STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055728	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clarita Post-Acute Care Center	23801 Newhall Avenue Newhall, CA 91321

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46445 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received care consistent with professional standards of practice to prevent from development of a Stage 3 pressure ulcers ([PU] a localized injury to the skin and/or underlying tissue usually over a bony prominence because of pressure) by failing to: 1. Ensure Resident 1 ' s right heel was elevated ([offloaded] minimizing or removing weight placed on the foot and heel to help prevent development and assisted in pressure ulcers healing) off the mattress and was not continuously laying directly on the mattress thus contributing to the development of Resident 1 ' s right heel pressure ulcer. 2. Provide Resident 1 with a Low Air Loss Mattress ([LALM] a mattress designed to distribute a resident's body weight over a broad surface area and help prevent skin breakdown. Air continually flows through tiny laser-made air holes in the top of the mattress surface so that a resident floats on a soft cushion of air) to prevent development of a Stage 3 pressure ulcer to the resident ' s right heel. 3. Ensure Resident 1 had an individualized plan of care with interventions to prevent development of a Stage 3 pressure ulcer to Resident 1 ' s right heel. 4. Ensure Resident 1 ' s Skin and Wound Assessment documentation was completed and accurate in accordance with facility ' s policy and procedure (P&P) titled, Charting and Documentation. 5. Ensure nursing staff inspected Resident 1 ' s skin on a daily basis when performed or assisted the resident with a personal care, or activities of daily living ([ADLs] a basic tasks that must be accomplished every day for an individual to thrive) in accordance with the facility ' s policy titled, Prevention of Pressure Injuries, and as indicated on the care plan titled, Activities of Daily Living. As a result, Resident 1 developed a Stage 3 (full thickness loss of skin in which subcutaneous fat may be visible in the ulcer) PU on the right heel which required Resident 1 to undergo a bone tissue debridement (the surgical process of removing skin and bone close to and surrounding an infected wound associated with bone injuries or diseases). Findings: (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/19/2024 with diagnoses including nondisplaced fracture (broken bones where the pieces were not moved enough during the break to be out of alignment) of the right femur (thigh bone), hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (commonly known as stroke, caused by a blockage in a blood vessel in the brain, leading to brain damage) affecting the right dominant side, and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). A review of Resident 1 ' s Skin Supplemental Assessment, dated 4/20/2024, indicated Resident 1 had a surgical incision (a cut made through the skin and soft tissue to facilitate an operation or procedure) on the right hip and multiple discoloration (a change to the original color of something that makes it look unpleasant or damaged) on both right and left upper extremity (the region of the body that included the arm, forearm, wrist, and hand). There was no documented evidence that Resident 1 had pressure ulcers on admission. A review of Resident 1 ' s Care Plan for ADLs initiated on 4/20/2024, indicated Resident 1 had mobility (ability to move) performance deficit related to activity intolerance (inability to endure), fatigue (an extreme sense of tiredness and lack of energy that can interfere with a person ' s usual daily activities), hemiplegia, history of right femur fracture, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and left knee osteoarthritis (condition that causes the joints to become very painful and stiff). The Care Plan interventions indicated Resident 1 required skin inspection, including observation for redness, open skin areas, scratches, cuts, bruises, and report the changes to the nurse. Resident 1 ' s Care Plan interventions did not indicate the frequency of skin inspections. A review of Resident 1 ' s Care Plan for a Pressure Ulcer, dated 4/20/2024, indicated Resident 1 had the potential for pressure ulcer development. Resident 1 ' s Care Plan goal indicated the resident will have intact skin, free from redness, blisters (a small pocket of fluid in the upper skin layers and one of the body ' s responses to injury or pressure) or discoloration. Resident 1 ' s Care Plan Interventions indicated to follow the facility ' s policies and protocol for the prevention and treatment of skin breakdown. Resident 1 ' s Care Plan indicated there were no listed interventions implemented to prevent the development of right heel PU. A review of Resident 1 ' s History and Physical (H&P), dated 4/22/2024, indicated Resident 1 had a right