

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  23801 Newhall Avenue Newhall, CA 91321	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent developing a pressure ulcer (PU - a localized injury to the skin and or underlying tissue usually over a bony prominence as a result of pressure, or a pressure in combination with shear [occur when forces are applied to body tissues or parts that cause these tissues to move in opposite directions]) for one of three sampled residents (Resident 1) by:</p> <ol style="list-style-type: none"> <li>1. Failing to inform the Physician on 6/23/2024 of Resident 1 ' s PU.</li> <li>2. Failing to inform Family Member 1 (FM 1) of Resident 1 ' s PU on 6/23/2024.</li> </ol> <p>These deficient practices resulted in delay of obtaining appropriate instructions from the physician for proper management and violated FM 1 ' s right to be informed.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record, it indicated the facility admitted Resident 1 on 6/9/2024 with diagnoses that included fracture (bone break) of unspecified (unconfirmed) part of neck of left femur (thigh bone), generalized muscle weakness, and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1 ' s History and Physical, dated 6/10/2024, it indicated Resident 1 can make needs known but cannot make medical decisions.</p> <p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/11/2024, it indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, showering, bathing, personal hygiene and needed maximum assist to roll from left to right position. The MDS indicated Resident 1 was occasionally incontinent (unable to control) of bladder functions and always incontinent of bowel functions. The MDS indicated Resident 1 was at risk for PU.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR) Communication Form (form that provides communication between members of the health care team), dated 6/23/2024, it indicated Resident 1 had an open area on coccyx (tailbone).</p> <p>a. During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the Director of Staff Development (DSD), Resident 1 ' s SBAR dated 6/23/2024 and Progress Notes dated 6/23/2024 were reviewed. The SBAR, dated 6/23/2024, indicated Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse 1 (LVN1) that Resident 1 had an open area in the coccyx (tailbone). The SBAR indicated physician ' s date and time of notification were left blank. The DSD stated there was no documented evidence that the physician was notified of Resident 1 ' s PU. The DSD stated the nurse should have called and notify the physician to obtain treatment to prevent worsening of PU and prevent infection.</p> <p>During an interview on 7/22/2024 at 10:43 a.m., Registered Nurse 1 (RN 1) stated she (RN 1) was notified of Resident 1 ' s open wound on 6/23/2024 and she (RN 1) created the SBAR. RN 1 stated she cannot remember and did not document who notified her (RN 1). RN 1 stated LVN 1 should have called the physician to get an order. RN 1 stated Resident 1 ' s open wound could get infected and can get worst if not provided a treatment.</p> <p>During an interview on 7/22/2024 at 11:05 a.m., the Director of Nursing (DON) stated the physician was not notified of Resident 1 ' s PU, The DON stated if staff observed any change in condition, staff should call the physician to obtain treatment to prevent the wound from getting infected. The DON stated it is the facility ' s policy to notify the physician of the resident ' s change in condition.</p> <p>During a record review of facility ' s policy and procedure (PnP) titled, Change in a Resident ' s Condition or Status, dated 2/2021 and reviewed on 6/27/2024, it indicated, The nurse will notify the resident ' s attending physician or physician on call when there have been a (an) b. discoveries of injuries of an unknown source, d. significant change in the resident ' s physical, emotional, mental condition. A significant change of condition is a major decline or improvement in the resident ' s status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting).</p> <p>b. During an interview on 7/22/2024 at 7:49 a.m., FM 1 stated on 7/3/2024, Resident 1 was discharged from the facility to a Board and Care. FM 1 stated Board and Care Caregiver changed Resident 1 ' s incontinent brief on 7/3/2024 and noted a wound in Resident 1 ' s tailbone. FM 1 stated she was notified by Home Health Nurse that Resident 1 had a stage 2 (are open wounds, is usually tender and painful that expands into deeper layers of the skin. It can look like a scrape [abrasion], blister, or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid) PU in the tailbone. FM 1 stated she was not notified by the facility that Resident 1 had a stage 2 PU.