

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within residents` reach for five (5) of ten sampled residents (Residents 39, 44, 81, 73, and 117) investigated under environment facility task. These deficient practices had the potential to result in the residents` inability to call for assistance when needed, placing the residents at risk for unmet needs, delayed care, accidents, injury, and harm. Findings: 1. During a review of Resident 39's admission Record (AR), the AR indicated that the facility admitted the resident on 2/27/2026, with diagnoses including dysphagia (difficulty swallowing), spinal stenosis (a tunnel inside the spine gets too narrow, cramping the nerves or spinal cord), anxiety disorder (an intense, uncontrollable fear and worry about everyday things), and muscle weakness. During a review of Resident 39's History and Physical (H&P), dated 2/27/2026, the H&P indicated that the resident had the capacity to make needs known but cannot make medical decisions. During a review of Resident 39's Minimum Data Set (MDS-a resident assessment tool), dated 3/02/2026, the MDS indicated the resident had a moderate cognitive impairment but can make needs known. The MDS also indicated that Resident 39 required substantial/maximal assistance with eating, personal hygiene, and was dependent on staff for toileting, bathing, and transferring. During a review of Resident 39's Care Plan (CP), initiated on 3/02/2026, the CP had a focus indicated that the resident had an activities of daily living (ADL &ndash; routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) self-care and/or mobility performance deficit (.). The care plan intervention was to encourage the resident to use the call light/bell to call for assistance. During a concurrent observation and interview on 6/01/2026 at 10:14 a.m. with Licensed Vocational Nurse (LVN 2), inside Resident 39's room, LVN 2 stated that the call light was by the resident's right side of the bed close to her shoulder and was not accessible Resident 39. LVN 2 stated that the call light should have been closer to the resident. LVN 2 stated that it is important for the resident to use the call light to address her needs. LVN 2 further stated that the residents may feel neglected if the call light is not within reach, which also creates safety concerns. During an interview on 6/05/2026 at 11:24 a.m. with the Director of Nursing (DON), the DON stated that call light must always be within residents` reach. The DON stated that the purpose of the call light is to allow residents to request assistance for their needs. The DON stated that the policy was not adhered to if a resident was unable to access the call light. The DON further stated that there will be a delay in care if the call light is not accessible for the residents to use. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Call light, last revised on 9/2022, the P&P indicated that The purpose of this procedure is to ensure timely responses to the resident's requests and needs. (.) 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 2.During a record review of Resident 44's AR, the AR indicated the facility admitted the resident on 1/11/2023, with diagnoses including Alzheimer's Disease, unspecified (a disease characterized by a progressive decline in mental abilities); dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety(problems with memory, thinking and decision-making caused by another medical condition, the severity is not specified, and person also show behavior or mood changes); contracture, unspecified (tight or stiff, making it hard to straighten or move normally). During a review of Resident 44's H&P, dated 5/20/2026, the H&P indicated the resident did not have capacity to make medical decisions. During a review of Resident 44's MDS, dated [DATE], the MDS indicated the resident rarely had the ability to make self-understood and understand others. The MDS further indicated that Resident 44 had severe cognitive impairment (has major problems with thinking, memory, understanding, and may need significant assistance with daily activities and supervision for safety). The MDS indicated that the resident was dependent on staff for mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 44's Quarterly Risk Assessment (QRA), dated 4/15/2026, the QRA indicated that the resident was at risk for falls. During a record review of Resident 44's Care Plan (CP) Report, Focus, titled, Resident 44 is at risk for falls related to mobility, cognitive impairment, incontinence (unable to fully control when urine comes out), on antidepressants revised on 4/19/2026, the CP goal was to have no fall/injury through the next review date. The CP intervention was to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 6/1/2026, at 10:05 a.m., with Certified Nursing Assistant (CNA) 1 inside Resident 44's room, CNA 1 observed call light clipped under the pillow on left side of Resident 44's head. CNA 1 stated Resident 44 would not have been able to call for help because the call light was underneath the pillow on left side and resident had a splint on left hand. During a concurrent interview and record review on 6/4/2026, at 12:23 p.m., with the Minimum Data Set Coordinator (MDSC)1, Resident 44's CPs were reviewed. The MDSC 1 stated residents use the call light to communicate with staff if requesting assistance. The MDSC 1 stated there was a possibility that Resident 44 would not be able to get to the call light because it was under the pillow on the left side and the resident was wearing a splint on left hand. The MDSC 1 stated that when the call light is not within reach there is no way for the resident to call the staff for assistance. The MDSC 1 stated that Resident 44's needs would not be met, and the resident can potentially fall trying to reach for the call light. The MDSC 1 stated Resident 44 does not have the capacity to look for the call light if not within reach. The MDSC 1 reviewed the CP revised on 4/19/2026 and the QRA dated 4/15/2026 indicated resident was at high risk for falls. The MDSC 1 stated the care plan and policy titled, Call Light were not followed. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2026 at 1:00p.m., with the Director of Nursing (DON), the DON stated the purpose of the call light is for the residents to call when they need assistance and if the call light is not within reach, then there will be a delay in care. The DON stated that the call light should be answered in a timely manner and staff need to make sure that the call light is always within reach of residents. The DON stated the policy titled, Call Light was not followed. 3.During a record review of Resident 81's AR, the AR indicated the facility originally admitted Resident 88 on 1/23/2020 and readmitted on [DATE], with diagnoses including metabolic encephalopathy((confusion or changes in thinking caused by a medical problem in the body); schizophrenia, unspecified(a mental illness that is characterized by disturbances in thoughts); depression, unspecified (a condition that causes sadness, loss of interest in activities, low energy, and changes in sleep, appetite, or concentration, can affect a person's feelings, thoughts, and daily activities). During a review of Resident 81's H&P, dated 5/25/2026, the H&P indicated the resident did not have capacity to understand and make decisions. During a review of Resident 81's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood. The MDS further indicated that Resident 81 had severe cognitive impairment (has major problems with thinking, memory, understanding, and may need significant assistance with daily activities and supervision for safety). The MDS indicated that the resident was dependent or required partial/moderate assistance with mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 81's Quarterly Risk Assessment (QRA), dated 5/13/2026, the QRA indicated that the resident was at risk for falls. During a review of Resident 81's Care Plan (CP) Report, Focus, titled Resident 81 is at risk for falls secondary to impaired mobility (difficulty moving around or performing physical activities normally), prefers to stay in bed, requires assistance in self-care and mobility, incontinence, cognitive impairment, use of anti-anxiety medications, use of anti-depressant medications, use of anti-psychotic medications, psychosis (a condition in which a person has trouble telling what is real and what is not) revised on 5/27/2026. The CP indicated a goal that the resident's risk for falls/injuries will be reduced through implementation of safety devices and other interventions. The CP intervention was to maintain call light within reach. During a concurrent observation and interview on 6/1/2026, at 10:20 a.m., with CNA 6 inside Resident 81's room, CNA 6 observed call light on the floor under the bed. CNA 6 stated Resident 81 would not have been able to call for assistance, which could have resulted in an emergency. CNA 6 stated Resident 81 may have attempted to reach the call light, placing them at risk for a fall. During a concurrent interview and record review on 5/13/2026, at 12:23 p.m., with the Minimum Data Set Coordinator (MDSC)1, Resident 81's CP revised 5/27/2026 and the QSA dated 5/13/2026 were reviewed. The MDSC 1 stated Resident 81 was at risk for falls. The MDSC 1stated if the call light was under the bed on the floor, the resident would not have been able to reach the call light, and the resident could have potentially fallen. The MDSC 1 stated the care plan and policy titled, Call Light were not followed. During an interview on 6/5/2026 at 1:00p.m., with the Director of Nursing (DON), the DON stated the (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's call light was accessible and within immediate reach in accordance with facility policy. 5. During a review of Resident 73's AR, the AR indicated the facility admitted the resident on 04/09/2026, with diagnoses including generalized muscle weakness (reduction in muscle strength affecting mobility and daily functioning), unsteadiness on feet (impaired balance increasing the risk for falls), chronic obstructive pulmonary disease (chronic lung disease causing airflow limitation and breathing difficulties), asthma (chronic inflammatory airway disease that can cause wheezing and shortness of breath), dysphagia (difficulty), obesity (excess body), essential hypertension (chronic high blood pressure), lumbar spondylosis with radiculopathy (degenerative spinal condition causing pain, weakness, numbness, and impaired mobility), abdominal wall cellulitis (bacterial infection of the skin and underlying soft tissues of the abdomen), and status post artificial joint replacement (history of surgically replaced joint that may affect mobility and functional independence). During a review of Resident 73's MDS, the MDS indicated that the resident was cognitively intact and able to communicate needs. The MDS further indicated the resident utilized a walker and wheelchair and required staff assistance with transfers, toileting hygiene, bathing, dressing, mobility, and other activities of daily living. During a concurrent observation and interview on 06/01/2026 at 10:15 a.m., inside Resident 73's room with CNA6, the resident's call light was observed hanging on the bedside and was not within the resident's immediate reach. CNA 6 stated that the resident would be unable to call for assistance when needed, which could delay staff response to the resident's needs or emergencies. During an interview on 06/05/2026, the DON, the DON stated that residents' call lights should be within immediate reach at all times to allow residents to request assistance as needed. The DON stated that if a call light is not accessible, the resident may be unable to summon staff for toileting assistance, pain management, emergencies, respiratory concerns, or changes in condition. The DON acknowledged that failure to ensure call light accessibility may place residents at risk for delayed care, unmet needs, falls, injuries, and avoidable adverse outcomes. This practice was not consistent with the facility's expectation for maintaining resident safety and prompt access to assistance. During a review of the facility's P&P, titled Call Light, the P&P indicated the purpose of the procedure is to ensure timely responses to resident requests and needs. The policy further directed staff to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor. The facility failed to ensure the resident's call light was accessible and within immediate reach in accordance with facility policy.