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 _____	**03/10/2020**

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medication was ordered in timely manner for one of three sampled residents (Resident 1) when the [MEDICATION NAME] (a medication to relax the muscle) was not available during medication administration. This failure had the potential to affect the health and safety of the resident. Findings: Review of Resident 1's clinical record indicated she had [DIAGNOSES REDACTED]. Her minimum data set (MDS, an assessment tool) dated 1/19/2020, indicated she could make decision, required assistance for bed mobility, transfer, dressing toileting, and personal hygiene. Review of Resident 1's physician order [REDACTED]. Review of Resident 1's progress note dated 1[DATE]20, indicated Resident 1 had no [MEDICATION NAME] tablet at the medication cart. Review of Resident 1's progress note dated 12/25/2020, indicated Resident 1 had a pain of 10 out 10 all night and the [MEDICATION NAME] medication did not arrive on the night delivery. During an interview with Resident 1 on [DATE] at 9:10 a.m., Resident 1 stated the licensed nurses did not order her [MEDICATION NAME] medication and she had severe pain during the night on [DATE]20. During an interview with licensed vocational nurse (LVN A) on [DATE] at 3:15 p.m., he confirmed Resident 1's [MEDICATION NAME] medication was not administered on 4:00 p.m. and 10:00 p.m. on [DATE]20. During an interview with the director of nursing (DON) on [DATE] at 11:50 a.m., she confirmed Resident 1's [MEDICATION NAME] medication was not administered and the pharmacy should have informed the facility to reorder the medication in timely manner. Review of the facility's 2001 policy, Pharmacy Services Overview, indicated the facility should accurately and safely provide or obtain pharmaceutical services, including the provision of routine, emergency medications, and biological medications. The pharmacy services are available to residents 24-hours a day and seven days a week.

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.