</p> <p>During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the DSD, Resident 1 ' s SBAR and Progress Notes, dated 6/23/2024, were reviewed. The SBAR indicated family notification was left blank. The DSD stated no documented evidence in Resident 1 ' s Progress Notes that FM 1 was notified of Resident 1 ' s PU. The DSD stated FM 1 ' s rights were violated when FM 1 was not informed of Resident 1 ' s PU. The DSD stated nurses should notify family with any change in condition.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/22/2024 at 12:03 p.m., with the DON, facility ' s policy and procedure titled, Change in a Resident ' s Condition or Status, dated 2/2021 and reviewed on 6/27/2024, it indicated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status. The DON stated it is the facility ' s policy to notify family with any change in condition.</p> <p>During a record review of the facility ' s PnP titled, Wound, Pressure Ulcer, Injury Risk Assessment, undated and reviewed on 6/27/2024, it indicated, Report other information in accordance with facility policy and professional standards of practice. Notify attending MD if new skin alteration noted.</p> <p>During a record review of facility ' s PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 6/27/2024, it indicated, Documentation of procedures and treatments will include care specific details, including: f. notification of family, physician or other staff, if indicated.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent developing a pressure ulcer (PU - a localized injury to the skin and or underlying tissue usually over a bony prominence as a result of pressure, or a pressure in combination with shear [occur when forces are applied to body tissues or parts that cause these tissues to move in opposite directions]) for one of three sampled residents (Resident 1) by:</p> <ol style="list-style-type: none"> <li>1. Failing to inform the Physician on 6/23/2024 of Resident 1 ' s PU.</li> <li>2. Failing to provide treatment to Resident 1 ' s PU from 6/23/2024 to 7/3/2024.</li> <li>3. Failing to inform Family Member 1 (FM 1) of Resident 1 ' s PU on 6/23/2024.</li> <li>4. Failing to develop a care plan to address Resident 1 ' s PU on 6/23/2024.</li> <li>5. Failing to accurately assess Resident 1 ' s Braden Scale (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client ' s risk for developing pressure injuries) on 6/24/2024.</li> </ol> <p>As a result, Resident 1 developed a PU. On 7/3/2024, Resident 1 was discharged to a Board and Care with stage 2 PU (are open wounds, the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful. The wound expands into deeper layers of the skin. It can look like a scrape [abrasion], blister, or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid. At this stage, some skin may be damaged beyond repair or may die).</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record, it indicated the facility admitted Resident 1 on 6/9/2024 with diagnoses that included fracture (bone break) of unspecified (unconfirmed) part of neck of left femur (thigh bone), generalized muscle weakness, and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1 ' s History and Physical, dated 6/10/2024, it indicated Resident 1 can make needs known but cannot make medical decisions.</p> <p>During a record review of Resident 1 ' s Care Plan on at risk for PU, dated 6/10/2024, it indicated interventions that included to assess, record, monitor wound healing, measure length, width, and depth where possible, assess and document status of wound perimeter (the total length around the outside of a shape), wound bed and healing progress, and report improvements and decline to the physician. Resident 1 ' s Care Plan also indicated to monitor, document, and report any changes in skin status.</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 - Few</p>	<p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/11/2024, it indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, showering, bathing, personal hygiene and needed maximum assist to roll from left to right position. The MDS indicated Resident 1 was occasionally incontinent (unable to control) of bladder functions and always incontinent of bowel functions. The MDS indicated Resident 1 was at risk for PU.</p> <p>During a record review of Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk, dated 6/17/2024, it indicated Resident 1 was at risk for PU.</p> <p>During a record review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR) Communication Form (form that provides communication between members of the health care team), dated 6/23/2024, it indicated Resident 1 had an open area on coccyx (tailbone).