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment was free of accident hazards for two (2) of two (2) sampled residents (Resident 93 and Resident 116) reviewed for accidents by failing to: 1. Ensure that no medications were left unattended at Resident 93's bedside. This deficient practice had the risk of accidental ingestion or unsafe medication administration. 2. Promptly identify and remove a puddle of water observed on the floor at the foot of Resident 116's bed. This deficient practice had the potential to result in slips, falls, fractures, head injuries, pain, hospitalization, and other avoidable injuries to residents, staff, and visitors. Findings: a. During a review of Resident 93's admission Record (AR), the AR indicated the facility originally admitted the resident on 10/29/2019, and readmitted on [DATE], with diagnoses including Alzheimer's Disease, unspecified (a disease characterized by a progressive decline in mental abilities); Unspecified dementia, unspecified severity, with other behavioral disturbances (problems with memory, thinking and decision-making caused by another medical condition, the severity is not specified, and person also show behavior or mood changes); neuromuscular dysfunction of bladder, unspecified (the nerves and muscles that control the bladder are not working properly making it difficult to control urination or empty the bladder completely). During a review of Resident 93's History and Physical (H&P) dated 2/2/26, the H&P indicated that the resident was able to make medical decisions. During a review of Resident 93's Minimum Data Set (MDS-a resident assessment tool) dated 4/22/2026, the MDS indicated that Resident 93 was able to make self- understood and had the ability to understand others and had intact cognitive function (normal thinking). The MDS indicated the resident required maximal assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on 6/1/2026, at 10:05 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 93's room, observed an open packet of A&D ointment (is a thick, petroleum jelly containing vitamin A and D, used to protect, soothe dry, or irritated skin) packet on Resident 93's bedside table. CNA 1 stated that an open packet of A&D ointment should not be left at the resident's bedside because they pose an infection control risk and a confused resident may grab it. During an interview on 6/4/2026, at 12:05 p.m., with the Minimum Data Set Coordinator (MDSC) 1, the MDSC 1 stated licensed staff are required to assess the residents to ensure they have the capacity to self-medicate and perform teaching assessment and evaluation to ensure the resident has the knowledge about that medication. The MDSC 1 stated residents need to inform the license nurse when medication was administered. The MDSC 1 stated there needs to be a physician's order, self-administer medication assessment and a care plan for the resident to self-administer medications. The MDSC 1 stated that there was no order for A&D ointment, no assessment or care plan was developed for Resident 93 to self-administer medications. The MDSC 1 stated the A&D ointment was not supposed to be at Resident 93's bedside because there was no assessment performed for the resident to self-medicate and it is unknown how long the A&D ointment package was opened. The MDSC 1 stated Resident 93 can utilize the medication in the wrong way, and there is a risk for another resident to grab it and potentially ingest it. The MDSC 1 stated the policy and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedure (P&P) titled; Self-Administration of Medications was not followed. During an interview on 6/5/2026, at 11:43 a.m., with the Director of Nursing (DON), the DON stated that by leaving medication at Resident 93's bedside without an appropriate assessment the resident might apply to area where they are not supposed to and other residents can get the medication. The DON stated the P&P titled; Self-Administration of Medications was not followed. During a review of the facility's P&P titled, Self-Administration of Medication, revised on 2/2021, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. During a review of the facility-provided A+D Original Ointment, no date, the Information indicated WARNINGS: For external use only, when using this product do not rub on eyes. Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away. b. During a review of Resident 116's AR (Face Sheet), the AR indicated the facility admitted the resident on 05/27/2026, with diagnoses including urinary tract infection (infection affecting the urinary system that may cause pain, confusion, and functional decline), unsteadiness on feet (impaired balance increasing the risk for falls), generalized muscle weakness (reduction in muscle strength affecting mobility and performance of daily activities), type two diabetes mellitus without complications (chronic condition affecting blood sugar regulation), hyperlipidemia (elevated cholesterol levels), depression (mood disorder affecting emotional well-being and functioning), hereditary and idiopathic neuropathy (nerve disorder causing weakness, numbness, pain, and impaired sensation), and essential hypertension (chronic high blood pressure). During a review of Resident 116's MDS, dated [DATE], the MDS indicated that the resident had diagnoses affecting mobility, balance, strength, cardiovascular status, and safety awareness. During a concurrent observation and interview on 06/01/2026 at approximately 09:55 a.m., inside Resident 116's room, with Certified Nursing Assistant 3 (CNA 3), a puddle of water was observed on the floor at the foot of the resident's bed. CNA 3 stated that someone could slip and fall, resulting in injury to residents, staff, or visitors. CNA 3 stated that the puddle created a potential environmental hazard in the resident care area. During an interview on 06/05/2026 at 11:38 a.m., with the Director of Nursing (DON), the DON stated that water on the floor constitutes an environmental hazard and should be removed immediately, or the area should be secured until it can be cleaned. The DON stated that wet floors increase the risk of slips, falls, fractures, head injuries, pain, hospitalization, and other avoidable injuries. The DON acknowledged that maintaining a safe environment free from accident hazards is the facility's responsibility and is consistent with the facility's falls prevention policy. (continued on next page)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to ensure: Residents with a n indwelling catheter (a thin, flexible hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for one of one sampled resident (Resident 93) reviewed for urinary catheter or UTI care area, by failing to ensure the indwelling catheter tubing and bag was not on the floor. The deficient practice had the potential for Resident 93 to develop UTI. Medications were administered in a manner that prevented contamination and maintained infection control standards for one of one sampled resident (Resident 14). This deficient practice had the potential to expose Resident 14 to infectious organisms and contamination, placing the resident at increased risk for infection, medication-related complications, and adverse health outcomes. Findings: a. During a review of Resident 93's admission Record (AR), the AR indicated the facility originally admitted the resident on 10/29/2019, and re-admitted on [DATE], with diagnoses including Alzheimer's Disease, unspecified (a disease characterized by a progressive decline in mental abilities); Unspecified dementia, unspecified severity, with other behavioral disturbances (problems with memory, thinking and decision-making caused by another medical condition, the severity is not specified, and person also show behavior or mood changes); neuromuscular dysfunction of bladder, unspecified (the nerves and muscles that control the bladder are not working properly making it difficult to control urination or empty the bladder completely)." During a review of Resident 93's History and Physical (H&P) dated 2/2/26, the H&P indicated that the resident was able to make medical decisions." "During a review of Resident 93's Minimum Data Set (MDS- a resident assessment tool) dated 4/22/2026, indicated Resident 93 was able to make self- understood and has the ability to understand others and had intact cognitive function (normal thinking). The MDS indicated the resident required dependent to maximal assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene." During a concurrent observation and interview on 6/1/2026, at 2:23 p.m., with Certified Nurse Assistant (CNA) 1, inside Resident 93's room, observed the foley catheter bag (a type of indwelling catheter) and tubing on the floor. CNA 1 stated the foley catheter bag and tubing should not be placed on the floor due to infection control concerns." During an interview on 6/4/2026 at 12:05 p.m., with Minimum Data Set Coordinator (MDSC) 1, the MDSC 1 stated the foley catheter is supposed to be at the lowest part of the bladder and the foley catheter tubing and draining bag is not supposed to be on the floor because the floor is dirty and is high risk for bacteria that can lead to possible UTI. The MDSC 1 stated the policy and procedure (P&P) titled, Catheter Care, Urinary was not followed." ^ During an interview on 6/5/2026 at 11:43 a.m., with the Director of Nursing (DON), the DON stated that by placing the foley catheter tubing and draining bag on the floor, there is a risk for Resident 93 to get an infection such as UTI. The DON stated the P&P titled, Catheter Care, Urinary, was not followed." (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a review of the facility's P&P titled, Catheter Care, Urinary, revised on 8/2022, the P&P indicated, the purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections. Infection Control-Be sure the catheter tubing and draining bag are kept off the floor. b. During a review of Resident 14's AR (Face Sheet), the AR indicated that the facility admitted the resident on 04/11/2025 with diagnoses including anorexia (loss of appetite resulting in inadequate food intake), unilateral primary osteoarthritis of the right hip (degenerative joint disease causing pain, stiffness, and decreased mobility in the right hip), hypothyroidism (underactive thyroid gland resulting in decreased hormone production), schizophrenia (chronic mental disorder affecting thought processes, perception, and behavior), depression (mood disorder characterized by persistent feelings of sadness and loss of interest), anxiety disorder (condition characterized by excessive worry, fear, or nervousness), and benign prostatic hyperplasia (noncancerous enlargement of the prostate gland that may affect urinary function). ^ During a review of Resident 14's MDS, dated [DATE], the MDS indicated that the resident had moderately impaired cognition (decisions poor, cues supervision required). The MDS further indicated that the resident demonstrated deficits in temporal orientation and memory recall. The resident required supervision to partial/moderate assistance with