sided weakness. The H&P indicated Resident 1 had a fall at home that led Resident 1 to undergo surgical intervention for an open reduction internal fixation [(ORIF] a surgical procedure for repairing fractured bones using either plates, screws, or an intramedullary rod to stabilize the bone) of the right femur. The H&P indicated Resident 1 could make needs known but could not make medical decisions. A review of Resident 1 ' s Minimum Date Set ([MDS]a standardized assessment and care screening tool), dated 4/23/2024, indicated Resident 1 ' s cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were intact. The MDS indicated Resident 1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) from staff to roll left and right (the resident ' s ability to roll from lying on back to left and right side and return to lying back on the bed) in bed. The Skin Condition section of the MDS indicated that Resident 1 was at risk of developing pressure ulcers or injury. The MDS indicated Resident 1 did not have any pressure ulcers or injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Braden Scale for Predicting Pressure Sore (ulcer) Risk, dated 4/26/2024, indicated the resident ' s score of 16. The score of 16 indicated Resident 1 was at risk for developing a pressure ulcer. A review of Resident 1 ' s Skin Observation Monitoring, dated 5/2024, indicated Resident 1 ' s skin condition was not monitored on 5/5/2024 on day shift (7 a.m. to 3 p.m.) and on 5/10/2024 on night shift (11 p.m. to 7 a.m.). Resident 1 ' s Skin Observation Monitoring indicated the resident ' s skin condition monitoring was not applicable on the night shift on 5/25/2024, 5/27/2024, 5/28/2024, 5/30/2024, and 5/31/2024. A review of Resident 1 ' s Progress Notes, dated 4/19/2024 to 5/25/2024, indicated no documented evidence that Resident 1 was on a pressure relieving mattress (LALM) and that Resident 1 ' s right heel was offloaded from the mattress to prevent the development of a pressure ulcer. A review of Resident 1 ' s Situation, Background, Assessment, and Recommendation (SBAR) Communication Form, dated 5/23/2024, indicated Resident 1 had an open wound on the right heel. SBAR section ' Skin Changes ' indicated Resident 1 ' s right heel wound was described as a vascular wound (wounds on the skin that develop because of problems with blood circulation) with 15 percent (%) necrosis (the death of a body tissue), 25% slough (a necrotic tissue formed when dead cells and/or bacteria accumulate in the wound), 30% granulation (a development of new tissue and blood vessels in a wound during the healing process), 30% epithelization (the final stage of wound healing), and mild to moderate serosanguineous (contains or relates to both blood and the liquid part of blood [serum]) exudate (any fluid that had been forced out of the tissue because of inflammation or injury). On 5/23/2024 at 10:40 a.m., Resident 1 ' s Attending Physician (MD 1) and the resident representative 1 (FM 1) was notified about Resident 1 ' s right heel wound. A review of Resident 1 ' s Skin Ulcer (wound) Report-Initial, dated 5/23/2024, indicated Resident 1 had an acquired (developed while in the facility) right heel Unstageable pressure ulcer (full thickness skin and tissue loss in which the extent of tissue damage within the wound cannot be confirmed because the wound bed is obscured by slough or eschar [a collection of dry, dead tissue within an wound]). The Skin Ulcer (wound) Report-Initial section ' Ulcer Dimensions ' indicated Resident 1 ' s right heel PU was measured 3.5 centimeters ([cm]- unit of measurement) in length, 2.5 cm in width, with undetermined depth. The Skin Ulcer Report-Initial indicated Resident 1 ' s right heel PU had a 100% brown to black necrosis, was boggy (feels like it has fluid in it), had macerated (the process of skin softening and breaking down) per-wound (the surrounding area of the wound edge) with stable dry eschar (a collection of dry, dead tissue within a wound). A review of Resident 1 ' s Physician ' s Orders, dated 5/23/2024, indicated an order for STAT (urgent or rush) arterial (blood vessels that distribute oxygen-rich blood to the body) /vascular ultrasound (a noninvasive test to determine how blood flows in arteries and veins in the arms, neck, and legs) of the right lower extremity. A review of Resident 1 ' s Radiology (the branch of medicine that use imaging technology to diagnose and treat disease) Report Interpretation, dated 5/23/2024, indicated Resident 1 had a right lower extremity arterial ultrasound. The Radiology Report ' Impression ' section indicated that Resident 1 had no significant obstruction to arterial blood flow on the right lower extremity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Progress Notes, dated 5/26/2024, indicated the Licensed Vocational Nurse (LVN 3) clarified with MD 1 the change of Resident 1 ' s right heel peripheral vascular disease ([PVD] a reduced circulation of blood to a