

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 02/26/2026
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to follow Resident 1's physician order for collecting stool culture for one of three sampled residents (Resident 1) when Resident 1 had several days of diarrhea (loose stools). This failure had the potential to affect Resident 1's health and condition. During a review of Resident 1's medical record it indicated he was admitted to the facility on [DATE]. During a review of Resident 1's nursing progress notes, dated 3/11/25 at 3:23 p.m., it indicated, Patient has been having diarrhea on and off since he has been here. During a review of Resident 1's physician order, dated 2/13/25, it indicated, Collect stool to r/o (rule out) C-diff (Clostridioides difficile, is a bacterium that causes severe, watery diarrhea and intestinal inflammation (colitis)) and norovirus (is a very contagious virus that causes vomiting and diarrhea). During a review of Resident 1's nursing progress notes, dated 3/12/25 at 1:25 p.m., it indicated, Resident 1 is due for a stool culture and c-diff sample to be sent to lab; however, he did not have a bm (BM, bowel movement) on PM shift (3 p.m. to 11 p.m.) and will need to collect sample on next shift. No further documentations regarding the stool culture would need to follow up. Review of this resident's Documentation Survey Report V2 for bowel continence record in 3/2025, it indicated Resident 1 had BM in AM (7 a.m. to 3 p.m.) and PM shift on 3/13/25 and also, he had a BM the next day on 3/14/25. During an interview on 1/30/26, at 3:30 p.m. and 2/10/26, at 2:45 p.m., with the director of nursing (DON), the DON confirmed nursing staff did not carry out the physician's order for stool culture. There was no documented evidence that the physician canceled or discontinued collection of stools for culture. During a review of the facility's undated policy and procedure (P&P) titled, Lab and Diagnostic Test Results -Clinical Protocol, The staff will process test requisitions and arrange for tests. A nurse will identify the urgency of communicating with the Attending Physician. Physicians or nurses who have concerns about how test results have been handled or reported should communicate such concerns to the DON and/or Medical Director. Such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment and services in accordance with professional standards of practice for one of three sampled residents (Resident 1)'s when:1. The Licensed Nurses (LN) did not consistently provide the treatment per physician's order to Resident 1's open wound on bilateral heels during the process of reclassification from a blister (is a painful skin condition where fluid fills a space between layers of skin) to deep tissue injury (DTI, is a type of subcutaneous tissue damage that results from an externally applied mechanical load (pressure)) then a diabetic ulcer (is an open sore or wound on the foot of a person with diabetes (high blood sugar)).2. Licensed nurses did not obtain a wound treatment order to provide pressure ulcer care in timely manner for Resident 1 on 7/20/25, 7/21/25, 7/23/25 and 7/24/25 upon identification of a stage two (St. 2) pressure ulcer on his sacrum area when he returned from the hospital on 7/19/25.3. The facility did not develop a care plan to address Resident 1's PU on his sacrum (a bony structure that is located at the base of the spine)These failures could delay Resident 1's diabetic foot ulcer and pressure ulcers' healing and treatment.1. During a review of Resident 1's clinical record indicated he was admitted on [DATE] and readmitted to the facility on [DATE] with several emergency department (ED, a 24/7 facility that provides rapid diagnosis, urgent care, and inpatient admission for stabilizing seriously ill) visits on 2/15/25, 2/22/25 and 2/23/25 associated with his change of condition. During an interview on 2/2/26, at 11:10 a.m. and 12:20 p.m., with the director of nursing director (DON), the DON stated Resident 1 had blisters on his bilateral heel upon admission, and after the wound treatment his left heel was healed by 3/10/25. The right heel remained not healed requiring wound treatment. The DON further stated, in the year 2025, the facility had employed several registry nurses, and this could have resulted in some missing wound treatment. A review of Resident 1's treatment administration record (TAR) from