activities of daily living (ADLs), including bathing, dressing, personal hygiene, toileting hygiene, footwear management, transfers, and mobility. The MDS further indicated the resident required supervision and assistance with bed mobility, transfers, ambulation, and toileting activities and utilized a walker for mobility. The residents' diagnoses included schizophrenia, depression, and anxiety disorder, requiring ongoing monitoring, supervision, and assistance with care and medication administration. ^ During an observation on 06/01/2026 at 9:02 a.m., observed Registered Nurse 1 (RN1) administered medications to Resident 14. Resident 14 placed the medications on the bedside table and picked up the pills one at a time using a saliva-moistened index finger before placing each pill into his mouth. RN1 observed the resident handling the medications in this manner and allowed the practice to continue without intervention. RN1 was further observed watching Resident 14 ingest the medications using the saliva-moistened finger. During a concurrent interview immediately following the observation, RN1 stated that Resident 14 had been doing this all the time. ^ During an interview on 06/05/2026 at 11:28 a.m., with the Director of Nursing (DON), the DON stated that medications should be administered in a manner that maintains their integrity and prevents contamination. The DON stated that when a resident handles medications with a saliva-contaminated finger, the nurse should intervene and replace contaminated medications as appropriate. The DON further stated that allowing contaminated medications to be ingested without intervention is not consistent with facility policy, accepted standards of nursing practice, or infection control principles. The DON acknowledged that the observed practice did not ensure safe medication administration. The DON stated staff failed to implement appropriate infection prevention and control measures, placing Resident 14 at risk for infection and other adverse outcomes. ^ ^ During a review of the facility's policy and procedure (P&P), titled Infection Prevention and Control Program, revised October 2018, the policy indicated the facility's infection prevention and control program is established to help prevent the development and transmission of communicable diseases and infections. The policy further indicated staff are to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adhere to accepted infection prevention and control standards and implement measures to prevent contamination and the spread of infection. The observed practice of allowing a resident to handle medications with a saliva-contaminated finger and ingest contaminated medications without intervention was not consistent with the facility's prevention and control policy.^ ^ ^		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the resident's right to be treated with dignity and respect for personal privacy for one randomly observed resident (Resident 39) by failing to ensure the resident's buttocks was not exposed to other residents, staff, and visitors while being transported down the hallway to the shower room. This deficient practice violated the resident's right to be treated with respect and dignity potentially resulting in a decline in the psychosocial well-being of the resident. Findings: During a record review of Resident 39's Face Sheet (FS, admission Record), the FS indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included nondisplaced fracture (broken bone) of second cervical (neck region) vertebra (spine), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), unsteadiness on feet, and muscle weakness. During a review of Resident 39's History and Physical (H&P), dated 2/28/2026, the H&P indicated the resident had the capacity to make needs known but could not make medical decisions. During a record review of Resident 39's Minimum Data Set (MDS, resident assessment tool) dated 3/2/2026, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident was dependent on staff for toileting, bathing, lower body dressing, and mobility with shower transfers. During a review of Resident 39's Care Plan (CP) titled, The resident has an Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) self-care and/or mobility performance deficit., initiated 3/4/2026, the CP indicated the resident had interventions that included to provide privacy during care. During a concurrent observation and interview on 6/2/2026 at 8:40 a.m., with the Medical Records Assistant (MRA), while standing in the main hallway near Nursing Station 1, observed Resident 39 exited her room in a shower chair being pushed by Certified Nursing Assistant (CNA) 4. Observed a sheet was placed over the resident that did not provide full body coverage and the resident's buttocks was visible. Observed the MRA walked down the hallway toward the surveyor and stated Resident 39's buttocks was not fully covered and visible. The MRA stated she (MRA) was sorry and a resident should be fully covered while being transported to the shower. Observed the MRA walk down the hallway to the shower room to speak with CNA 4. During an interview on 6/2/2026 at 9:45 a.m., in the hallway near Nursing Station 1 with CNA 4, CNA 4 stated she (CNA 4) transported Resident 39 to the shower. CNA 4 stated she (CNA 4) must not have fully checked that the resident was covered. CNA 4 stated it was important to fully cover a resident for privacy and to protect them because the resident would not know if they were fully covered or not. During a concurrent interview and record review on 6/5/2025 at 11:25 a.m., in the conference room, with the Director of Nursing (DON), facility policy and procedures (P&P) regarding personal privacy and dignity was reviewed. The DON stated residents have the right to privacy and dignity. The DON stated Residents are covered for privacy while being transported to the shower to respect their right to dignity. The DON stated the facility P&P was not followed when Resident 39's buttocks was visible while being transported to the shower room potentially affecting the resident emotionally. During a review of the facility P&P titled, Confidentiality of Information and Personal Privacy, last reviewed 5/28/2026, the P&P indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. 2. The facility will strive to protect the resident's privacy regarding his or her: . d. personal care. During a review of the facility P&P titled, Dignity, last reviewed 5/28/2026, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During a review of the facility P&P (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Resident Rights, last reviewed 5/28/2026, the P&P 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: privacy.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of staff-to-resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) or mistreatment (inappropriate treatment or exploitation of a resident) immediately, but no later than two (2) hours after the allegation was made to the State Survey Agency (CDPH, California Department of Public Health), the Ombudsman (a resident advocate), and local law enforcement (LLE) in accordance with federal and state law for one of three sampled residents (Resident 25) reviewed under the Abuse care area. This deficient practice had the potential to result in unidentified abuse and mistreatment in the facility and failure to protect Resident 25 and other residents from harm. Findings: During a review of Resident 25's admission Record (AR), the AR indicated the facility originally admitted the resident on 5/6/2025 and most recently admitted the resident on 5/29/2025 with diagnoses that included encounter for orthopedic (involving the musculoskeletal system) aftercare following surgical amputation (removal of a limb or body part), absence of left leg below the knee (BKA - below knee amputation), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD -irreversible kidney failure), and dependence on renal dialysis hemodialysis (HD - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 5/13/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, lower body dressing, and transfer mobility; required substantial/maximal assistance from staff for toileting, upper body dressing, and rolling left to right; required partial/moderate assistance for personal hygiene; and required setup or cleanup assistance with eating. During a review of Resident 25's History and Physical (H&P), dated 5/20/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, At Risk for emotional distress related to alleged mental abuse, initiated on 5/31/2026, the CP indicated a goal that the resident would not exhibit signs and symptoms of psychosocial or emotional distress with interventions that included to encourage the resident to report fear and feelings of anxiety. During a review of Resident 25's CP titled, At Risk for falls and injuries related to . weakness, left BKA., initiated 2/15/2026, the CP indicated a goal that the resident's risk for falls/injuries will be reduced with interventions that included to assess and anticipate resident's toileting needs and body positioning, bilateral grab bars in bed to aid in mobility. During a review of Resident 25's Grievance/Complaint Resolution Report (GR), dated 9/15/2026, the GR indicated on 9/13/2026 Resident 25 expressed dissatisfaction with Certified Nursing Assistant (CNA) 9's approach and communication style and CNA 9 was removed and would no longer be assigned to Resident 25 as per the resident's request. During a review of the Stop and Watch Early Warning Tool (SWT - a written communication tool for reporting early signs in a potential resident change of condition), dated 9/13/2026 and completed by CNA 9, the SWT indicated on 9/13/2025 at about 6:50 p.m. CNA 9 placed Resident 25 on a bedpan and left to assist another resident. The SWT also indicated when CNA 9 returned, Resident 25 was visibly upset and expressed frustration in the delay in response to the call light (CL). The SWT further indicated while CNA 9 provided care to the resident, Resident 25 yelled, You wanted to throw me out of the bed. During an interview on 6/1/2026 at 11:35 a.m., in the hallway outside Resident 25's room, Resident 25 stated that about a year ago CNA 9 attacked him. Resident 25 stated that night he was on the bedpan for over an hour and kept using the CL to call for assistance. Resident 25 stated CNA 9 came into the room angry and was being rough with him and almost pushed him out of the bed. Resident 25 stated he filed a grievance and they removed CNA 9 from his care, but nothing else was ever done. Resident 25 stated he does not trust (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the people in charge because they showed their true faces a year ago. Resident 25 stated the situation with CNA 9 made him feel paranoid and he felt the facility Administrator (ADM) tried to make him the villain. During an interview on 6/4/2026 at 10:20 a.m., with CNA 9, CNA 9 stated she (CNA 9) has cared for Resident 25 twice in the last year. CNA 9 stated sometime last September she was assigned to the resident and she placed him on a bedpan at 6:50 p.m. and she was supposed to go on break at 7 p.m. CNA 9 then stated she left Resident 25 on the bedpan to assist another resident. CNA 9 stated when she returned to the room Resident 25 was screaming and shouting and he had a large bowel movement and she had to change all the bed linens. CNA 9 then stated that while she changed the resident, Resident 25 accused her of trying to push him out of the bed. CNA 9 stated she told Registered Nurse (RN) 4 that Resident 25 was upset, she completed a SWT and reported the incident to the facility Director of Staff Development (DSD), but the DSD no longer works at the facility. CNA 9 then stated that Resident 25 made an allegation of abuse that