STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was treated with respect and dignity when the maintenance assistant (MA) yelled and used foul language toward Resident 1. This failure had the potential to negatively affect the resident's psychosocial well-being. Findings: Review of Resident 1's progress notes, dated 5/4/2020, indicated Resident 1 reported an alleged verbal altercation between himself and the MA. The notes indicated Resident 1 overheard the MA say something bad about his daughter. The notes also indicated Resident 1 stated he and the MA exchanged insults and profanity words toward each other. According to the note, Resident 1 stated Resident 2 was present during the alleged altercation. During an interview with Resident 2 on 6/4/2020 at 10:34 a.m., he stated the MA did not say anything negative about Resident 1's daughter. However, Resident 2 confirmed the MA did use foul language toward Resident 1 on the day of the alleged altercation. During an interview with the administrator (ADM) on 6/16/2020 at 1:21 p.m., he stated the MA admitted he yelled and used foul language toward Resident 1. The ADM explained the MA was not allowed to return to work. Review of the MA's Separation Checklist indicated he was officially terminated from the facility as of 5/28/2020.

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

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.