnormal heart rhythm) , COVID-19 (a contagious respiratory illness caused by virus) positive, and chronic kidney disease (kidneys are damaged and lose their ability to filter waste and fluid out of blood). Review of Resident 1's vital signs summary record indicated his blood pressures measurements on 10/26/23 at 12:04 a.m. was 131/82 millimeters of mercury (mmHg, a unit of pressure) and at 8:33 a.m. was 114/60 mmHg, and on 10/27/23 at 1:14 a.m. was 122/69 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further Review of Resident 1's vital signs summary record indicated his blood pressures measurements on 10/28/23 at 4:08 p.m. was 96/53 mmHg and on 10/29/23 at 11:03 a.m. was 80/38 mmHg. During an interview with the Director of Medical Record (DMR) on 12/24/24 at 10:50 a.m., she confirmed there was no other blood pressures measurements documented in Resident 1's medical records on 10/28/23 excpet the documentation at 4:08 p.m., and on 10/29/23 at 11:03 a.m. During an interview with LN C on 12/26/24 at 9:40 a.m., she stated the blood pressures measurements taken on the above dates on 10/28/23 and 10/29/23 should have been rechecked by facility's staff using manual blood pressure apparatus and if it is still the same, LNs should have notified Resident 1's physician and follow any order or instructions. During an interview with the AM Unit Supervisor (AM US) 12/26/24 at 10:58 a.m., she stated the blood pressure measurements taken on the above dates on 10/28/23 and 10/29/23 should have been rechecked by facility's staff using manual blood pressure apparatus and if it is still the same measurement, the LNs should have notified Resident 1's physician and should have followed up for any order. During an interview with the DON on 12/26/24 at 2:37 p.m., she confirmed she did not find any records in Resident 1's medical record that facility staff rechecked the blood pressure measurements after it was taken on 10/28/23 at 4:08 p.m. and on 10/29/23 at 11:03 a.m., and no evidence of documentation that Resident 1's physician was notified of the abnormally low blood pressure measurements. The DON acknowledged facility staff should have rechecked the blood pressures using manual and digital blood pressure (BP) apparatus and if still low or the same, LNs should have been notified Resident 1's physician and should have followed instructions or any orders. Review of the revised facility's policy and procedures dated 2/2021 titled Change in a Resident's Condition or Status indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): .significant change in the physical .condition. 2. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting). Review of the facility's policy and procedures dated 11/2018 titled Job Description: LPN/LVN indicated, Consult with the resident's physician in providing the resident's care, treatment ., etc., as necessary. Notify the resident's attending physician and .when there is a change in the resident's condition. Take and record TPRs, blood pressures, etc., as necessary. Review of the facility's policy and procedures dated 9/2018 titled Job Description: Registered Nurse (RN) indicated, Notify the resident's attending physician and .when there is a change in the resident's condition. Take and record TPRs (temperature, pulse, respiration), blood pressures, etc., as necessary. Assist in overall supervision of and management of the nursing staff.Based on interview and record review, the facility failed to ensure services were provided that met professional standard for one of two residents (Resident 1) when there was no evidence of documentations of the followings: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) Review of Resident 2's medical record indicated she was admitted to the facility on [DATE] with diagnoses that included spondylosis (a chronic condition that resulted from age-related wear and tear on the spine's joint and disks), neuromuscular dysfunction of bladder (a condition that occurs when the nerve and muscles that control the bladder don't work properly) and difficulty of walking. Review of Resident 2's skin and wound evaluation assessment on 11/1/24 indicated she had abrasion on right gluteus (buttock) measuring 1 centimeter (cm, unit of measurement) by 0.85 cm. Review of Resident 2's medical record on 12/9/24 indicated there was no documentation that Resident 2's physician was notified regarding the abrasion on right gluteus after TN B conducted the skin and wound assessment on 11/1/24. There was also no documentation that a treatment order was obtained from Resident 2's physician for the abrasion on right gluteus. There was also no NCP developed for abrasion on Resident 2's abrasion on right gluteus. Review of Resident 2's Treatment Administration Record (TAR) on 12/9/24 indicated no treatment was done for the abrasion on right gluteus the day after skin and wound assessment was conducted on 11/1/24 until Resident 2's discharged on [DATE]. During an interview with the TN B on 12/9/24 at 10:15 