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	09/02/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received services with reasonable accommodation for one of three sampled residents (Resident 4), who was at risk for falls, had the call light (an alerting device for residents to call for assistance) within Resident 4's reach.This deficient practice had the potential for not meeting Resident 4's needs for assistance. Findings:During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted the resident on 3/26/2010 with diagnoses including hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (a medical condition affecting the blood supply to the brain) affecting the right dominant side, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition).During a review of Resident 4's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/21/2024, the H&P indicated the resident did not have the capacity to understand and make medical decisions.During a review of Resident 4's Minimum Data Set (MDS - resident assessment tool), dated 6/10/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills were severely impaired. During a review of Resident 4's Fall Risk Assessment, dated 6/10/2025, the Fall Risk Assessment indicated the resident had a total score of 10. A total score of 10 and above represented high risk for falls.During a review of Resident 4's Care Plan on Falls, last revised on 3/22/2023, the Care Plan indicated the resident was at risk for falls. The Care Plan Intervention indicated be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation and interview on 9/2/2025 at 2:45 p.m. with the Director of Nursing (DON), observed Resident 4's call light rolled and hung on the wall at the head part of the resident's bed. The DON stated Resident 4's call light was not within Resident 4's reach. The DON stated a call light was a resident's way of communication with the staff. The DON stated the facility failed to ensure the call light was within Resident 4's reach. During a review of the facility's policy and procedure (PnP) titled, Answering the Call Light, last reviewed on 5/29/2025, the PnP indicated the purpose . to ensure timely responses to the resident's requests and needs. The PnP indicated . ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan with measurable objectives and interventions for one of three sampled residents (Resident 1) was created and implemented. The facility failed to develop and implement an individualized care plan with interventions addressing Resident 1's food preferences as indicated in the resident's medical records.This deficient practice resulted to Resident 1 being served food identified as the resident's food dislike. Findings:During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 8/19/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities), and epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]). During a review of Resident 1's Physician Order, dated 8/19/2025, the Physician Order indicated the resident's diet was controlled carbohydrate, no added salt, regular texture, no fish. During a review of the facility-provided Menu, dated 8/18/2025 to 8/24/2025, the Menu indicated on 8/20/2025, the lunch served to the residents included fish. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 8/21/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills were moderately impaired.During an interview on 9/2/2025 at 12:59 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was not aware Resident 1 did not like fish. CNA 1 stated the meal ticket on Resident 1's lunch tray did not indicate the resident's food preference for no fish. CNA 1 stated she placed Resident 1's lunch tray that had fish on the resident's table. CNA 1 stated Family Member (FM) 1 informed her that Resident 1's food preference was communicated to the nursing staff on 8/19/2025, the night the resident was admitted . CNA 1 stated she brought Resident 1's lunch tray back to the kitchen and had the lunch tray replaced. During an interview on 9/2/2025 at 1:46 p.m. and concurrent record review of Resident 1's Care Plans, reviewed with Registered Nurse (RN) 1, RN 1 stated the resident's food preference should be identified and documented as part of the admission process. RN 1 stated the admitting licensed nurse should create a care plan on Resident 1's food preference. RN 1 stated Resident 1 did not have a care plan that addressed the resident's food preference for no fish. During an interview on 9/2/2025 at 3:07 p.m. with the Director of Nursing (DON), the DON stated licensed nurses and dieticians should create individualized resident care plans that addressed the residents' concerns and preferences. The DON stated Resident 1's Care Plan did not indicate the resident's food preference for no fish. The DON stated Resident 1's Care Plan on nutrition was not individualized. The DON stated the facility failed to update and revise Resident 1's Care Plan on nutrition to indicate the resident's food preference.During a review of the facility's policy and procedure (PnP) titled Care Plans, Comprehensive Person-Centered, last reviewed on 5/29/2025, the PnP 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. The PnP indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) was free from significant medication errors by failing to ensure the physician orders were followed. The facility failed to ensure Resident 2's midodrine hydrochloride (HCl) oral tablet (a medication, taken by mouth, used to