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	12/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of practice for two of three sampled residents (Resident 1 and Resident 3) by failing to: 1. Ensure licensed nurses monitored Resident 1's medical status after the resident's changes of condition (COC) on 11/15/2025 and 11/29/2025. 2. Ensure Resident 1's physician order for oxygen therapy (O2 therapy - a treatment that provides a person with supplemental or extra oxygen) at two liters per minute was followed. On 1/30/2025, Resident 1's oxygen therapy was at three liters per minute (lpm - unit of measurement). 3. Ensure licensed nurses monitored Resident 3's gastrointestinal (stomach and intestines) status after the resident's COC on 12/4/2025. These deficient practices had the potential to place Resident 1 and Resident 3 at risk for undetected and worsening medical conditions which could negatively impact the residents' health and safety.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/13/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), anemia (condition in which the body does not get enough oxygen-rich blood) and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During an interview on 12/9/2025 at 11:46 a.m. and concurrent record review of Resident 1's medical records, reviewed with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1's Situation, Background, Assessment, and Recommendation (SBAR) Communication Forms indicated the resident had a COC on 1/15/2025 and 1/29/2025. LVN 1 stated on 1/15/2025, Resident 1 had two COCs for low hemoglobin (amount of oxygen-carrying protein in the red blood cells) and hematocrit (percentage of blood volume made up of red blood cells) levels and for a mass on Resident 1's left arm. LVN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that monitoring was done on 1/16/2025 and 1/17/2025, 7 a.m. to 3 p.m. shifts. LVN 1 stated Resident 1's SBAR Communication Form, dated 1/29/2025, indicated the resident had a COC for high blood urea nitrogen (BUN - checks the waste products in the blood to test the kidney function) level, low potassium (a mineral the body needs to work properly), and high ammonia (a waste product from protein breakdown in the blood). LVN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that monitoring was done on 1/29/2025, 3 p.m. to 11 p.m. shift and on 1/30/2025, 7 a.m. to 3 p.m. shift. LVN 1 stated residents should be monitored every shift for 72 hours after a COC. LVN 1 stated Resident 1's medical condition had the potential to be missed and worsen. Resident 1's Physician Orders, dated 1/13/2025, indicated an order for continuous oxygen at two lpm using a nasal cannula (a device used to deliver supplemental oxygen). Resident 1's SBAR Communication Form, dated 1/30/2025, indicated the resident had oxygen at three liters per minute using nasal cannula. LVN 1 stated the licensed nurses did not follow Resident 1's oxygen therapy order. LVN 1 stated Resident 1 had the potential to be over oxygenated that may cause respiratory distress (difficulty breathing). During an interview on 12/9/2025 at 2:57 p.m. with the Director of Nursing (DON), the DON stated Resident 1 should be monitored every shift for at least 72 hours after the resident's COC. The DON stated there was no documented evidence that Resident 1 was monitored on 1/16/2025 and 1/17/2025, 7 a.m. to 3 p.m. shift, after the resident's COC on 1/15/2025. The DON stated there was no documented evidence that Resident 1 was monitored on 1/29/2025, 3 p.m. to 11 p.m. shift, and on 1/30/2025, 7 a.m. to 3 p.m. shift, after the resident's COC on 1/29/2025. The DON stated Resident 1's oxygen therapy was administered at three lpm instead of two lpm. The DON stated not following the physician's oxygen therapy order had the potential to negatively affect the resident's health. The DON stated the facility failed to ensure the licensed nurses monitored and documented Resident 1's condition after the resident's COC. The DON stated the facility failed to ensure Resident 1's physician order on oxygen therapy was followed. During a review of the facility's policy and procedure (PnP) titled, Acute Condition Changes - Clinical Protocol, last reviewed on 5/29/2025, the PnP indicated, The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. During a review of the facility's PnP titled, Oxygen Administration, last reviewed on 5/29/2025, the PnP indicated The purpose of this procedure is to provide guidelines for safe oxygen administration. The PnP indicated verify that there is a physician's order