body part other than the brain or heart) wound to a Stage 3 pressure ulcer. Resident 1 ' s Progress Notes indicated there was no indication of PVD and arterial/venous occlusion. The Progress Notes indicated that FM 1 was notified. A review of Resident 1 ' s Surgical Consult Notes, dated 6/4/2024, indicated MD 2 was consulted for Resident 1 ' s right heel wound. The Surgical Consult Notes indicated Resident 1 ' s right heel wound was a pressure ulcer that was measured 2.0 cm in length, 2.8 cm in width, with undetermined depth, covering 5.6 square cm wound area. The Surgical Consult Notes section ' Tissue Type by Percentage ' indicated Resident 1 ' s right heel wound had 100% necrotic tissue. Resident 1 ' s Surgical Consult Notes indicated Resident 1 had a bone tissue debridement. On 7/1/2024 at 9:30 a.m., during an interview, Resident 1 stated the right heel PU developed in the facility. Resident 1 stated that she required assistance with lifting her right leg. Resident 1 stated the facility staff did not elevate her right leg and her right heel was continuously laying on directly on the mattress. Resident 1 stated facility staff placed the ankle-foot orthoses ([AFO] a supportive device intended to control the position and motion of the ankle, to compensate for weakness, or to correct deformities) while she was on the wheelchair. Resident 1 stated that FM 1 provided the air mattress after the facility staff discovered Resident 1 had right heel PU. On 7/1/2024 at 11:09 a.m., during a concurrent interview and record review, LVN 2 stated that on 5/23/2024, a Certified Nursing Assistant 2 (CNA 2) assisted Resident 1 with shower. LVN 2 stated CNA 2 observed Resident 1 had a wound on the right heel. LVN 2 stated that LVN 1 checked Resident 1 and found a PU on the right heel. Resident 1 ' s Admission Assessment, dated 4/20/2024, was reviewed with LVN 2 and indicated Resident 1 had no PU. LVN 2 stated Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk, dated 4/26/2024, indicated Resident 1 was at risk for developing PU. LVN 2 stated on 5/26/2024 Resident 1 ' s physician ordered to offload the resident ' s right heel, and use of LALM after the right heel PU was discovered. On 7/1/2024 at 12:02 p.m., during a concurrent interview and record review, Resident 1 ' s medical records were reviewed with LVN 1. LVN 1 stated Resident 1 was admitted in the facility on 4/19/2024 without PU. LVN 1 stated Resident 1 was at risk for developing PU because of Resident 1 ' s limited mobility after right hip ORIF and Resident 1 ' s history of hemiplegia and hemiparesis. LVN 1 stated that on 5/23/2024, LVN 2 informed her that Resident 1 complained of right heel pain. LVN 1 stated Resident 1 ' s right heel was brown to black in color with 100% necrotic eschar. LVN 1 stated Resident 1 ' s right heel was boggy with macerated peri-wound Resident 1 ' s Care Plans were reviewed with LVN 1 which indicated there were no interventions to offload the resident ' s heels. LVN 1 stated Resident 1 ' s Care Plan was incomplete and not individualized. LVN 1 stated there was no documented evidence indicating Resident 1 ' s heels were offloaded and a LALM was used to prevent PU. On 7/1/2024 at 2:01 p.m., during an interview, CNA 2 stated that on 5/23/2024, during Resident 1 ' s shower, CNA 2 observed Resident 1 ' s right heel to be purplish in color. CNA 2 stated LVN 1 and LVN 2 were notified. CNA 2 stated that she used pillows to offload Resident 1 ' s right leg. CNA 2 stated that she did not document Resident 1 ' s right leg on a pillow because it was an ongoing intervention to prevent PU. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/2/2024 at 10:27 a.m., during an interview, CNA 3 stated Resident 1 had pillows under the right leg to keep the heel off the bed. CNA 3 was not able to provide documented evidence that Resident 1 ' s right leg was offloaded to prevent PU. On 7/2/2024 at 1:55 p.m., during a concurrent interview and record review, Resident 1 ' s medical record from 4/19/2024 through 5/23/2024 was reviewed with RN 2 and indicated Resident 1 was at risk for developing PU. RN 2 stated Resident 1 was status post ([s/p]after surgery or other medical intervention) right hip ORIF, had hemiparesis and hemiplegia on the right dominant side, and had vascular dementia which increased Resident 1 ' s risk in developing PU. RN 2 stated Resident 1 required assistance to reposition the right leg. RN 2 stated that LALM was provided to residents with PU and to those residents who were identified as a high risk for developing PU. Resident 1 ' s Care Plans were reviewed with RN 2 and indicated there were no individualized and specific care plan interventions addressing Resident 1 ' s risk for developing pressure ulcers. Resident 1 ' s Care Plan did not indicate the use of LAL mattress or offloading Resident 1 ' s heels to prevent PU. A review of Resident 1 ' s Weekly Summary, dated 5/28/2024, 6/4/2024, 6/11/2024, 6/18/2024, and 