</p> <p>During a record review of Resident 1 ' s Care Plan on potential for skin breakdown, dated 6/26/2024, it indicated an intervention to assess, document and monitor for treatment effectiveness, initiate treatment as per physician orders and wound consult.</p> <p>a. During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the Director of Staff Development (DSD), Resident 1 ' s SBAR dated 6/23/2024 and Progress Notes dated 6/23/2024 were reviewed. The SBAR, dated 6/23/2024, indicated Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse 1 (LVN1) that Resident 1 had an open area in the coccyx (tailbone). The SBAR indicated physician ' s date and time of notification were left blank. The DSD stated there was no documented evidence that the physician was notified of Resident 1 ' s PU. The DSD stated the nurse should have called and notify the physician to obtain treatment to prevent worsening of PU and prevent infection.</p> <p>During an interview on 7/22/2024 at 10:43 a.m., Registered Nurse 1 (RN 1) stated she (RN 1) was notified of Resident 1 ' s open wound on 6/23/2024 and she (RN 1) created the SBAR. RN 1 stated she cannot remember and did not document who notified her (RN 1). RN 1 stated LVN 1 should have called the physician to get an order. RN 1 stated Resident 1 ' s open wound could get infected and can get worst if not provided a treatment.</p> <p>During an interview on 7/22/2024 at 11:05 a.m., the Director of Nursing (DON) stated the physician was not notified of Resident 1 ' s PU, The DON stated if staff observed any change in condition, staff should call the physician to obtain treatment to prevent the wound from getting infected. The DON stated it is the facility ' s policy to notify the physician of the resident ' s change in condition.</p> <p>During an interview on 7/22/2024 at 11:21 a.m., Treatment Nurse (TN) stated licensed vocational nurses (LVNs) call the physician for any resident skin changes and place the physician ' s order in the computer.</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 - Few</p>	<p>During a record review of facility ' s policy and procedure (PnP) titled, Change in a Resident ' s Condition or Status, dated 2/2021 and reviewed on 6/27/2024, it indicated, The nurse will notify the resident ' s attending physician or physician on call when there have been a (an) b. discoveries of injuries of an unknown source, d. significant change in the resident ' s physical, emotional, mental condition. A significant change of condition is a major decline or improvement in the resident ' s status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting).</p> <p>During a record review of the facility ' s PnP titled, Wound, Pressure Ulcer, Injury Risk Assessment, undated and reviewed on 6/27/2024, it indicated, Report other information in accordance with facility policy and professional standards of practice. Notify attending MD if new skin alteration noted.</p> <p>During a record review of facility ' s PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 6/27/2024, it indicated, Documentation of procedures and treatments will include care specific details, including: f. notification of family, physician or other staff, if indicated.</p> <p>b. During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the DSD, Resident 1 ' s Physicians Order dated 6/2024 and Treatment Administration Record (TAR), dated 6/2024 and 7/2024, were reviewed. The DSD stated there was no documented evidence that an order was obtained from the physician to treat Resident 1 ' s PU and no documented evidence that treatment was done for Resident 1 ' s PU from 6/23/2024 to 7/3/2024. The DSD stated staff were not able to obtain physician order to treat the PU that can result to infection.</p> <p>During an interview on 7/22/2024 at 11:05 a.m., the DON stated no treatment was obtained from the physician and no treatment was provided to treat Resident 1 ' s PU. The DON stated it is the facility ' s policy to provide treatment with any wound or PU to prevent the PU from getting infected.</p> <p>During an interview on 7/22/2024 at 11:21 a.m., Treatment Nurse (TN) stated she (TN) was not informed of Resident 1 ' s PU. TN stated she (TN) did not provide any treatment to address Resident 1 ' s PU.</p> <p>During a record review of facility ' s PnP titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 4/2018 and reviewed on 6/27/2024, it indicated, Treatment/Management 1. The physician will order pertinent wound treatment, including pressure reduction surfaces, wound cleansing and debridement (the removal of dead or infected skin tissue to help a wound heal) approaches, dressings (occlusive [used for sealing particular types of wounds and their surrounding tissue off from air], absorptive [ indicated if a wound has a high level of drainage] et cetera [etc. - and other similar things]) and application of topical agents (medication that is applied to a particular place on or in the body). 