she (CNA) 9 tried to push him out of the bed. CNA 9 stated she could not remember if she told anyone that Resident 25 alleged she tried to push him out of the bed while she was changing him. CNA 9 stated it was important to make sure allegations are reported to ensure there is an investigation and documentation regarding the allegation. During a concurrent interview and record review on 6/10/2026 at 10:47 a.m. with the Director of Nursing (DON), the DON reviewed the GR, dated 9/15/2026. The DON stated the facility protocol for allegations of abuse is to report all allegations of abuse to CDPH, the ombudsman, and the police, monitor the resident, and suspend the staff member involved pending an investigation. The DON stated Resident 25 had an incident with CNA 9 when she cared for him. The DON stated there was a GR dated 9/15/2026 that indicated Resident 25 had a concern regarding CNA 9's approach and communication style. The DON stated she was not aware Resident 25 alleged that CNA 9 tried to push him out of the bed. The DON stated she (the DON) spoke with CNA 9 after the incident in September and CNA 9 did not mention any allegations of abuse at that time. The DON stated CNA 9 should have reported that Resident 25 alleged she tried to push him out of the bed and she (the DON) would have followed the facility protocol. The DON stated it was important to report and investigate allegations of abuse to protect the safety of the residents and ensure the residents feel safe in the facility. The DON stated Resident 25's allegation should have been reported and investigated and was not, potentially resulting in psychosocial issues in the resident. During a follow-up interview on 6/4/2026 at 11:39 a.m., on the patio, with Resident 25, Resident 25 stated last September CNA 9 went to his room and was upset. Resident 25 stated while CNA 9 changed him, he turned to the right side and CNA 9 was pushing him and he had to hold onto the SR to prevent himself from going further. Resident 25 stated at that time, he felt CNA 9 was trying to harm him. Resident 25 stated the facility leadership did not talk to him about the incident. During a concurrent interview and record review on 6/4/2026 at 4 p.m., in the conference room, with the ADM, reviewed Resident 25's SWT dated 9/15/2026 and the facility policy and procedure (P&P) regarding abuse and stated she (the ADM) was the facility abuse coordinator. The ADM stated the SWT indicates that Resident 25 made an allegation of physical abuse on 9/13/2026 that CNA 9 wanted to throw Resident 25 out of the bed. The ADM stated she (the ADM) was not aware of the allegation because the DSD did not inform the ADM of the SWT. The ADM stated the DSD was responsible for following up on the SWT and the DSD no longer works at the facility. The ADM stated if she had been aware that the SWT indicated you wanted to throw me out of the bed, then she (the ADM) would have followed the facility abuse protocol to immediately report and investigate the allegation, but she did not. The ADM stated the facility P&P was not followed potentially resulting in a negative outcome for the resident with another incident of abuse leading to possible injuries in the resident. During a follow up concurrent interview and record review on 6/5/2026 at 10:14 a.m. in the conference room, with the ADM, the ADM reviewed the P&P regarding abuse reporting and investigating. The ADM stated based on the SWT dated 9/13/2026, Resident 25 made an allegation of abuse that should have been reported immediately or within 2 hours of the allegation but was not, the CNA should have been suspended and was not, the resident should have (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been interviewed and was not, there should have been some documentation of follow-up and there was not, and the physician should have been notified and was not. The ADM stated the facility P&P was not followed. During a review of the facility provided P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed 5/28/2026, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities. 1.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected. the suspicion must be reported immediately to the administrator and to other officials according to state law. 4.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 5. Immediately" is defined as: a. within two hours of an allegation involving abuse or result in physical harm/serious bodily injury; . 7.Notices include, as appropriate: a. the resident's name; b. the resident's room number; c. the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); d. the date and time the alleged incident occurred; e. the name(s) of all persons involved in the alleged incident; and f. what immediate action was taken by the facility. 8. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to implement its policy and procedure (P&P) by failing to thoroughly investigate an allegation of staff-to-resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) or mistreatment (inappropriate treatment or exploitation of a resident) and report the results of the investigation to in accordance with State law, including to the State Survey Agency (CDPH, California Department of Public Health), the Ombudsman (a resident advocate) for one of three sampled residents (Resident 25) reviewed under the Abuse care area. This deficient practice had the potential to result in unidentified abuse and mistreatment in the facility, retaliation from staff, and failure to protect Resident 25 and other residents from harm. Findings: During a review of Resident 25's admission Record (AR), the AR indicated the facility originally admitted the resident on 5/6/2025 and most recently admitted the resident on 5/29/2025 with diagnoses that included encounter for orthopedic (involving the musculoskeletal system) aftercare following surgical amputation (removal of a limb or body part), absence of left leg below the knee (BKA - below knee amputation), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD -irreversible kidney failure), and dependence on renal dialysis hemodialysis (HD - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 5/13/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, lower body dressing, and transfer mobility; required substantial/maximal assistance from staff for toileting, upper body dressing, and rolling left to right; required partial/moderate assistance for personal hygiene; and required setup or cleanup assistance with eating. During a review of Resident 25's History and Physical (H&P), dated 5/20/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, At Risk for emotional distress related to alleged mental abuse, initiated 5/31/2026, the CP indicated a goal that the resident would not exhibit signs and symptoms of psychosocial or emotional distress with interventions that included to encourage the resident to report fear and feelings of anxiety. During a review of Resident 25's CP titled, At Risk for falls and injuries related to . weakness, left BKA., initiated 2/15/2026, the CP indicated a goal that the resident's risk for falls/injuries will be reduced with interventions that included to assess and anticipate resident's toileting needs and body positioning, bilateral grab bars in bed to aid in mobility. During a review of Resident 25's Grievance/Complaint Resolution Report (GR), dated 9/15/2026, the GR indicated on 9/13/2026 Resident 25 expressed dissatisfaction with Certified Nursing Assistant (CNA) 9's approach and communication style and CNA 9 was removed and would no longer be assigned to Resident 25 as per the resident's request. During a review of the Stop and Watch Early Warning Tool (SWT-a written communication tool for reporting early signs in a potential resident change of condition), dated 9/13/2026 and completed by CNA 9, the SWT indicated on 9/13/2025 at about 6:50 p.m. CNA 9 placed Resident 25 on a bedpan and left to assist another resident. The SWT also indicated when CNA 9 returned, Resident 25 was visibly upset and expressed frustration in the delay in response to the call light (CL). The SWT further indicated while CNA 9 provided care to the resident, Resident 25 yelled, You wanted to throw me out of the bed. During an interview on 6/1/2026 at 11:35 a.m., in the hallway outside Resident 25's room, Resident 25 stated about a year ago CNA 9 attacked him. Resident 25 stated that night he was on the bedpan for over an hour and kept using the CL to call for assistance. Resident 25 stated CNA 9 came into the room angry and was being rough with him and almost pushed him out of the bed. Resident 25 stated he filed a grievance and they removed CNA 9 from his care, but nothing else was ever done. Resident 25 stated he doesn't trust the people in charge because they showed their true faces a year ago. Resident 25 stated the situation (continued on next page)		

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 06/05/2026
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with CNA 9 made him feel paranoid and he felt the facility Administrator (ADM) tried to make him the villain. During an interview on 6/4/2026 at 10:20 a.m., with CNA 9, CNA 9 stated she (CNA 9) has cared for Resident 25 twice in the last year. CNA 9 stated sometime last September she was assigned to the resident and she placed him on a bedpan at 6:50 p.m. and she was supposed to go on break at 7 p.m. CNA 9 then stated she left Resident 25 on the bedpan to assist another resident. CNA 9 stated when she returned to the room Resident 25 was screaming and shouting and he had a large bowel movement and she had to change all the bed linens. CNA 9 then stated that while she changed the resident, Resident 25 accused her of trying to push him out of the bed. CNA 9 stated she told Registered Nurse (RN) 4 that Resident 25 was upset, she completed a SWT and reported the incident to the facility Director of Staff Development (DSD), but the DSD no longer works at the facility. CNA 9 then stated that Resident 25 made an allegation of abuse that she (CNA) 9 tried to push him out of the bed. CNA 9 stated she could not remember if she told anyone that Resident 25 alleged she tried to push him out of the bed while she was changing him. CNA 9 stated it was important to make sure allegations are reported to ensure there is an investigation and documentation regarding the allegation. During a concurrent interview and record review on 6/10/2026 at 10:47 a.m. with the Director of Nursing (DON), the DON reviewed the GR, dated 9/15/2026. The DON stated the facility protocol for allegations of abuse is to report all allegations of abuse to CDPH, the ombudsman, and the police, monitor the resident, and suspend the staff member involved pending an investigation. The DON stated Resident 25 had an incident with CNA 9 when she cared for him. The DON stated there was a GR dated 9/15/2026 that indicated Resident 25 had a concern regarding CNA 9's approach and communication style. The DON stated she was not aware Resident 25 alleged that CNA 9 tried to push him out of the bed. The DON stated she (the DON) spoke with CNA 9 after the incident in September and CNA 9 did not mention any allegations of abuse at that time. The DON stated CNA 9 should have reported that Resident 25 alleged she tried to push him out of the bed and she (the DON) would have followed the facility protocol. The DON stated it was important to report and investigate allegations of abuse to protect the safety of the residents and ensure the residents feel safe in the facility. The DON stated Resident 25's allegation should have been reported and investigated and was not, potentially resulting in psychosocial issues in the resident. During a follow-up interview on 6/4/2026 at 11:39 a.m., on the patio, with Resident 25, Resident 25 stated last September CNA 9 went to his room and was