the month of 2/2025 through 8/2025, the TAR indicated Resident 1's wound treatment order had changed several times from 2/2025 to 8/2025, and found missing wound treatment as follows: A wound order dated 2/1/25 to 2/21/25 for Abrasion to Right Lateral Malleolus - Cleanse with NS (normal saline, is a crystalloid fluid), pat dry, apply Medi honey (is a medical-grade, antibacterial Leptospermum honey used to treat acute and chronic wounds, including burns, diabetic foot ulcers), cover with dry dressing every dayshift in 2/2025's TAR had missing entries for wound care on 2/10/25 and 2/19/25. A wound order dated 2/19/25 to 3/11/25 for Blister to Left Lateral Heel - Cleanse with NS, pat dry, apply Betadine, cover with dry dressing every dayshift in 2/2025 and 3/2025's TAR had missing entries for wound care on 2/23/25 and 3/10/25. A wound order dated 2/19/25 to 3/26/25 for Blister to Right Lateral Heel - Cleanse with NS, pat dry, apply betadine, wrap with Kerlix every dayshift in 2/2025 and 3/2025's TAR had missing entries for wound care on 2/23/25, 2/24/25, 3/15/25 and 3/26/25. A wound order dated 3/27/25 to 4/2/25 for Blister to Right Lateral Heel - Cleanse with NS, pat dry, apply triple antibiotic ointment to wound bed, cover with dry dressing every dayshift in 3/2025's TAR had missing entries for wound care on 3/29/25. A wound order dated 4/3/25 to 4/4/25 for Blister to Right Lateral Heel - Cleanse with NS, pat dry, apply Medi honey to wound bed, cover with dry dressing every dayshift in 4/2025's TAR had missing signatures for wound care on 4/4/25. A wound order dated 4/5/25 to 4/17/25 for DTI to right Lateral Heel - Cleanse with NS, pat dry, apply TAO to wound bed, cover with dry dressing every dayshift in 4/2025's TAR had missing entries for wound care on 4/12/25 and 4/13/25. A wound order dated 5/8/25 to 5/13/25 for Diabetic Ulcer to Right Lateral Heel - Cleanse with NS, pat dry, apply Medi Honey, cover with ABD (abdominal) pad, cover with dry dressing every dayshift in 5/2025's TAR had missing entries for wound care on 5/10/25 and 5/11/25. A</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>wound order dated 5/14/25 for Mupirocin External Ointment 2 % (Mupirocin, is used to treat secondarily infected traumatic skin lesions due to specific bacteria) Apply to Right Lateral Heel topically every dayshift every other day for Wound Care for 30 Days in 5/2025 and 6/2025's TAR had missing entries for wound care on 5/24/25, 5/28/25 and 6/13/25. A wound order dated 6/21/25 to 6/24/25 for Diabetic Ulcer to Right Lateral Heel - Cleanse with NS, pat dry, apply Mupirocin ointment to wound bed, Apply Santyl to Wound bed, cover with dry dressing every dayshift every other day had missing entries for wound care on 6/21/25. A wound order dated 6/25/25 to 7/17/25 for Diabetic Ulcer to Right Lateral Heel - Cleanse with NS, pat dry, apply barrier cream, apply clotrimazole cream, cover with calcium alginate AG, cover with dry dressing, wrap with Kerlix, secure with tape every dayshift in 6/2025's TAR had missing entries for wound care on 6/26/25. During an interview on 2/24/26, at around 10:10 a.m., with the DON, she confirmed missing wound treatment as listed above. On 2/10/25, 2/19/25, 2/23/25, 3/10/25, 2/23/25, 2/24/25, 3/15/25, 3/29/25, 3/25, 4/4/25, 4/12/25, 4/13/25, 4/12/25, 4/13/25, 5/10/25, 5/11/25, 5/24/25, 5/28/25, 6/13/25, 6/21/25 and 6/26/26/25, Resident 1's TAR was not signed by the licensed nurses. The DON admitted , if there was no signature, the treatment was not done. 2. During a review of Resident 1's TAR in 7/2025, it indicated a wound treatment order for stage 2 pressure ulcer (is damage to the skin and underlying tissue caused by prolonged pressure) to sacrum, cleanse with NS or soap and water, pat dry, apply barrier cream, cover with foam dressing every dayshift. Start date on 7/26/25. During a review of Resident 1's weekly wound assessment, it indicated his sacrum wound was assessed on 7/22/25 and 7/25/25 during a wound dressing change to cleanse with NS, apply barrier cream and cover with foam dressing. During a telephone interview on 2/10/26, at 2:35 p.m., with the DON, she confirmed the St.2 pressure ulcer was found upon his return from the hospital on 7/19/25 and the staff missed to obtain a wound treatment order; hence, the wound treatment were not done on the following days: 7/20/25, 7/21/25, 7/23/25 and 7/24/25. The DON further stated that Resident 1 had a hospitalization from 7/9/25 through 7/19/25, and the St.2 pressure ulcer was acquired during his hospital stay. During a review of the facility's undated policy and procedure (P&P) titled, Wound Care, the P&P indicated, Verify that there is a physician's order for this procedure. Apply treatments as indicated. 