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| 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 08/17/2024 |
| 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) |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48142</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a written or electronic record containing all the information the resident needs to effectively manage their own health) for one of three sampled residents (Residents 1) by failing to ensure Resident 1 had a care plan regarding change of condition.</p> <p>This deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay or lack of delivery of care and services.</p> <p>Findings:</p> <p>A review of Resident ' s 1 Admission Record indicated the facility admitted the resident on 1/17/2024, with diagnoses including pressure ulcer of the hips (the most severe stage of pressure ulcers and involve full-thickness skin loss that extends through the fascia and into muscle, bone, tendon, or joint tissue).</p> <p>A review of Resident 1's History and Physical, dated 1/19/2024, indicated that resident can make needs known but cannot make medical decisions.</p> <p>A review of Resident 1's Change of Condition Assessment, dated on 8/3/2024, indicated that Resident 1 had productive cough.</p> <p>During a concurrent interview and record review on 8/17/2024 at 10:06 a.m., License Vocational Nurse (LVN 1) stated there was no care plan made for productive cough and should have one to indicate the interventions and goals for Resident 1.</p> <p>During an interview on 8/17/2024 at 11:10 a.m., the Director of Nursing (DON) stated that a care plan was important to indicate the interventions that was done for Resident 1's change of condition.</p> <p>During a review of the facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, last revised date on 12/2016, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>48142</p> <p>Based on interview and record review, the facility failed to monitor one of three sampled residents (Resident 1) after having a change of condition.</p> <p>This deficient practice could result to Resident 1 encountering serious health issues that may go undetected, leading to complications and potentially life-threatening situations.</p> <p>Findings:</p> <p>A review of Resident ' s 1 Admission Record indicated the facility admitted the resident on 1/17/2024, with diagnoses including pressure ulcer of the hips (the most severe stage of pressure ulcers and involve full-thickness skin loss that extends through the fascia and into muscle, bone, tendon, or joint tissue).</p> <p>A review of Resident 1's History and Physical, dated 1/19/2024, indicated that resident can make needs known but cannot make medical decisions.</p> <p>A review of Resident 1's Change of Condition Assessment, dated on 8/3/2024, indicated that Resident 1 had productive cough.</p> <p>During a concurrent interview and record review on 8/17/2024, at 9:55 a.m., License Vocational Nurse (LVN 1) stated there were no progress notes regarding Resident 1 ' s monitoring for productive cough. LVN 1 further stated that nurses should monitor and document the condition of the resident every shift for 72 hours if there was a change of condition.</p> <p>During an interview on 8/17/2024, at 10:40 a.m., LVN 2 stated that he got busy with Resident 1 and forgot to document. LVN 2 further stated that LVN 2 monitored Resident 1 closely with resident's family member at bedside that time because we were waiting for the x-ray (a n electromagnetic radiation of an extremely short wavelength that can penetrate various thicknesses of solids and to act on photographic film as light does) technician to come.</p> <p>During an interview on 8/17/2024, at 11:10 a.m., with Director of Nursing (DON), the DON stated the importance of monitoring and documenting Resident 1's condition every shift. The DON stated that failure to monitor could result in missed changes in the resident's condition, potentially leading to delays in care.</p> <p>A review of facility policy and procedure titled, Change in a Resident ' s Condition or Status, last revised date on 2/2021, indicated that the nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status.</p> |