treat low blood pressure that causes severe dizziness or fainting) 10 milligrams (mg - unit of measurement) was administered and documented at the scheduled time. This deficient practice placed Resident 2 at risk for inadequate blood pressure management which can cause hypotension (low blood pressure) and irregular heartbeat. Findings:During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/6/2020 with diagnoses including cerebral palsy (a group of conditions that affect movement and posture), hypotension, and heart failure (a progressive heart disease that affects pumping action of the heart muscles). During a review of Resident 2's Physician Orders, dated 9/25/2020, the Physician Orders indicated midodrine HCl tablet 10 mg three times a day for hypotension. During a review of Resident 2's Care Plan on hypotension, last revised on 1/27/2025, the Care Plan Goal indicated the resident will remain free of complications related to hypotension. The Care Plan Intervention indicated Resident 2 was on midodrine 10 mg three times a day. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 2's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of Resident 2's Medication Administration Audit Report, dated 9/2/2025, the Medication Administration Audit Report indicated on 9/2/2025 at 9:08 a.m., Resident 2 received the midodrine HCl 10 mg tablet. The Medication Administration Audit Report indicated Licensed Vocational Nurse (LVN) 1 documented the medication administration of Resident 2's midodrine HCl 10 mg tablet on 9/2/2025 at 11:08 a.m. (two hours after the medication was administered).During a concurrent observation and interview on 9/2/2025 at 10:44 a.m. with the Director of Staff Development (DSD), observed a white round pill on the hallway floor outside Resident 2's room. The DSD stated the pill had an imprint of L50. The DSD searched for the pill imprint online and stated the medication with an imprint of L50 was a midodrine tablet. The DSD stated the midodrine was used for blood pressure management. The DSD stated the licensed nurse should ensure the residents swallowed the medication given. The DSD stated other residents had the potential to pick up and ingest the medication found on the floor. During a concurrent observation, interview, and record review on 9/2/2025 at 10:50 a.m., Resident 2's Medication Administration Record (MAR) was reviewed with LVN 1. LVN 1 stated a colored red on Resident 2's midodrine HCl 10 mg meant the medication was not given. Observed Resident 2's midodrine HCl 10 mg bubble pack for 9/2/2025 was empty. LVN 1 stated he thought he gave Resident 2's midodrine HCl 10 mg tablet with apple sauce. LVN 1 stated medications given to Resident 2 should be documented before providing care to the next resident. LVN 1 stated Resident 2 had the potential for hypotension that may result in the Resident 2's dizziness and weakness. During an interview on 9/2/2025 at 3:07 p.m. with the Director of Nursing (DON) and a concurrent record review of the facility's policy and procedure (PnP) titled Administering Medications, last reviewed on 5/29/2025, the DON stated LVN 1 should ensure Resident 2's medications were given and documented before providing care to the next resident. The DON stated the facility's PnP indicated medications are administered in a safe and timely manner, and as prescribed. The DON stated the facility's PnP indicated, the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview and record review, the facility failed to ensure a resident's food preference was followed for one of three sampled residents (Resident 1). The facility served Resident 1 with fish that Resident 1 disliked.This deficient practice had the potential to result in decreased meal satisfaction and affect Resident 1's nutritional status. Findings:During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 8/19/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities), and epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]). During a review of Resident 1's Physician Order, dated 8/19/2025, the Physician Order indicated the resident's diet was controlled carbohydrate, no added salt, regular texture, and no fish. During a review of Resident 1's Diet Communication Form, dated 8/19/2025, the Diet Communication Form did not indicate the resident's food preference of no fish as documented in the Physician Order. During a review of the facility-provided Menu, dated 8/18/2025 to 8/24/2025, the Menu indicated on 8/20/2025, the lunch served to the residents included fish. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 8/21/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills were moderately impaired.During an interview on 9/2/2025 at 12:59 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was not aware Resident 1 did not like fish. CNA 1 stated the meal ticket on Resident 1's lunch tray did not indicate the resident's food preference for no fish. CNA 1 stated she placed Resident 1's lunch tray that had fish on the resident's table. CNA 1 stated Family Member (FM) 1 informed her that Resident 1's food preference was communicated to the nursing staff on 8/19/2025, the night the resident was admitted . CNA 1 stated she brought Resident 1's lunch tray back to the kitchen and had the lunch tray replaced. During an interview on 9/2/2025 at 1:21 p.m. and a concurrent record review of Resident 1's medical records, reviewed with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was not aware of