a.m., she confirmed there was no written documentation regarding notification of Resident 2's physician regarding abrasion on right gluteus including getting a treatment wound order on 11/1/24. TN B also confirmed there was no documentation that treatment was done on abrasion on right gluteus the day after wound assessment was conducted on 11/1/24 until Resident 2's discharged on [DATE]. TN B stated she notified the Resident 2's physician regarding Resident 2's abrasion on right gluteus including obtaining of treatment on 11/1/24 but forgot to put it in Resident 2's electronic record. During an interview with TN D on 12/9/24 at 10:58 a.m., he confirmed there was no evidence of record in Resident 2's medical record that Resident 2's physician was notified regarding abrasion on right gluteus. TN D also confirmed there was no evidence of record in Resident 2's medical record that treatment was provided the day after wound assessment was conducted on 11/1/24 until Resident 2's discharged on [DATE]. During an interview with the Director of Nursing (DON) on 12/9/24 at 2:21 p.m., she stated TN B should have documented that she notified Resident 2's MD regarding abrasion on right gluteus and obtained treatment order. DON acknowledged TN B should have recorded the treatment provided as ordered by Resident 2's physician in Resident 2's TAR. The DON further stated NCP should have been developed for Resident 2's right gluteus abrasion by facilitys' LNs. Review of facility's policy and procedures dated 10/2016 titled Job Description: Treatment Nurse indicated, Chart nurses' notes in an informative and descriptive manner that reflect the care provided to the resident . Provide resident care including carrying out physician's orders for care including providing medication and treatment. Communicate with physicians and other health professionals regarding resident care, treatment, and condition. Review of the revised facility's policy and procedures dated 3/2022 titled Care Plans-Baseline indicated, A baseline plan of care to meet resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's medical record indicated physician medication orders on 10/31/24 of Basaglar Kwik Pen (medication used to control high blood sugar in the body) 100 unit/milligrams, inject 30 unit subcutaneously (SQ, under the skin) one time a day for blood sugar management; on 11/1/24 of Olanzapine (antipsychotic medication) 2.5 mg tablet, give one tablet at bedtime for bipolar disorder; on 11/1/24 of Montelukast Sodium (medication used for asthma)10 mg tablet, give one tablet in the evening for asthma; and on 10/31/24 Fluticasone Propionate (medication used for nasal allergy) 50 mcg/ACT, give one spray in both nostril two times a day, then was changed on 11/1/24 to give two sprays in both nostrils two times a day for asthma. Review of Resident 2's Medication Administration Record (MAR) on 11/13/24 indicated the above Basaglar Kwik Pen medication 30 unit SQ was not administered on 11/1/24 and 11/2/24; Olanzapine 2.5 mg tablet was not administered from 11/1/24 to 11/4/24; Montelukast Sodium 10 mg was not administered on 11/1/24 and 11/2/24; and Fluticasone Propionate 50 mcg/ACT was not administered on 11/1/24 at 9 a.m. and 5 p.m., on 11/2/24 at 5 p.m., on 11/3/24 at 9 a.m., on 11/4/24 at 9 a.m. and 5 p.m., and on 11/5/24 at 9 a.m. During a review of Resident 2's pharmacy dispensed medication report with the DON on 12/26/24 at 1:43 pm indicated 3 Basaglar Kwik Pen injection 100 unit/ml was dispensed on 10/31/24; 4 tablets of 10 mg Montelukast was dispensed on 11/1/24, and no record that Olanzapine 2.5 mg was dispensed from 11/1/24 to 11/5/24. The DON confirmed the above Resident 2's pharmacy medication dispensed report. During a concurrent interview and record review with the Director of Nursing (DON) on 12/26/24 at 2:10 p.m., she confirmed the above medications were not administered by the facility's LNs on the above dates and times for Resident 2 because it was noted in Resident 2's progress notes that they were not available. The DON further stated there were no evidence of documentations that Resident 2's physician was notified of the above medications' unavailability. The DON acknowledged LNs should have informed Resident 2's physician that the above medications were not available on the above dates and times for the physician to prescribe alternatives or order to monitor Resident 2's condition. During an interview with the Pharmacy Manager (PM) on 12/27/24 at 3:27 p.m., he stated that Basaglar Kwik Pen with Pen was delivered to the facility on [DATE] at 4:00 a.m. The PM further stated they communicated with the facility's management team on 11/2/24, 11/3/24, and 11/4/24 if the facility is willing to pay for it cost because it was billed in another pharmacy but the PM did not receive an answer from the facility until 11/7/24 indicating that the facility will pay for the Olanzapine 2.5 mg tablets for Resident 2. The PM stated that Montelukast Sodium 10 mg tablets