6/25/2024, indicated Resident 1 had no skin breakdown (tissue damage caused by friction, shear, moisture, or pressure and limited to the top layer of the skin). Resident 1 ' s Weekly Summary section ' Pressure Ulcer Prevention Measures ' indicated Resident 1 had pillows. The pressure reducing mattress, turning, and repositioning program, were not included in Resident 1 ' s PU prevention measures. RN 2 stated that Resident 1 ' s Weekly Summary was inaccurate. RN 2 stated that inaccurate documentation had the potential to prevent facility staff to properly identify Resident 1 ' s risk for developing PU. RN 2 stated that the facility failed to provide Resident 1 with interventions to prevent PU, including offloading the resident ' s heels and provide LAL mattress. A review of the facility ' s P&P titled, Prevention of Pressure Injuries, dated 6/27/2024, indicated the purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy indicated to inspect the skin on a daily basis when performing or assisting with personal care or ADLs. The policy indicated to reposition the resident as indicated on the care plan. The P&P section ' Support Surfaces and Pressure Redistribution ' indicated to select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. A review of the facility ' s P&P titled, Comprehensive Person-Centered Care Plans, dated 6/27/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives to meet the resident ' s physical, psychosocial, and functional needs were developed and implemented for each resident. The policy indicated that care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The Care Planning Process section indicated to incorporate risk factors associated with identified problems and to aid in preventing or reducing decline in the resident ' s functional status and / or functional levels. A review of the facility ' s P&P titled, Charting and Documentation, dated 6/27/2024, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record. The policy indicated documentation in the medical record will be objective, complete, and accurate.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46445 Based on observation, interview, and record review, the facility failed to ensure that a resident with a urinary indwelling catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) received proper care and services that included to anchor (secure) the urinary catheter tubing to the resident ' s thigh for one of four sampled residents (Resident 4). This deficient practice had the potential to result in urinary catheter dislodgement (forcefully pulled out of a secure position) causing urethral (the tube through which urine leaves the body) tearing that may result in pain, bleeding, and infection. Findings: A review of Resident 4 ' s Admission Record indicated the facility admitted the resident on 10/29/2019 with diagnoses that included stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of Resident 4 ' s Physician Order Sheet, dated 5/28/2024, indicated foley catheter (one of many types of urinary catheters) indicated for neurogenic bladder (the lack of bladder control because of a brain, spinal cord, or nerve problem). A review of Resident 4 ' s History and Physical, dated 5/30/2024, indicated the resident can make needs known but cannot make medical decisions. A review of Resident 4 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/31/2024, indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 4 was dependent on facility staff for toileting hygiene. The Bladder and Bowel section indicated Resident 4 had an indwelling catheter and was incontinent of bowel. On 7/1/2024 at 11:01 a.m., during a concurrent observation and interview, observed Resident 4 lying in bed with white sheet and a brown personal blanket covering from chest down to toes, and an indwelling catheter tubing hanging on the left side of the bed frame. Registered Nurse 1 (RN 1) removed the blankets from Resident 4 exposing the resident ' s left leg and noted the urinary catheter did not have a securement device (strap free device which locks the catheter in place, stabilizes the catheter and eliminates any chance of sudden pull) on Resident 4. RN 1 stated that Resident 4 ' s indwelling urinary catheter should be anchored to the resident's leg with a securement device. RN 1 stated Resident 4 ' s unsecured urinary catheter had the potential to cause the resident to bleed and develop infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 4:33 p.m., during a concurrent interview and record review, the facility ' s policy and procedure titled, Urinary Catheter Care, dated 6/27/2024, was reviewed with the Director of Nursing (DON). The DON stated that Resident 4 ' s indwelling urinary catheter should be secured to prevent pulling of the catheter, accidental dislodgement, and infection. The General Guidelines section of the policy and procedure indicated to ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site.