upset. Resident 25 stated while CNA 9 changed him, he turned to the right side and CNA 9 was pushing him and he had to hold onto the SR to prevent himself from going further. Resident 25 stated at that time, he felt CNA 9 was trying to harm him. Resident 25 stated the facility leadership did not talk to him about the incident. During a concurrent interview and record review on 6/4/2026 at 4 p.m., in the conference room, with the ADM, reviewed Resident 25's SWT dated 9/15/2026 and the facility policy and procedure (P&P) regarding abuse and stated she (the ADM) was the facility abuse coordinator. The ADM stated the SWT indicates that Resident 25 made an allegation of physical abuse on 9/13/2026 that CNA 9 wanted to throw Resident 25 out of the bed. The ADM stated she (the ADM) was not aware of the allegation because the DSD did not inform the ADM of the SWT. The ADM stated the DSD was responsible for following up on the SWT and the DSD no longer works at the facility. The ADM stated if she had been aware that the SWT indicated you wanted to throw me out of the bed, then she (the ADM) would have followed the facility abuse protocol to immediately report and investigate the allegation, but she did not. The ADM stated the facility P&P was not followed potentially resulting in a negative outcome for the resident with another incident of abuse leading to possible injuries in the resident. During a follow up concurrent interview and record review on 6/5/2026 at 10:14 a.m. in the conference room, with the ADM, the ADM reviewed the P&P regarding abuse reporting and investigating. The ADM stated based on the SWT dated 9/13/2026, Resident 25 made an allegation of abuse that should have been reported immediately or within 2 hours of the allegation but was not, the CNA should have been suspended and was not, the resident should have been interviewed and was not, there should have been some documentation of follow-up and there (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not, and the physician should have been notified and was not. The ADM stated the facility P&P was not followed. During a review of the facility provided P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed on 5/28/2026, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected. the suspicion must be reported immediately to the administrator and to other officials according to state law. 8. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations. 1. All allegations are thoroughly investigated. The administrator initiates investigations. 2. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. 3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator. or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; J. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: d. Witness statements are obtained in writing, signed and dated. 9. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participate in the review process. a. If the ombudsman declines the invitation to participate in the investigation, that information is noted in the investigation record. b. The ombudsman is notified of the results of the investigation as well as any corrective measures taken. Reporting Results of Investigations. l. The administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 3) had a preadmission screening and annual resident review (PASARR a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level II care plan to personalize the special needs of the resident. This deficient practice placed the residents at risk of not receiving necessary care and/or delay of services that residents need. Findings: During a review of Resident 3's admission Record (AR), the AR indicated that the facility originally admitted the resident on 6/25/2024, and readmitted on [DATE], with diagnoses including multiple sclerosis (MS - a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), functional quadriplegia (a functional paralysis from neck down, including legs, and arms, usually due to a spinal cord injury), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), depression (a mood disorder that causes persistent feeling of sadness and loss of interest), muscle wasting and atrophy (the wasting away or shrinking of a body part, tissue or organ). During a review of Resident 3's History and Physical (H&P), dated 2/06/2026, the H&P indicated that the resident had the capacity to make needs known but cannot make medical decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 5/02/2026, the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired) and was dependent (requiring assistance) to staff for all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) and transferring. During a review of Resident 3's Preadmission Screening and Resident Review dated 2/06/2026, the PASARR review indicated that the facility staff will receive this PASARR Individual Determination Report, will discuss the results (.) in a timely manner, and will incorporate the determination into (.) care plan. During a concurrent interview and record review on 6/3/2026 at 9:30 a.m. with Minimum Data Set Coordinator 1 (MDSC 1), the MDSC 1 stated that PASARR is an evaluation to see what residents' needs are and based on the assessment, a determination can be made whether a resident will need a Level II evaluation. The MDSC 1 stated Resident 3 had a positive level two and required to complete a Level II evaluation. The MDSC 1 stated that Resident 3 had a positive Level II and stated that the resident did not have a care plan specific to the PASARR Level II recommendations. The MDSC 1 stated that as part of the personalized plan of care for the resident is to ensure that the facility is providing all the interventions needed like social, behavioral and emotional support to the resident. During an interview on 6/05/2026 at 11:35 a.m. with the Director of Nursing (DON), the DON stated that care plan should be developed for residents with PASARR Level II to ensure the facility can provide appropriate interventions. The DON stated that the process should be completed within 48 hours of admission. The DON stated that absence of a care plan can delay any interventions needed specifically tailored for residents' needs. The DON stated that when there is a delay in specific interventions, it could affect the mental or psychosocial wellbeing of the resident. During a review of the facility's Policy and Procedures (P&P) titled, admission Criteria, revised on 3/2019, the P&P indicate Our facility admits only residents who's medical and nursing care needs can be met. (.) 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) for the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RB. If the level I screen indicated that the individual may meet the criteria for a MD, ID, OR RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure residents who had a positive Level 1 Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) received the required Level II PASARR evaluation and determination for one of two sampled residents (Resident 11) investigated under the PASARR care area by failing to resubmit a Level 1 Screening after Resident 11's case was closed due to the facility staff were unresponsive to two or more separate attempts of communication within 48 hours of a Level I Screening. This deficient practice had the potential to result in a delay of specialized care and services for Resident 11. Findings: During a review of Resident 11's Face Sheet (FS, admission Record), the FS indicated the facility admitted the resident on 3/3/2026 with diagnoses including unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities), and falling. During a review of Resident 11's History and Physical (H&P) dated 3/3/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool), dated 3/8/2026, the MDS indicated the resident rarely/never had the ability to make herself understood and sometimes understood others. The MDS indicated the resident was dependent on staff for eating, toileting hygiene, shower/bathe self, dressing, and personal and oral hygiene. The MDS indicated the resident was taking antipsychotic medication (used to manage psychosis). During a review of Resident 11's PASARR Level I Screening, dated 3/13/2026, the PASARR Level I Screening indicated a result of positive for serious mental illness (SMI). During a review of Resident 11's Notice of PASARR Level I Screening Results letter, dated 3/13/2026, the Notice of PASARR Level I Screening Results letter indicated Resident 11's positive Level I Screening required a SMI Level II Mental Health Evaluation and the facility would be contacted within two to four days to set up an appointment for an evaluator to conduct an evaluation involving thorough review of the resident's records and may include a telephone contact or visit. The letter further indicated that once the evaluation was completed the resident would receive a report providing recommendations for specialized services. During a review of Resident 11's Notice of Attempted Evaluation letter, dated 3/15/2026, the Notice of Attempted Evaluation letter indicated the facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening and the case was closed. The letter further indicated to reopen the case, the facility must resubmit a new Level I Screening. During a review of Resident 11's Care Plan (CP) titled, The resident has psychosis, initiated 3/9/2026, the CP indicated a goal that staff would anticipate and meet the resident's needs. During a concurrent interview and record review on 6/3/2026 at 9:18 a.m., in the conference room, MDS Coordinator (MDSC) 1 reviewed Resident 11's Notice of PASARR Level I Screening Results letter dated 3/13/2026 and Notice of Attempted Evaluation letter dated 3/15/2026. The MDSC 1 stated the Positive Level I PASARR Screening process is that an evaluator will call the facility requesting additional information like the resident's diagnosis and level of function to determine if there will be an onsite evaluation. The MDSC 1 stated Resident 11 had a positive Level I Screening indicating the resident had a possible SMI and required an evaluation to determine the most appropriate services for the resident's plan of care. The MDSC 1 stated the facility received a letter indicating that the case was closed because the facility staff did not respond. The MDSC 1 stated when the letter was received, one of the licensed nurses (LN) that have access to the PASARR system should have resubmitted the Level 1 Screening, but it was not done. The MDSC 1 stated she (MDSC 1) was one of the LNs that could have resubmitted, but she (MDSC 1) was not aware of the Notice of Attempted Evaluation letter. MDSC 1 stated when a Level 1 Screening was not resubmitted it could potentially result in the facility not meeting the psychological needs of Resident 11 affecting the resident's psychosocial wellbeing. During a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent interview and record review on 6/5/2026 at 11:25 a.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding PASARR. The DON stated the facility PASARR process is to provide established interventions after a Level II Evaluation. The DON stated the facility P&P was not followed when the facility did not follow up regarding Resident 11's Notice of Attempted Evaluation letter potentially resulting in a delay of specific interventions for mental, emotional, and psychosocial care for Resident 11. During a review of the facility's P&P titled, admission Criteria, last reviewed on 5/28/2026, the P&P indicated, Our facility admits only residents whose medical and nursing care needs can be met. I. The objectives of our admission criteria policy are to: . admit residents who can be cared for adequately by the facility. 