were available in the dispenser machine, and it was dispensed on 11/1/24. Review of the facility's policy and procedures dated 11/2018 titled Job Description: LPN/LVN indicated, Prepare and administer medications as ordered by the physician. Order Prescribed medication . in accordance with established policy. Consult with the resident's physician in providing the resident's care, treatment ., etc., as necessary . Ensure that an adequate stock level of medication .is always maintained on your unit/shift to meet the needs of the residents. Review of the facility's policy and procedures dated 9/2018 titled Job Description: Registered Nurse (RN) indicated, monitor medication passes and treatments schedules to ensure that medications are being administered as ordered as scheduled. Ensure that an adequate stock level of medications .etc., is always maintained on premises to meet the needs of the resident. Assist with the overall supervision of and management of the nursing staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of revised facility's policy and procedures dated 4/2019 titled Administering Medications indicated Medications are administered in accordance with prescriber orders, including any required time frame. Review of revised facility's policy and procedures dated 6/2016 titled Medication and Treatment Orders indicated, 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 3.) Review of Resident 3's medical record indicated she was readmitted to the facility with diagnoses that included fracture of first lumbar vertebrae, fracture of right femur, dementia (a progressive state of decline in mental disabilities), unsteadiness on feet, difficulty in walking, depression (persistent feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), and history of repeated falls. Review of Resident 3's Minimum Data Set (MDS, a federally mandated asessment tool) dated 6/20/24 indicated, her cognition (the process of thinking , learning, remembering, and using judgement) was severely impaired. She needed assistance with the activity of daily living (ADL). Review od Resident 3's Fall Risk Assessment (FRA, an assesment to determine patient's risk of falling) dated 9/9/24 indicated she had a score of 16 (a score of 16-42 means high risk for fall). Review of Resident 3's medical record on 12/9/24 indicated she had incident of unwitnessed fall on 9/16/24 but there was no documentation on how the fall happened. Further review of the IDT notes dated 9/17/24 indicated there was no information on how the fall happened on 9/16/24. During a concurrent and record review with the Director of Nursing (DON) on 12/26/24 at 1:17 p.m., she confirmed the documentation for Resident 3's fall incident on 9/16/24 and IDT notes on 9/17/24 were incomplete. DON acknowledged the documentation of the incident of fall should have included the scenario on how the fall happened. DON also stated the IDT notes should have included the complete investigation of the root cause of the fall in order to formulate effective recommendations for Resident 3's NCP for fall prevention. Review of the revised facility's policy and procedures dated 9/2012 titled Falls-Clinical Protocol indicated: Assessment and recognition indicated In addition, the nurse shall assess and document/report the following: . h. Precipitating factors, details on how fall occurred. For cause identification it indicated For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. A. Causes refer to the factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. Often, multiple factors in varying degrees contribute to a falling problem. Review of the facility's policy and procedures dated 11/2018 Job Description: LPN/LVN indicated Complete accident/incident reports as necessary. Fill out and complete accident/incident reports. Submit to Director as required. Chart all reports of accident/incidents involving residents. Follow established procedures. Perform routine charting duties as required and in accordance with the established charting and documentation policies and procedures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedures dated 9/2018 Job Description: Registered Nurse (RN) indicated Complete accident/incident reports as necessary. Fill out and complete accident/incident reports. Submit to Director as required. Chart all reports of accident/incidents involving residents. Follow established procedures. Perform routine charting duties as required and in accordance with the established charting and documentation policies and procedures. Perform administrative duties such as completing medical forms, reports .charting, etc. Assist in the overall supervision of and management of the nursing staff. Review of the revised facility's policy and procedures dated 3/2022 titled Care Planning - Interdisciplinary Team indicated The Interdisciplinary team is responsible for the development of care plans. Comprehensive, person-centered care pals are based on resident assessments and developed by an IDT.