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic (dead) tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment.</p> <p>c. During an interview on 7/22/2024 at 7:49 a.m., FM 1 stated on 7/3/2024, Resident 1 was discharged from the facility to a Board and Care. FM 1 stated Board and Care Caregiver changed Resident 1 ' s incontinent brief on 7/3/2024 and noted a wound in Resident 1 ' s tailbone. FM 1 stated she was notified by Home Health Nurse that Resident 1 had a stage 2 PU in the tailbone.</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 - Few</p>	<p>During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the DSD, Resident 1 ' s SBAR and Progress Notes, dated 6/23/2024, were reviewed. The SBAR indicated family notification was left blank. The DSD stated no documented evidence in Resident 1 ' s Progress Notes that FM 1 was notified of Resident 1 ' s PU. The DSD stated FM 1 ' s rights were violated when FM 1 was not informed of Resident 1 ' s PU. The DSD stated nurses should notify family with any change in condition.</p> <p>During a concurrent interview and record review on 7/22/2024 at 12:03 p.m., with the DON, facility ' s policy and procedure titled, Change in a Resident ' s Condition or Status, dated 2/2021 and reviewed on 6/27/2024, it indicated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status. The DON stated it is the facility ' s policy to notify family with any change in condition.</p> <p>During a record review of facility ' s PnP titled, Wound, Pressure Ulcer, Injury Risk Assessment, undated and reviewed on 6/27/2024, it indicated, Notify family, guardian or resident update if new skin alteration noted.</p> <p>During a record review of facility ' s PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 6/27/2024, it indicated, Documentation of procedures and treatments will include care specific details, including: f. notification of family, physician or other staff, if indicated.</p> <p>d. During a concurrent interview and record review on 7/22/2024 at 10:43 a.m., with RN 1, Resident 1 ' s Care Plans were reviewed. RN 1 stated there was no care plan created to address Resident 1 ' s PU. RN 1 stated a care plan lists the interventions to treat Resident 1 ' s PU.</p> <p>During an interview on 7/22/2024 at 11:05 a.m., the DON stated if staff observed any change in condition, staff should develop a care plan.</p> <p>During a record review of facility ' s PnP titled, Change in a Resident ' s Condition or Status, dated 2/2021 and reviewed on 6/27/2024, it indicated, A significant change of condition is a major decline or improvement in the resident ' s status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting); c. requires interdisciplinary (IDT-a coordinated group of experts from several different fields who work together) review and or revision to the care plan.</p> <p>During a record review of facility ' s PnP titled, Clinical Protocol Pressure Ulcers/Skin Breakdown, dated 3/2020 and reviewed on 6/27/2024, it indicated, The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.</p> <p>During a record review of facility ' s PnP titled, Wound, Pressure Ulcer, Injury Risk Assessment, undated and reviewed on 6/27/2024, it indicated, Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure ulcers/injuries.</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 - Few</p>	<p>e. During a record review of Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk, dated 6/24/2024, it indicated Resident 1 was at risk for PU. The Braden Scale indicated Resident 1 was assessed with potential problem for friction (the action of one surface or object rubbing against another) and shear (occur when forces are applied to body tissues or parts that cause these tissues to move in opposite directions).</p> <p>During a record review of Resident 1 ' s Progress Notes, dated 6/24/2024 timed at 3:46 a.m., 6/25/2024 timed at 4:01 a.m., and 6/26/2024 timed at 5:32 a.m., they indicated Resident 1 was monitored for open area on coccyx.</p> <p>During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the DSD, Resident 1 ' s Braden Scale dated 6/24/2024 and 7/1/2024 were reviewed. The Braden Scale indicated on 6/24/2024 and 7/1/2024, Resident 1 required minimum assistance. The DSD stated TN should have documented under friction and shear that Resident 1 had a problem instead of documenting potential problem based on 6/23/2204 SBAR. The DSD stated TN documented inaccurately.</p> <p>During a record review of facility ' s PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 6/27/2024, it indicated, The following information is to be documented in the resident ' s medical record: a. objective observations. Documents in the medical record will be objective (not opinionated or speculative), complete and accurate.