the resident's food preference. LVN 2 stated the Physician Order on Resident 1's diet, dated 8/19/2025 at 6:18 p.m. indicated the resident cannot have fish. LVN 2 stated she documented on Resident 1's communication section of the medical records that the resident did not like fish after Resident 1 was served with fish for lunch on 8/20/2025. During an interview on 9/2/2025 at 2:37 p.m. and a concurrent record review of Resident 1's Diet Communication form, dated 8/19/2025, reviewed with the Dietary Supervisor (DS), the DS stated Resident 1's Diet Communication form did not indicate the resident's no fish preference. The DS stated after he spoke to FM 1 about the food preference concerns on 8/20/2025, he documented on the Diet Communication form Resident 1's preferred a no fish and seafood diet. During an interview on 9/2/2025 at 3:07 p.m. and a concurrent record review of Resident 1's medical records, reviewed with the Director of Nursing (DON), the DON stated Resident 1 had a physician order, dated 8/19/2025 (admission date) for no fish diet. The DON stated on 8/20/2025, Resident 1 was served fish for lunch. The DON stated Resident 1's food preference was not communicated to the dietary department. The DON stated the facility failed to ensure Resident 1's food preference was honored.During a review of the facility's policy and procedure (PnP) titled Dietary Profile, last reviewed on 5/29/2025, the PnP indicated a dietary profile will be kept on all residents in the facility. a nutritional profile will include the items listed below . diet order . food and beverage preference . food dislikes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program regarding Coronavirus disease 2019 (COVID-19, a viral infection that is highly contagious and easily transmits from person to person, causing respiratory problems and may cause death) for two of eight sampled facility staff (Licensed Vocational Nurse [LVN] 1 and Certified Nursing Assistant [CNA] 1) by failing to:1.Ensure CNA 1's N95 mask (respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) was worn while inside a COVID-19 isolation room (a set of precautions used to prevent the spread of COVID-19).2. Ensure LVN 1 wore the N95 mask properly while inside the facility. LVN 1's N95 mask was not covering the nose and mouth while at a resident care area. 3. Ensure LVN 1 performed hand hygiene (hand washing with soap and water and use of alcohol-based hand sanitizer) before touching the computer at nurse station 2.These deficient practices placed other residents and staff at risk for exposure and contracting COVID-19.Findings:During an observation on 9/2/2025 at 10:10 a.m., observed CNA 1 came out of Resident 2's room without a N95 mask. During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/6/2020 with diagnoses including cerebral palsy (a group of conditions that affect movement and posture), COVID-19, and heart failure (a progressive heart disease that affects pumping action of the heart muscles).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 2's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of Resident 2's SBAR-Infection form, dated 8/27/2025, the SBAR-Infection form indicated the resident had a positive COVID-19 test result. During an interview on 9/2/2025 at 10:23 a.m. with CNA 1, CNA 1 stated she removed and disposed all the personal protective equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses), including the N95 mask, inside Resident 2's room. CNA 1 stated the N95 mask should be removed, disposed, and replaced outside the COVID-19 isolation room. CNA 1 stated removing the N95 mask inside the COVID-19 isolation room had the potential to expose her and other residents to the infection. During a concurrent observation and interview on 9/2/2025 at 10:50 a.m., observed LVN 1's N95 mask was not worn properly while at nurse station 2. LVN 1's top elastic strap of the N95 mask was not worn over the head. LVN 1's N95 mask was under the chin, not covering LVN 1's nose and mouth. Observed LVN 1 wore his N95 mask and touched the outside part of the mask. LVN 1 did not perform hand hygiene before he touched the computer keyboard at nurse station 2. The Director of Staff Development (DSD) stated the N95 mask should be worn inside the facility and in patient care areas. The DSD stated the nurse stations were considered a patient care area. During an interview on 9/2/2025 at 3:07 p.m. with the Director of Nursing (DON), the DON stated the facility had COVID-19 positive cases. The DON stated N95 masks should be worn while inside the facility and while in patient care areas that included the nurse stations. The DON stated hand hygiene should be done after touching the soiled N95 mask. The DON stated there was potential for the spread of COVID-19 to residents, visitors, and staff. The DON stated the facility failed to follow infection prevention and control protocols. During a review of the facility's policy and procedure (PnP) titled, Personal Protective Equipment, last reviewed on 5/29/2025, the PnP indicated during respiratory outbreak, all staff must wear well-fitted N95 respirators.During a review of the facility's PnP titled, Infection Prevention Quality Control Plan, last reviewed on 5/29/2025, the PnP indicated, employees must wash their hands . after handling soiled equipment or utensils. The PnP indicated employees must perform hand sanitation . after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g. medical equipment).