3. During a review of Resident 1's care plans, there was care plan developed to address the resident's St.2 pressure ulcer on his sacrum. During an interview on 2/2/26 at 11:10 a.m. and 2/24/26 at 10:10 a.m., with the DON, the DON reviewed Resident 1's clinical record and could not find a care plan in place to address his pressure ulcer on his scrum. During a review of the facility's policy and procedure (P&P) titled, Prevention/Management of Pressure Ulcers/Injuries, revised 2/2023, the P&P indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, A comprehensive, Person-Centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTIs) for one of three sampled residents (Resident 1) with foley catheter when: 1. Staff failed to follow a prescribed order dated 12/22/25 to collect a urine sample for culture and sensitivity (C&S, is a two-part diagnostic test used to detect urinary tract infections (UTIs) and determine the best antibiotic treatment) in timely manner. The nurses failure to collect urine culture sample had delayed the provision of appropriate treatment contributing to worsening in his condition resulting to transfer to acute hospital on 2/28/25 .2. Resident 1's indwelling foley catheter (a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own) urine bag was found on the floor. This failure had the potential for Resident 1 to develop CAUTI (catheter associated urinary tract infection). 1. Review of Resident 1's admission record indicated he was initially admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses including retention of urine , other mechanical complication of indwelling urethral catheter and type two diabetes mellitus (is a chronic condition where your body cannot properly use or make enough insulin, leading to too much sugar (glucose) building up in your blood) with foot ulcer (is a serious complication affecting up to 34% of patients, often caused by neuropathy (loss of feeling), poor circulation, and infection risk). Review of Resident 1's minimum data set (MDS, is a federally mandated, standardized clinical assessment tool used to evaluate the physical, psychological, and psychosocial functioning of all residents), dated 11/25/25, it indicated his brief interview for mental status (BIMS, an assessment to screen for cognitive impairment in residents) score was 15 (score of 13 to 15 means cognitively Intact). He had an indwelling foley catheter. Review of Resident 1's physician's orders, dated 12/22/25 at 8:11a.m., it indicated, collect urine for C&S (culture and sensitivity) every shift for burning with urination. During a review of Resident 1's nurse's note, dated 12/23/25, it indicated, Spoke with resident and family regarding pain in bladder area. His urine is dark yellow; no sediment observed. Resident has PRN Norco (pain medication) which is effective for pain. Resident calls his daughter when in pain and daughter calls the facility , when resident has discomfort . Family is asking to send to the hospital for evaluation several times a week for bladder discomfort. Resident educated to ask nurses on duty for pain medications. Resident and daughter expressed that staff does not care. Resident has a follow up appointment with urologist (specialist doctor for problems with urinary system) on 1/22/26. unable to schedule anything sooner. During a concurrent interview and record review on 2/23/26, at 10:50 a.m., with the director of nursing (DON), the DON confirmed Resident 1's urine sample for urine culture was collected on 12/28/25 at 3:10 a.m. The DON stated the urine sample was collected prior to his transfer to the hospital. The DON further stated Resident 1 was found with UTI in the hospital. Resident 1's hospital record indicated a urinalysis (UA, a urinalysis is a diagnostic test that examines a urine sample for UTIs or kidney disease) reports dated 12/28/25 indicating the urine sample was collected at 8:45 a.m. with positive results. During an interview on 2/23/26, at 1:35 p.m., with the DON, she stated the nurse who received the urine culture order on 12/22/25 no longer works in the