</p> <p>During an interview on 7/30/2024 at 9:02 p.m., Caregiver stated Resident 1 arrived at the Board and Care on 7/3/2024 between 3 p.m., to 4 p.m. Caregiver stated at 5 p.m., Resident 1 appeared to be sleepy, so she (Caregiver) changed Resident 1 ' s incontinent brief to get her (Resident 1) ready for bed. Caregiver stated she (Caregiver) saw a dime size wound in Resident 1 ' s tailbone with no dressing. Caregiver stated Home Health Nurse came on 7/7/2024 and notified her (Caregiver) that Resident 1 had a stage 2 PU in the tailbone.</p> <p>During a record review of Resident 1 ' s General Acute Care Hospital (GACH) records titled, Wound Assessment, dated 7/7/2024, it indicated Resident 1 was seen at 12:12 p.m., with sacral (tailbone) stage 2 pressure ulcer measure 0.87 centimeter (cm-unit of measurement) in length and 0.65 cm in width.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to remove intravenous catheter (IV-a thin, flexible tube inserted into a vein, usually in the back of the hand, the lower part of the arm, or the foot to draw blood or give fluids) for one of three sampled residents (Resident 1) when Resident 1 completed the IV fluids hydration on 6/29/2024.</p> <p>This deficient practice had the potential to cause infection and discomfort.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record indicted the facility admitted Resident 1 on 6/9/2024 with diagnoses that included fracture (bone break) of unspecified (unconfirmed) part of neck of left femur (thigh bone), generalized muscle weakness and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1 ' s History and Physical dated 6/10/2024 indicated Resident 1 can make needs known but cannot make medical decisions.</p> <p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/11/2024, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, showering, bathing, personal hygiene and needed maximum assist to roll from left to right position.</p> <p>During a record review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR) Communication Form (form that provides communication between members of the health care team) dated 6/27/2024 indicated Resident 1 had poor oral intake. The SBAR indicated the Physician ordered Dextrose Normal Saline (D5NS- are specially formulated liquids that are injected into a vein to prevent or treat dehydration) at 60 milliliter (ml-unit of measurement) per hour (hr) for two liters.</p> <p>During a record review of Resident 1 ' s Physician ' s Order dated 6/27/2024 indicated an order for D5NS. Use 60 ml per hr IV every shift for hydration for two days for two liters.</p> <p>During a record review of Resident 1 ' s IV Record dated 6/2024 indicated Resident 1 had the IV fluids from 6/27/2024 at evening shift until 6/29/2024 at day shift.</p> <p>During an interview on 7/22/2024 at 7:49 a.m., Family Member 1 (FM 1) stated Resident 1 was discharged to a Board and Care on 7/3/2204 still with IV catheter on her right wrist.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  23801 Newhall Avenue Newhall, CA 91321	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the Director of Staff Development (DSD), Resident 1 ' s SBAR dated 6/27/2024 was reviewed. The SBAR dated 6/27/2024 indicated IV hydration was ordered due to Resident 1 ' s poor oral intake. The DSD stated IV hydration was completed on 6/29/2024. The DSD stated when IV hydration was completed, nurses should have notified the physician and if no further order for hydration, IV catheter should have been removed on 6/29/2024. The DSD stated RN 1 should have removed the IV needle when hydration was completed on her (RN 1) shift. The DSD stated RNs are responsible for removing IV catheter. The DSD stated LVN 1 discharged Resident 1 to Board and Care on 7/3/2024.</p> <p>During an interview on 7/22/2024 at 11:05 a.m., the Director of Nursing (DON) stated she (DON) received a call from Licensed Vocational Nurse 2 (LVN 2) that Resident 1 was discharged with IV catheter still on her wrist. The DON stated she (DON) informed LVN 2 to go to the Board and Care and remove the IV catheter. The DON stated she investigated and found that nurses missed removing the IV catheter. The DON stated IV catheter left in place can cause redness on the site, discomfort and infection. The DON stated whoever completed the IV fluids should have remove the IV catheter.</p> <p>During an interview on 7/22/2024 at 12:13 p.m., LVN 1 stated he (LVN 1) received a phone call from FM 1 on 7/3/2024 between 5 p.m., to 6 p.m., that Resident 1 was discharged to Board and Care with IV catheter still on the right wrist. LVN 1 stated he (LVN 1) notified the DON right away and DON gave him (LVN 1) permission to go to the Board and Care to remove the IV catheter. LVN 1 stated RN 1 should have removed the IV catheter after completion of physician ' s order.