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	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clarita Post-Acute Care Center	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)
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. 43878 Based on record review and interview, the facility failed to ensure one of three sampled residents (Resident 1) was treated with dignity and care in a manner that promotes maintenance or enhancement of their quality of life by failing to ensure Resident 1's right to refuse care was respected. This deficient practice had the potential to negatively affect Resident 1 psychosocially (involving mental, emotional, social, and spiritual aspects of a person's life). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 3/15/2025 with diagnoses including bilateral (pertaining to, involving, or affecting two or both sides) primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee, muscle weakness (generalized), and pain to right shoulder and ankle and joints of right foot. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/19/2025, the MDS indicated Resident 1 had the ability to understand and be understood. The MDS indicated Resident 1 was dependent (helper does all of the effort) with showering, lower body dressing, and putting on and taking of footwear, and requires substantial assistance (helper does more than half the effort) with oral hygiene, toileting, and upper body dressing. The MDS indicated Resident 1 was always incontinent (having no or insufficient voluntary control over urination or defecation) with urinary and bowel. During a review of Resident 1 ' s Situation-Background-Assessment-Recommendation (SBAR- a form that provides a framework for communication between members of the health care team about a resident ' s condition) Communication Form, dated 3/26/2025 at 12:20 p.m., the SBAR Communication Form indicated Resident 1 and Family Member (FM) 1 expressed concerns from a previous shift about a staff's potential misconduct. The SBAR indicated Resident 1 voiced concerns that she had issues with the way certain staff have been conducting themselves during care she (Resident 1) received and felt emotionally uneasy over it. (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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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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 7:35 a.m. with Resident 1, Resident 1 stated she had an incident with a staff but does not recall the actual day. Resident 1 stated it was her roommate (Resident 2) who pushed the call light around 3:25 a.m. and a staff (Certified Nursing Assistant [CNA] 1) came in and using the chux pad (a pad that is placed under a person to protect bedding and furniture from accidents or leaks due to incontinence [a condition where a person experiences involuntary leakage of urine or stool]) turned Resident 1 in her left side. Resident 1 stated she thought she was going to fall off the bed. Resident 1 stated she saw CNA 1 and CNA 4 and told them she did not need anything. Resident 1 stated CNA 1 was trying to change her incontinence brief (disposable, protective underwear designed to absorb and contain fecal [poop] or urinary [pee] incontinence) even if Resident 1 kept telling CNA 1 that she (Resident 1) did not want to be touched and did not want to be changed. Resident 1 stated CNA 1 then pulled her (Resident 1) blanket to check her incontinence brief and Resident 1 told her again she did not want to be touched. Resident 1 stated CNA 1 then finally left her (Resident 1) alone after CNA 1 realized that Resident 1 was dry and did not need to be changed. Resident 1 stated that after this incident she (Resident 1) got scared. During an interview on 4/2/2025 at 8:36 a.m. with CNA 1, CNA 1 stated on 3/26/2025 at around 4:30 a.m. the call light came on for Resident 2. CNA 1 stated she provided care for Resident 2 then went to check on Resident 1. CNA 1 stated she tapped Resident 1 on the shoulder and asked if she (CNA 1) could check Resident 1 ' s incontinence brief and Resident 1 initially nodded her head. CNA 1 stated she interpreted this as a yes. CNA 1 stated she gently pulled the blanket off Resident 1 and Resident 1 grabbed the blanket and pulled it up yelling don ' t touch me. CNA 1 stated she let go of the blanket and took a step back and that is when CNA 4 walked into Resident 1 ' s room. CNA 1 stated when Resident 1 saw CNA 4, Resident 1 became silent so CNA 1 continued to check Resident 1's incontinence brief. CNA 1 stated Resident 1 was dry and she (CNA 1) put the blanket back on Resident 1 and left the room. During an interview on 4/2/2025 at 9:12 a.m. with CNA 4, CNA 4 stated on the morning of 3/26/2025 around 4:30 a.m. she (CNA 4) passed by Resident 1's room and heard Resident 1 screaming. CNA 4 stated she could not hear what Resident 1 was saying. CNA 4 stated when she entered Resident 1 ' s room she saw CNA 1 pulling up Resident 1's blanket with both hands and was trying to check Resident 1's incontinence brief to see if it was wet. CNA 4 stated CNA 1 was frustrated and verbalized (CNA 1) that Resident 1 was not letting CNA 1 check her (Resident 1) and that Resident 1 had refused all night. CNA 4 stated Resident 1 stated she did not want to be touched and wanted to be left alone. CNA 4 stated both CNA 1 and Resident 1 were pulling on the blanket. CNA 4 stated CNA 1 then pulled Resident 1 ' s blanket from Resident 1 ' s feet. CNA 4 stated CNA 1 checked the pad (chux pad) and saw that Resident 1 was dry. CNA 4 stated CNA 1 tried to touch Resident 1 ' s incontinent brief but Resident 1 yelled that she (Resident 1) did not want to be touched so CNA 1 stopped. CNA 4 stated CNA 1 did not respect Resident 1's right to refuse care and should have called the charge nurse for help. During an interview on 4/2/2025 at 9:43 a.m. with CNA 1, CNA 1 stated Resident 1 did state leave me alone and don ' t touch me. CNA 1 stated she did not respect Resident 1 ' s wishes because she still went and checked Resident 1's incontinence brief. CNA1 stated if Resident 1 was upset and refusing care, she (CNA 1) should have just left Resident 1 alone and reported to the LVN. CNA 1 stated when a resident refuses care, we need to respect their wishes. CNA 1 stated Resident 1 can be negatively affected and can cause some sort of emotional harm. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 10:09 a.m. with the Director of Nursing (DON), the DON stated was made aware by FM 1 on 3/26/2025 at around 10 a.m. that on 3/26/2025 at around 4:30 a.m. The DON stated Resident 1 was asleep and CNA 1 went to check Resident 1's incontinence brief. The DON stated Resident 1 rights were violated because CNA 1 continued to check Resident 1's incontinence brief even after Resident 1 refused. The DON stated not respecting Resident 1's right to refuse care can potentially affect Resident 1's emotional feeling which may lead to further emotional breakdown. During a review of the facility-provided policy and procedure (P&P) titled, Resident Rights, last revised on 12/2019, the policy indicated employees shall treat all residents with kindness, respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: a. a dignified existence. b. be treated with respect, kindness, and dignity. During a review of the facility-provided P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, last revised 2/2021, the policy indicated, Resident and resident representatives have the right to request, refuse and/or discontinue treatment. 'Treatment' refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.