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	11/06/2025

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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure the safety of one of three sampled residents (Resident 1) during in-bed care (a wide range of activities to ensure the health, comfort, and hygiene of someone who is bedridden), when:1. The facility failed to maintain Resident 1's safety during in-bed care.2. The facility failed to accurately complete Resident 1's fall risk assessment; and3. The facility failed to implement Resident 1's ADL (activities of daily living like bed bath, shower, transfer, positioning, etc.) care plan intervention to Ensure proper position.These failures resulted in Resident 1 sustaining comminuted fractures (a broken bone where the bone is shattered into more than two pieces) to the right tibia and fibula (the two bones in the right lower leg), requiring hospital transfer on August 17, 2025.A review of Resident1's face sheet (a one-page summary document that provides a quick overview of essential information about a person, most commonly used in healthcare settings to present a patient's demographic, medical history, and insurance details) indicated he was admitted to the facility on [DATE], with diagnoses including unspecified dementia (the loss of cognitive functioning that interferes with daily life and activities) and dysphagia following cerebral infarction (difficulty swallowing commonly associated with neurological impairment), Traumatic subdural hemorrhage (a collection of blood that accumulates between the brain and the outermost layer of the brain's protective membranes)with loss of consciousness of unspecified duration, other seizures (abnormal electrical activity in your brain).A review of Resident 1's Minimum Data Set (MDS, an assessment tool), GG section (Functional abilities) indicated Resident 1 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helper is required for the resident to complete the activity) on staff for self-care (the ability to care for oneself including bathing, dressing, using the toilet, or eating), and mobility (the ability to move or be moved including toilet transfers, sitting to lying, lying to sitting on side of bed, and rolling left and right).A Review of Resident 1's MDS dated [DATE], indicated brief interview for mental status (BIMS, cognition level) score was 00 (severe cognitive impairment, as the 0-7 points range is used for this category). A further Review of Resident 1's MDS, GG section dated 7/18/2025, indicated Resident 1 had impairments on one upper extremity (the shoulder, elbow, wrist, and hand) and both lower extremities (hip, knee, ankle, and foot).1. A review of Resident 1's Interdisciplinary Team (IDT) Notes dated August 19, 2025, indicated that on August 14, 2025, at approximately 2:20 p.m., Resident 1 fell from bed during routine in-bed care performed by a CNA (certified nursing assistant).A review of Resident1's X-ray result dated August 17, 2025, revealed comminuted distal tibia and fibula fractures [a serious injury where the lower ends of both the shinbone (tibia) and calf bone (fibula) are broken into multiple pieces] with displacement and soft tissue swelling. During an interview with the Director of Nursing (DON) on October 3, 2025, at 1:10 p.m., the DON stated that certified nursing assistant (CNA) B rolled Resident 1 to the side of the bed while providing in-bed care. During this process, Resident 1 fell from the bed onto the floor mat on 8/14/2025. Resident 1's X-ray result dated August 17, 2025, revealed comminuted distal tibia and fibula fractures, and Resident 1 was transferred to the hospital for treatment the same day. The DON further stated that the CNA should have kept Resident 1 safe during care.During a phone interview with the Assistant Director of Nursing (ADON) on October 13, 2025, at 11:50 a.m., the ADON confirmed that the Minimum Data Set (MDS) Section GG, dated July 18, 2025, indicated Resident 1 was dependent and required the helper do all the effort or the assistance of two or more helpers for toilet transfers, sitting to lying, lying to sitting on side of bed, and rolling left and right. The ADON further confirmed that only one CNA was providing care to Resident 1 at the time of the fall incident on 8/14/2025, and that Resident 1 needed two-person assistance when rolling him to his left and right sides during care to prevent falls.During a phone interview with the MDS Coordinator (MDSC) on October 16, 2025, at 3:10 p.m., The MDSC confirmed that Minimum Data Set (MDS) Section GG, dated July 18, 2025, indicated Resident 1 was dependent and she further stated that Resident 1 had impairment on one of his upper extremity and both lower extremities, he need another helper to ensure safety when rolling left and right. A review of the facility's policy and procedure (P&P), Revision Date March 2018, titled Falls and Fall Risk, Managing indicated: .Several possible interventions may be identified considering resident fall risks, and staff may prioritize certain interventions based on the circumstances .2. A review of Resident 1's SBAR (an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication) Communication Form and Progress Note dated March 23, 2025, indicated an unwitnessed fall when a nurse was doing rounds and