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	05/11/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of practice when Licensed Vocational Nurse A (LVN A) and LVN B did not follow their policy and procedures for administering medication when they did not document their initials and make entries in the Electronic Medication Administration Record (eMAR) after giving medications for 1 of 2 residents (Resident 1). This failure has the potential not to track when the medications were last given that may lead to double dosing or missed medications that may compromise Resident 1's health and safety. Findings:Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), glaucoma (an eye disease that can cause blindness) depression, (persistent feeling of sadness and loss of interest) legal blindness (visual impairment), cervical radiculopathy (nerve compression in the neck) and hypertension (high blood pressure).Review of Resident 1's physicians' orders for April 1, 2026 to May 6, 2026 indicated, Tresiba (insulin injection medication for diabetes) 100 units per milliliter (U/ml, units of measurement) inject 35 units subcutaneously (fatty tissue layer between skin and muscle) one time a day at 1 p.m., Dorzolamide Hydrochloride (HCl) (eye drops) 2-0.5 percent, instill one drop in both eyes at 9 a.m. and 1 p.m., Brimonidine Tartrate (eye drops) 0.2 percent, instill one drop in both eyes at 9 a.m., 12 noon and 5 p.m., Gabapentin capsule (medication used for numbness and tingling of legs) 100 milligrams (mg, unit of measurement) give two capsules orally at 9 a.m., 12 noon and 5 p.m., Ibuprofen tablet (medication use for pain and inflammation) 400 mg give one tablet orally at 9 a.m., 1 p.m., and 9 p.m., Aspirin chewable (blood thinner medication) 81 mg give one tablet orally at 9 a.m., Meloxicam (pain medication) 7.5 mg give one tablet orally at 9 a.m., Multivitamin/Minerals (supplement) to give one tablet orally at 9 a.m., Omeprazole (medication used acid reflux) 20 mg give one tablet orally at 9 a.m., Sertraline HCl (antidepressant) 150 mg give one capsule orally at 9 a.m., Atropine Sulfate 1% (eye drops) instill one drop in right eye at 9 a.m. and 5 p.m., Glucophage (medication used for DM) 1000 mg give one tablet orally at 9 a.m. and 5 p.m.Review of Resident 1's printed eMAR for April 1, 2026 to May 10, 2026 indicated, on 4/2/26 there were no licensed nurse initials and entries for the following medications: Tresiba 35 units injection at 1 p.m., Dorzolamide HCl eye drops at 1p.m., Brimonidine Tartrate eye drops at 12 noon, Gabapentin 100 mg, 2 capsules at 12 noon, and Ibuprofen 400 mg tablet at 1p.mDuring an interview and record review of the April 2, 2026 eMAR with the LVN B on 5/11/26 at 1:58 p.m., she confirmed that she was assigned to Resident 1 on 4/2/26 in the morning shift. LVN B stated she forgot to put her initials and entries in eMAR for the above medications after she gave them to Resident 1. LVN B acknowledged she should have put her initials and entries immediately after the above medications were given to Resident 1 on 4/2/26 morning shift scheduled times as per their facility's policy and procedures.Review of Resident 1's printed eMAR for May 2026 on 5/11/26 indicated, on 5/6/26 there were no licensed nurse initials and entries for the following medications: Tresiba 35 units injection at 1 p.m., Dorzolamide HCl eye drops at 9 a.m. and 1p.m., Brimonidine Tartrate eye drops at 9 a.m. and 12 noon, Gabapentin 100 mg, 2 capsules at 9 a.m. and 12 noon, Ibuprofen 400 mg tablet at 9 a.m. and 1p.m., Aspirin chewable 81 mg tablet at 9 a.m., Meloxicam 7.5 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg one tablet at 9 a.m., Multivitamin/Minerals one tablet at 9 a.m., Omeprazole 20 mg tablet at 9 a.m., Sertraline HCl 150 mg one capsule at 9 a.m., Atropine Sulfate 1 percent one drop in right eye at 9 a.m., and Glucophage 1000 mg one tablet at 9 a.m.During an interview and record review of the May 6, 2026 eMAR with the LVN A on 5/11/26 at 1:48 p.m., she confirmed that she was assigned to Resident 1 on 5/6/26 in the morning shift. LVN A stated she forgot to put her initials and entries in eMAR for the above medications after she gave them to Resident 1. LVN A acknowledged she should have put her initials and entries immediately after the above medications were given on 5/6/26 morning shift scheduled times as per their facility's medication administration practices and procedures.During an interview with the Director of Nursing (DON) on 5/11/26 at 1:30 p.m., she acknowledged that LVNs A and B should have documented their initials and entries immediately in the eMAR after they gave the above medications to Resident 1 on 4/2/26 and 5/6/26 morning shifts scheduled times as per facility's procedures and practices.Review of the revised facility's policy and procedures dated 4/2019 titled, Administering Medications indicated, the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. If the drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will initial and circle the MAR space provided for that drug and dose. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR maybe flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.