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) was revised for one of two sampled residents (Resident 9) reviewed during the Respiratory care area and one of one sampled residents (Resident 2) reviewed during the Comm-Sensory care area by failing to: 1.Ensure the CP for Resident 9's use of supplemental oxygen (O2) reflected the physician's order for continuous O2 at four (4) liters per minute (LPM, a measurement of flow rate). 2.Ensure that Resident 2's CP reflected the resident's correct Primary language. This deficient practice had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives and a potential for delay of necessary care and services to Resident 9 and Resident 2. Findings: a. During a review of Resident 9's Face Sheet (FS - admission record), the FS indicated the facility originally admitted the resident on 2/24/2026, and most recently admitted the resident on 5/14/2026, with diagnoses that included chronic myelomonocytic leukemia (CMML - a blood cancer), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), and pulmonary embolism (PE - a blood clot that blocks and stops blood flow to the lung). During a review of Resident 9's History and Physical (H&P), dated 2/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS - resident assessment tool), dated 3/3/2026, the MDS indicated the resident had the ability to understand others and had the ability to make herself understood. The MDS further indicated the resident received continuous O2 therapy while a resident in the facility. During a review of Resident 9's Physician Order Summary Report, the Physician Order Summary Report indicated the following order: - Observe for continuous O2 at 4 LPM via nasal cannula (NC, a thin, flexible tube with two prongs that delivers supplemental O2 to a resident's nose every shift for a diagnosis of COPD, dated 5/11/2026. During a review of Resident 9's Care Plan (CP) titled, The resident has oxygen therapy related to COPD, chronic respiratory failure. on continuous O2 at 4 LPM NC, initiated 5/11/2026, the CP indicated a goal that the resident will have no signs or symptoms of poor oxygen absorption with interventions that included an O2 setting at two (2) LPM via NC continuously. During an observation on 6/1/2026 at 9:18 a.m., observed Resident 9 lying in bed and administered O2 at two (2) LPM via NC. Resident 9 stated she (Resident 9) needed O2 24 hours of every day. During an observation on 6/2/2026 at 8:30 a.m., observed Resident 9 lying in bed being administered O2 at 2 LPM via NC. During a concurrent observation, interview, and record review on 6/2/2026 at 8:51 a.m., in the hallway (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at Nursing Station 1, with Registered Nurse (RN) 3, Resident 9's physician orders and CPs were reviewed. RN 3 stated the resident has a physician's order for continuous O2 at 4 LPM and the resident should be administered O2 at 4 LPM. Observed RN 3 entered Resident 9's room and stated the resident had O2 administered at 2 LPM via NC. RN 3 stated she would assess the resident and correct the concentrator setting. RN 3 then reviewed Resident 9's CPs O2 administration and stated the O2 CP intervention indicated for oxygen to be set to a flow rate of 2 LPM. RN 3 stated the CP intervention was not correct and did not match the physician's order. RN 3 stated the CP should indicate a flow rate of 4 LPM and did not. During a concurrent interview, and record review on 6/3/2026 at 7:41 a.m., in the conference room, with MDS Coordinator (MDSC) 1, Resident 9's physician orders and CPs were reviewed. The MDSC 1 stated CPs are a communication tool between the facility staff that includes a resident focus problem, the goals for that problem, and the interventions to implement to achieve the goals. The MDSC 1 stated CPs are customized depending on the individual needs of the resident because every resident is different and the approach should be different. The MDSC 1 stated Resident 9 had a physician's order for O2 at 4 LPM via NC and the CP should indicate 4 LPM. The MDSC 1 stated when Resident 9's CP indicated 2 LPM, it was not an appropriate intervention for the resident, and the CP should have been revised but was not. The MDSC 1 stated when Resident 9's CP was not revised to reflect the physician's order of 4 LPM there was the potential to cause confusion leading to the resident not being administered the correct flow rate for supplemental O2. During a concurrent interview and record review on 6/5/2026 at 11:25 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding O2 administration and CPs. The DON stated CPs are used as a reference for the interventions to implement for resident care. The DON stated when Resident 9's CP did not indicate the correct amount of LPM for supplemental O2 there was the potential that the resident would not be administered the correct flow rate resulting in a change of condition in the resident leading to respiratory failure. The DON stated the P&Ps were not followed. During a review of the facility P&P titled, Oxygen Administration, last reviewed 5/28/2026, the P&P indicated. The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. During a review of the facility P&P titled, Care Plans Comprehensive, last reviewed 5/28/2026, the P&P 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. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 2's admission Record (AR), the AR indicated that the facility admitted the resident on 3/1/2026, with diagnoses including metabolic encephalopathy (change in how your brain works due to an underlying condition), muscle weakness generalized (overall, whole-body lack of physical strength), and adult failure to thrive (failing to grow or function at an expected physical or cognitive rate). During a review of Resident 2's H&P, dated 3/1/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident's preferred language was Arabic. During a review of Resident 2's Care Plan (CP) Report titled, Resident 2 has a communication problem r/t (related to) cognitive impairment and language barrier, last revised 3/16/2026, the CP indicated the resident speaks Farsi. During an interview on 6/2/2026 at 8:59 a.m. with Resident 2's Family Member (FM), FM stated that the resident only speaks Arabic and not Farsi. During an interview on 6/2/2026 at 2:45 p.m. with Certified Nurse Assistant (CNA) 8, CNA 8 stated Resident 2 speaks Arabic. Resident 2's care plan did not indicate the resident's correct language, which could negatively affect the resident's care and treatment. During an interview on 6/4/2026 at 11:47 a.m. with the MDSC 1, the MDSC 1 1 stated that care plans must be personalized, goal oriented, and listing the wrong language can cause miscommunication about a resident's care and treatment. During an interview on 6/5/2026 at 11:57 a.m. with the DON, the DON stated care plans must be individualized and accurately document the resident's language; listing Farsi instead of Arabic for Resident 2 could lead to miscommunication and improper care interventions. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, care plans must be updated and revised. During a review of the facility's P&P titled, Charting and Documentation, dated July 2017, the P&P indicated, medical records will be accurate.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation and interview, the facility failed to ensure residents who were incontinent of bladder received services and assistance for one of one sampled resident (Resident 113) by failing to ensure Resident 113's urinal bottle (a portable, handheld container designed to collect urine) was labeled with the name of the resident. This deficient practice had the potential for Resident 113's urinal bottle to be contaminated (making a substance, surface, or place dirty, impure, or hazardous by introducing a harmful, unwanted, or foreign material) which may lead to development of urinary tract infection (UTI, a common infection that occurs when bacteria enter and multiplies in the urinary system, which includes the kidneys, bladder, and urethra). Findings: During a review of Resident 113's admission Record, the AR indicated the facility admitted the resident on 5/31/2026, with diagnoses including muscle weakness (Generalized) (weakness in many muscles throughout the body); chronic kidney disease, Stage 4 (Severe) (a condition that developed over time where kidneys are severely damaged and most of their function is lost being unable to clean waste and extra fluid from the blood); benign prostatic hyperplasia without lower urinary tract symptoms (the prostate gland is enlarged but it is not causing any urinary problems). During a review of Resident 113's History and Physical (H&P) dated 6/1/26, the H&P indicated the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 6/1/2026, at 10:43 p.m., with Registered Nurse (RN) 2 inside Resident 113's room, observed urinal was not labeled. RN 2 stated it is important to label urinals, so it does not get mixed up with other residents' urinals and for infection control purposes. RN 2 threw the urinal away, got a new one and labeled it with the resident's name. During an interview on 6/4/2026, at 10:33 a.m., with Certified Nurse Assistant (CNA) 10, CNA 10 stated that when a urinal is given to residents, the staff member writes patient's name on urinal. CNA 10 stated if the urinal does not have a name, then it can get mixed up with the other residents' urinal and the resident can get an infection such as UTI. During an interview on 6/4/2026, at 12:35 p.m., with the Minimum Data Set Coordinator (MDSC) 1, the MDSC stated that when a urinal is given to a resident the name of resident is written on the urinal and the urinal is changed as needed. The MDSC 1 stated that when a urinal does not have a name it can be misplaced, other residents can use it and there is a risk for infection like UTI or skin infection. The MDSC 1 stated that if the urinal has no name, it should be disposed and a new one should be given. During an interview on 6/5/2026, at 11:43 a.m., with the Director of Nursing (DON), the DON stated that if the urinal does not have the residents' name the urinal could potentially be used by other residents, resulting in cross-contamination and placing residents at risk for infections such as UTI. During a review of the facility's P&P titled, Cleaning and Disinfecting Non-Critical Resident-Care Items dated 2001, the P&P indicated the purpose of this procedure is to provide guidelines for disinfection of non-critical resident care items. General Guidelines 1. Discard resident-care items when damaged or so grossly soiled that a disinfection process is not effective in rendering the item clean. 2. Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure the water flush bag was labeled with the correct information for one of one sampled resident (Resident 47). This failure had the potential to cause fluid overload (body holds onto more water than it can manage) or dehydration (body loses or uses more fluids than it takes in) to the resident. Findings: During a review of Resident 47's admission Record (AR), the AR indicated the facility admitted the resident on 12/29/2024, with diagnosis of hemiplegia (the severe or complete loss of motor function on one side of the body) and hemiparesis (weakness or partial paralysis affecting only one side of the body) following cerebral infarction (supply of blood to the brain becomes blocked, cutting off oxygen and vital nutrients) affecting left non-dominant side, muscle weakness generalized (an overall, whole-body reduction in physical strength), and encounter for attention to gastrostomy (a routine medical visit for the routine care, cleaning, or changing of a feeding tube). During a review of Resident 47's History and Physical (H&P), dated 12/29/2026, the H&P indicated the resident was alert with periods of confusion. During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2026, the MDS indicated the resident was rarely/never understood and was dependent with activities of daily living (ADL). During a review of Resident 47's physician order, dated 4/1/2026, the order indicated for the resident to receive 80 milliliters per hour (mL/hr) of water. During a review of Resident 47's physician order, the physician order indicated for the resident to receive 60 mL/hr of Diabetisource (type of tube feeding). During an observation on 6/1/2026 at 9:44 a.m. inside Resident 47's room, a flush bag hanging from a pole with clear liquid, had a label that indicated the bag was filled with Diabetisource. During an interview on 6/3/2026 at 1:42 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the flush bag label should include the rate, time, and date, and must state water instead of Diabetisource. LVN1 stated using Diabetisource on the water bag label is confusing and may lead to errors. During an interview on 6/5/2026 at 12:16 p.m. with the Director of Nursing (DON), the DON stated the flush bag was incorrectly labeled as Diabetisource instead of water, which could cause confusion and possible errors in administering the correct rates for water. This error could potentially affect Resident 47's water intake. Licensed nurses are responsible for proper labeling, but facility policy was not followed, and expectations were not met. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding via Continuous Pump, dated November 2018, the P&P indicated to ensure the safe administration of enteral nutrition.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care are provided care consistent with professional standards of practice for two of two sampled residents (Resident 9 and 114) reviewed under the Respiratory care area by failing to: 1.Ensure oxygen (O2) was administered per physician orders at four (4) liters per minute (LPM, a measurement of flow rate) to Resident 9 on 6/1/2026 and 6/2/2026. 2.Ensure O2 was administered per facility policy and procedure (P&P) with a physician's order and monitored while in use for Resident 114. These deficient practices had the potential to place residents at risk for respiratory distress with a delay in necessary care and treatment. Findings: 1.During a review of Resident 9's Face Sheet (FS - admission record), the FS indicated the facility originally admitted the resident on 2/24/2026 and most recently admitted the resident on 5/14/2026, with diagnoses that included chronic myelomonocytic leukemia (CMML - a blood cancer), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), and pulmonary embolism (PE - a blood clot that blocks and stops blood flow to the lung). During a review of Resident 9's History and Physical (H&P), dated 2/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS - resident assessment tool), dated 3/3/2026, the MDS indicated the resident had the ability to understand others and had the ability to make herself understood. The MDS further indicated the resident received continuous O2 therapy while a resident in the facility. During a review of Resident 9's Physician Order Summary Report, the Physician Order Summary Report indicated the following order: - Observe for continuous O2 at 4 LPM via nasal cannula (NC, a thin, flexible tube with two prongs that delivers supplemental O2 to a resident's nose) every shift for a diagnosis of COPD, dated 5/11/2026. During a review of Resident 9's Care Plan (CP) titled, The resident has oxygen therapy related to COPD, chronic respiratory failure. on continuous O2 at 4 LPM NC, initiated 5/11/2026, the CP indicated a goal that the resident will have no signs or symptoms of poor oxygen absorption. During an observation on 6/1/2026 at 9:18 a.m., observed Resident 9 lying in bed and administered O2 at two (2) LPM via NC. Resident 9 stated she (Resident 9) needed O2, 24 hours of every day. During an observation on 6/2/2026 at 8:30 a.m., observed Resident 9 lying in bed being administered O2 at 2 LPM via NC. During a concurrent observation and interview on 6/2/2026 at 8:48 a.m., inside Resident 9's room, observed Certified Nursing Assistant (CNA) 7 entered Resident 9's room and stated she (CNA 7) often cares for Resident 9 and the resident is usually on O2 via NC at 4 LPM. CNA 7 observed the O2 concentrator (device that delivers supplemental O2) and stated the resident was administered O2 at 2 LPM. CNA 5 stated the licensed nurse knows more about the resident's use of O2. During a concurrent observation, interview, and record review on 6/2/2026 at 8:51 a.m., in the hallway at Nursing Station 1, with Registered Nurse (RN) 3, Resident 9's physician orders were reviewed. RN 3 stated the resident has a physician's order for continuous O2 at 4 LPM and the resident should be administered O2 at 4 LPM. RN 3 stated she (RN 3) had been in Resident 9's room earlier and did not check the O2 concentrator setting for O2 flow rate. Observed RN 3 entered Resident 9's room and stated the resident had O2 administered at 2 LPM via NC. RN 3 stated she (RN 3) would assess the resident and correct the concentrator setting. During a concurrent interview and record review on 6/5/2026 at 11:25 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding O2 administration. The DON stated supplemental O2 is a treatment that requires a physician's order that includes the flow rate in LPM. The DON stated the P&P was not followed when Resident 9's O2 via NC was not administered per the physician's orders potentially resulting in a change of condition in the resident leading to respiratory failure. During a review of the facility P&P titled, Oxygen Administration, last reviewed 5/28/2026, the P&P indicated. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed. Steps in the Procedure. 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. b. During a review of Resident 114's FS, the FS indicated the facility originally admitted the resident on 11/6/2021 and most recently admitted the resident on 5/25/2026, with diagnoses that included acute respiratory failure with hypoxia, pulmonary edema (buildup of fluid in the lungs), PE, and interstitial pulmonary disease (a term for a group of conditions that cause inflammation and scarring in the lungs). During a review of Resident 114's H&P, dated 5/27/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 114's Physician Order Summary Report, the Physician Order Summary Report indicated the following completed order: - Initial application of oxygen at 2 LPM via NC for continuous use, one time only for respiratory failure, for one day, ordered 5/25/2026, completed date 5/26/2026. During a review of Resident 114's Baseline CP, initiated 5/25/2026, the CP indicated the resident was on continuous oxygen while a resident in the facility. During an observation on 6/1/2026 at 10:17 a.m., observed Resident 114 lying in bed and administered O2 at 2 LPM via NC. Family Member (FM) 1 stood at bedside and stated Resident 114 wasn't always on supplemental O2, but the resident needs it now. During an interview on 6/2/2026 at 9:24 a.m., in the hallway outside Resident 114's room, CNA 5 stated Resident 114 has been on supplemental O2 since admission. During a concurrent interview, and record review on 6/2/2026 at 9:27 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 114's physician orders, medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), and Progress Notes were reviewed. LVN 3 stated oxygen is considered a medication and requires a physician's order to administer. LVN 3 stated it was important to obtain a physician's order for O2 because if a resident was on O2 without an order it may be considered a change of condition that should be reported to the physician. LVN 3 stated residents that are administered O2 should be monitored for effectiveness and side effects. LVN 3 stated Resident 114 was admitted on [DATE] on continuous O2 at 2 LPM via NC and did not have an active physician's order for O2 administration from 5/26/2026 to 6/1/2026. LVN 3 then reviewed Resident 114's Weights and Vitals Summary and noted the resident was administered O2 without a physician's order or monitoring on the following dates and times: - On 5/28/2026 at 12:16 a.m., Resident 114's O2 Sat was 97.0% on Oxygen via NC. - On 5/29/2026 at 1:04 p.m., Resident 114's O2 Sat was 96.0% on Oxygen via NC. - On 5/31/2026 at 1:01 a.m., Resident 114's O2 Sat was 96.0% on Oxygen via NC. - On 6/1/2026 at 1:15 a.m., Resident 114's O2 Sat was 96.0% on Oxygen via NC. LVN 3 further stated Resident 114 should have had an order to administer O2 between 5/26/2026 and 6/1/2026 and did not. During a concurrent interview, and record review on 6/3/2026 at 7:41 a.m., in the conference room, with the MDS Coordinator (MDSC) 1, Resident 114's physician orders, MAR, and CPs were reviewed. The MDSC 1 stated O2 use requires an active physician's order during the treatment. The MDSC 1 stated it was important to have a physician's order because the order is the communication between the physician and the nursing staff to ensure that treatments are administered per the physician's indications. The MDSC 1 stated Resident 114 had a completed order to initiate O2 administration on 5/25/2026, but there were no physician's orders to continue the administration of O2 between 5/26/2026 and 6/1/2026 but there should have been. The MDSC 1 stated there was no documented evidence that Resident 114 was monitored while on O2 between 5/26/2026 and 6/1/2026 but there should have been. The MDSC 1 stated when Resident 114 was administered O2 without a physician's order or monitoring there was the potential that the resident could have a negative outcome when the need for supplemental O2 resulted in an unidentified change (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of condition leading to hospitalization of the resident. During a concurrent interview and record review on 6/5/2026 at 11:25 a.m., with the DON, the DON reviewed the facility policy and procedures (P&P) regarding O2 administration. The DON stated supplemental O2 is a treatment that requires a physician's order and monitoring. The DON stated the P&P was not followed when Resident 114's O2 via NC was not administered per the physician's orders and monitored potentially resulting in a change of condition in the resident leading to respiratory failure. During a review of the facility P&P titled, Physician Orders, last reviewed 5/28/2026, the P&P indicated. Verbal, written and telephone orders may be accepted from each resident's Attending Physician. 1. Verbal, written and telephone orders may only be received by licensed personnel (e.g., RN, LPN/LVN, pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3. The receiving nurse with order/s will carry out the order and print the medication or treatment record/s. 4. New order/s will be communicated to the responsible party/agent, charge nurse, pharmacy, other department/s as indicated. During a review of the facility P&P titled, Oxygen Administration, last reviewed 5/28/2026, the P&P indicated. The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed. Assessment. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); Vital signs; Lung sounds; Arterial blood gases and oxygen saturation, if applicable; and Other laboratory results. Steps in the Procedure. 8. Turn on the oxygen. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure one of two food scoopers (used to scoop dry goods food) were clean. This failure had the potential to for the food scooper to carry harmful germs, bacteria, or chemical residues which can contaminate the residents' meals and increase the rise of foodborne illness to the residents. Findings: During a concurrent observation and interview on 6/1/2026 at 8:06 a.m. in the kitchen with the Dietary supervisor, there were one of two food scoopers on top of a food preparation table that had a white residue. Dietary Supervisor (DS) stated this food scooper must be cleaned after each use to prevent contamination risk to the residents. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated the utensils shall be kept clean.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete clinical records in accordance with accepted professional standards and practices for one of three sampled residents (Resident 110) reviewed during the closed records (death) task by failing to ensure Registered Nurse (RN) 2 documented the vital sign numeric values (measurements of the body's most basic functions including temperature [Temp], blood pressure [BP], heart rate [HR/pulse] and respiratory rate [RR], and oxygen saturation level [O2 sat- a measurement of how much oxygen the blood is carrying as a percentage]) for the night shift (11 p.m. to 7 a.m.) on [DATE]. This resulted in an incomplete documentation in Resident 110's medical chart. Findings: During a review of Resident 110's Face Sheet (FS, admission Record), the FS indicated the facility admitted the resident [DATE] with diagnoses including displaced fracture of right femur (hip fracture), presence of right artificial hip joint, essential (primary) hypertension (high blood pressure with an unknown cause), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots [clumps that occur when blood hardens from a liquid to a solid] in the heart), pleural effusion (PE, a collection of fluid around the lungs), and acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), and mesothelioma (cancer that forms in the thin tissue that lines many of your internal organs). During a review of Resident 110's Admission/readmission Initial Assessment (AIA) dated [DATE], the AIA indicated the resident arrived at the facility on [DATE] at 1:15 p.m. by ambulance and was oriented (a person's awareness) to person, place, time, and was able to follow simple commands with intermittent confusion. The AIA indicated the resident was able to understand others and make himself understood. During a review of Resident 110's Progress Note, dated [DATE] at 5 a.m., and completed by RN 2, the Progress Note indicated the following: -During routine rounds at 11:00 p.m., resident was observed lying in bed, breathing spontaneously with no signs or symptoms of respiratory distress noted. Vital signs assessed and within normal limits. At 4:00 a.m. Certified Nursing Assistant (CNA) went to the resident's room to provide care and noted the resident appeared pale and was not breathing. Resident DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). During a concurrent interview and record review on [DATE] at 12:48 p.m., in the conference room, with MDS Coordinator (MDSC) 1, Resident 110's Progress Notes dated [DATE] to [DATE] and Weights and Vital Signs form dated [DATE] to [DATE] were reviewed. The MDSC 1 stated vital sign numeric values are important to document to know if there are any changes in the resident. The MDSC 1 stated that the facility process is newly admitted residents' vital signs are measured and the numeric values including HR, BP, RR, Temp, and O2 sat are documented during every shift. The MDSC 1 stated that Resident 110 was admitted on [DATE] at 1:15 p.m. during the day shift (7 a.m. to 3 p.m.) and expired on [DATE] at approximately 4 a.m. on the night shift. The MDSC 1 stated RN 2 documented that vital signs were taken at 11 p.m., but there was no documented evidence of the vital sign numeric values including Resident 110's HR, RR, BP, Temp, and O2 sat, but there should have been. During a concurrent interview and record review on [DATE] at 2:03 p.m., in the conference room with RN 2, Resident 110's Progress Notes dated [DATE] to [DATE] and Weights and Vital Signs form dated [DATE] to [DATE] were reviewed. RN 2 stated that newly admitted residents have the vital signs measured every shift. RN 2 stated she (RN 2) helped care for Resident 110 on the night shift on [DATE]. RN 2 stated she (RN 2) took Resident 110's vital signs but missed documenting the numeric values. RN 2 stated it was important to document the numeric values to show that the resident was stable and there was no change in the resident's condition and the (continued on next page)		

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Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record should reflect the care provided. RN 2 stated when she (RN 2) did not document Resident 110's HR, RR, Temp, BP, and O2 sat, the resident's documentation was not complete. During a concurrent interview and record review on [DATE] at 11:25 a.m., in the conference room, the Director of Nursing (DON) reviewed the facility policy and procedure (P&P) regarding vital signs and documentation. The DON stated newly admitted residents have their vital signs measured every shift and the values are documented. The DON stated Resident 110 should have had documented vital sign values on [DATE] for the night shift and did not. The DON stated the facility P&P was not followed when Resident 110's vital sign numeric values were not documented resulting in incomplete medical records for the resident. During a review of the facility P&P titled, Resident Examination and Assessment, last reviewed [DATE], the P&P indicated, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Physical Exam. 1. Vital Signs: blood pressure (standing and sitting); pulse (carotid); respirations; and temperature. Documentation. The following information should be recorded in the resident's medical record: The date and time the procedure was performed. The name and title of the individual(s) who performed the procedure. All assessment data obtained during the procedure. During a review of the facility P&P titled, Charting and Documentation, last reviewed [DATE], the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2. The following information is to be documented in the resident medical record: c. Treatments or services performed. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all parts of the call light system (CL, an alerting device for nurses or other personnel to assist a patient when in need) were functional for one of eight sampled residents (Resident 67) investigated under the Environment task. This deficient practice had the potential to result in the delay of care and services and falls with injury in residents. Findings: During a record review of Resident 67's Face Sheet (FS, admission Record), the FS indicated Resident 67 was originally admitted to the facility on [DATE] and most recently admitted [DATE] with diagnoses including sepsis (a life-threatening blood infection), muscle weakness, unsteadiness of feet, and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 67's History and Physical (H&P), dated 6/1/2026, the H&P indicated the resident had the capacity to understand but could not make medical decisions. During a review of Resident 67's Physician Orders Summary Report, the Physician Orders Summary Report indicated the following order: - Dated 3/30/2026 perianal moisture associated skin damage (MASD - skin damage caused from prolonged exposure to moisture), cleanse with normal saline (a sterile solution), pat dry and apply medicated powder, leave open to air, every day shift. During a review of Resident 67's Care Plan (CP) titled, The resident is at risk for falls and injuries., initiated 6/2/2025, the CP indicated interventions to maintain the call light within reach and to assess and anticipate the resident's toileting needs. During a review of Resident 67's CP titled, (Resident 67) has an activities of daily living self-care and/or mobility performance deficit ., initiated 5/30/2025, the CP indicated an intervention to maintain the call light within reach and encourage the resident to use the call light for assistance. During a concurrent observation and interview on 6/1/2026 at 11:01 a.m., inside Resident 67's shared room, observed Resident 67 lying in bed with the CL button placed on the right side of the resident with the cord clipped to the sheet. Resident 67 stated that she (Resident 67) had been calling for assistance all morning and nobody came in. Resident 67 stated her adult brief was wet and she (Resident 67) needed to be changed. Observed Resident 67 pressed the CL button and the notification light at the door did not light up. Resident 67 stated the CL was not working. Observed the CL cord was not connected to the wall mounted control plate, and the end of the CL cord was severed and resting on top of the resident's bed. During a concurrent observation and interview on 6/1/2026 at 11:05 a.m., inside Resident 67's shared room, observed the Social Services Assistant (SSA) entered Resident 67's room and stood at the foot of the bed from where the severed CL cord was visible. Observed Resident 67 stated to the SSA that she (Resident 67) had not been changed all morning and nobody heard her. The SSA stated she (SSA) would find the resident's Certified Nursing Assistant (CNA) to assist. The SSA exited the room and the severed CL cord remained on the bed. During an observation on 6/1/2026 at 11:14 a.m., in Resident 67's shared room, observed the Activities Assistant (AA) entered the room and stood at the foot of the bed from where the severed CL cord was visible. Observed the AA then exited the room and the severed CL cord remained on the bed. During a concurrent observation and interview on 6/1/2026 at 11:20 a.m., in Resident 67's shared room, observed CNA 5 entered the resident's room and stated she would assist the resident. Observed Resident 67 stated she (Resident 67) was wet, and nobody came to assist. Observed Resident 67 pushed the CL button and CNA 5 confirmed the CL was not functioning. CNA 5 then stated the CL cord was broken and not connected to the wall. CNA 5 stated she (CNA 5) was in the room earlier assisting Resident 67's roommate and did not notice the CL cord was broken. CNA 5 stated all staff that enter the resident's room are responsible to check the resident's CL to identify any issues and make sure the CL is functioning, especially when the resident stated they had called and no staff came to the room. During an interview on 6/4/2026 at 12:37 p.m., in the conference room, with MDS Coordinator (MDSC) 1, MDSC 1 stated the CL is the method of communicating any needs between the residents and the staff. MDSC 1 stated the CL should always be functioning. MDSC 1 stated it was (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important that Resident 67 had a functioning CL because the resident was bedbound and a high risk for falls. MDSC 1 stated Resident 67 also had MASD and should not remain wet because there was the potential for a decline in the resident's skin condition. MDSC 1 stated every staff member that enters the residents' room is responsible for doing an environment check and checking the CL system. MDSC 1 stated when Resident 67 reported to the SSA that nobody was answering the CL, the SSA should have checked the CL and did not potentially resulting in the resident becoming frustrated and sustaining a fall while trying to get staff assistance. During a concurrent interview and record review on 6/5/2026 at 11:25 a.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding CLs. The DON stated CLs should be working and properly placed within reach, so residents have access to staff assistance. The DON stated that when residents do not have a CL it could potentially result in residents not getting what they need. The DON stated the facility policy was not followed when Resident 67's CL was broken. During a review of the facility P&P titled, Call Light, last reviewed on 5/28/2026, the P&P indicated. Purpose . The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines . 1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. 2. Ask the resident to return the demonstration. 4. Be sure that the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly.		