</p> <p>During an interview on 7/30/2024 at 9:02 p.m., Caregiver stated Resident 1 arrived at the Board and Care on 7/3/2024 between 3 p.m., to 4 p.m. Caregiver stated at 5 p.m., Resident 1 appeared to be sleepy, so she (Caregiver) changed Resident 1 ' s incontinent brief to get her (Resident 1) ready for bed. Caregiver stated she (Caregiver) saw the IV catheter still on Resident 1 ' s right wrist. Caregiver stated FM 1 was notified right away and she (Caregiver) also called the facility.</p> <p>During a record review of facility ' s policy and procedure titled, Peripheral IV Catheter Removal dated 3/2023 and reviewed on 6/27/2024 indicated, The purpose of this procedure is to provide guidelines for safe, aseptic (medically clean or without infection) removal of a peripheral IV catheter.</p> <p>General Guidelines:</p> <p>2. Remove the peripheral midline IV catheter if:</p> <p>a. infusion therapy is discontinued.</p> <p>b. it is not used for more than 24 hours.</p> <p>c. it is no longer in the plan of care; or</p> <p>Documentation</p> <p>The following should be documented in the resident's medical record.</p> <p>1. Date, time of procedure, and resident tolerance</p> <p>(continued on next page)</p>		

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

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>2. Location of catheter that was removed.</li> <li>3. Reason for removal of catheter (end of treatment, complication, rotation of site, etc.).</li> <li>4. Any complications and interventions taken.</li> <li>5. Any communication with physician or oncoming shift.</li> <li>6. Change any areas needed on treatment Kardex.</li> </ol>

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NAME OF PROVIDER OR SUPPLIER  Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  23801 Newhall Avenue Newhall, CA 91321	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of three sampled residents (Resident). On 6/24/2024 and 7/1/2024 Resident 1 ' s Situation Background Assessment and Recommendation (SBAR) Communication Form (form that provides communication between members of the health care team) nurses did not accurately document date and time the physician and the family were called.</p> <p>This deficient practice had the potential to result in confusion in the care and services rendered to Resident 1 and resulted in inaccurate information entered into Resident 1 ' s medical record.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 6/9/2024 with diagnoses that included fracture (bone break) of unspecified (unconfirmed) part of neck of left femur (thigh bone), generalized muscle weakness and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1 ' s History and Physical, dated 6/10/2024, indicated Resident 1 can make needs known but cannot make medical decisions.</p> <p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/11/2024, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, showering, bathing, personal hygiene and needed maximum assist to roll from left to right position. The MDS indicated Resident 1 was occasionally incontinent (unable to control) of bladder functions and always incontinent of bowel functions.</p> <p>During a concurrent interview and record review on 7/22/2024 at 9:55 a.m., with the Director of Staff Development (DSD), Resident 1 ' s SBAR Communication Form dated 6/24/2024 and 7/1/2024 was reviewed. The SBAR dated 6/24/2024 indicated the Physician and Family Member 1 (FM 1) were informed of Resident 1 ' s weight loss on 6/24/2024 at 12 midnight. The SBAR dated 7/1/2024 indicated notification to the physician and FM 1 was left blank. The DSD stated on 6/24/2024 the SBAR was created at 3:47 p.m. and nurses did not document accurate time the physician was called. The DSD stated on the SBAR dated 7/1/2024 the nurses did not document if physician and FM 1 was notified. The DSD stated it is important to document accurately date and time FM 1 and the physician was notified to get order for treatment.</p> <p>During an interview on 7/22/2024 at 12:03 p.m., the Director of Nursing (DON) stated it is their policy to notify family and the physician of any change in condition and to document accurately.</p> <p>During a record review of facility ' s PnP titled, Charting and Documentation dated 7/2017 and reviewed on 6/27/2024 indicated, Documentation of procedures and treatments will include care specific details, including:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. notification of family, physician or other staff, if indicated.</p>