facility. The DON stated nurses should have followed the physician's order to collect urine sample for culture. During an interview on 2/23/26, at 2:50 p.m., with registered nurse A (RN A), RN A stated after receiving the physician's order for urine culture order, the nurse had to put the order in electronic health records to be carried out during the shift, and if unable to collect urine sample then this should have been endorsed</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to next shift for follow up. During a telephone interview on 3/2/26, at 8:38 a.m., with the case manager (CM), the CM stated, Resident 1's urine culture test should have been done sooner or earlier to determine the best antibiotic treatment to prevent Resident 1's ED visit on 12/28/25. According to Resident 1's emergency department (ED, a specialized, 24/7 hospital facility designed to provide immediate, unscheduled care for acute, life-threatening, or severe health conditions) notes on 12/28/25, his labs (laboratory) showed evidence of UTI. The notes indicated, daughter at bedside expresses concerns that patient has been complaining of abdominal pain for the last one to two weeks and she feels that the staff in the nursing facility has been ignoring his complaints. Resident 1 received intravenous (IV, is a quick way to get fluids, medicine, or blood directly into a person's vein through a small tube) antibiotics (medications to treat infection) and the foley catheter was changed. The computed tomography (CT, a medical imaging scan) revealed that Resident had cystitis (inflammation typically caused by bacterial infections (E. coli), resulting in painful, frequent, and urgent urination). During a review of Resident 1's SBAR (situation, background, assessment, recommendation, is a communication tool in nursing), dated 12/28/25, it indicated, Went to patients room to administer medication and noticed he was in a lot of pain. He said he had pain at his catheter site, and it feels like chills (chills or shivering) when he urinates he wanted to go to the hospital. Administered routine pain medicine and his pain level went down to a 5/10 but he said he still wanted to go. During an interview on 2/23/26, at 1:35 p.m. with the DON, she stated the nurse who received the urine culture order on 12/22/25 was no longer working in the facility. DON confirmed Resident 1's urine culture order should be followed on 12/22/25 to collect urine culture, the urine specimen was delayed for follow-up. No endorsement or communication in place for the urine culture would need to be collected. During an interview on 2/23/26, at 2:50 p.m., with the registered nurse A (RN A), RN A stated after receiving the urine culture order would need to put in their system of electronic health records for carrying out during the shift, if not able to then would need to endorse to the nurse in next shift for collecting urine specimen. During a telephone interview on 3/2/26, at 8:38 a.m., with case manager (CM), CM stated that Resident 1's urine culture test should have been done sooner or earlier to determine the best antibiotic treatment for Resident 1 to prevent 12/28/25's ED visit. Review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, dated 11/2018, it indicated, The staff will process test requisitions and arrange for tests. A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Before contacting the physician, the person who is to communicate, be prepared to discuss the following (to the extent that such information is available) including why the lab and diagnostic tests were obtained (for example, as a routine screen or follow-up; to assess a condition change or recent onset of sign and symptoms, or to monitor a serum medication level. 2. During an observation on 2/23/26, at 12:55 p.m., Resident 1's urine collection bag connected to his urinary catheter was placed on the floor. Certified nursing assistant B (CNA B) who was present inside Resident 1's room validated the observation. CNA B stated the urine bag should not be placed on the floor. It should be secured on the bed rail above the floor and below the bladder of Resident 1 to prevent infections. During a review of the facility's policy and procedure (P&P) titled, Catheter Care , Urinary, dated 8/2022, it indicated, . Be sure the catheter tubing and drainage bag are kept off the floor. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.</p>		