Recepted. 2/16/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED Surger: 25487 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING_ 055728 B. WING 01/24/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 23801 NEWHALL AVENUE SANTA CLARITA POST-ACUTE CARE CENTER NEWHALL, CA 91321 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 **INITIAL COMMENTS** "This Plan of Correction constitutes Santa Clarita Post-Acute Care Center's written The following reflects the findings of the credible allegation of Department of Public Health during an compliance. Santa Clarita Post-Abbreviated survey to investigate a complaint. Acute Care Center (herein referred to SCPA) makes its Complaint number: CA00558941 best effort to operate in full compliance with both federal Representing the Department of Public Health: and state laws. Nothing included in this plan of Health Facilities Evaluator Nurse ID: 25487 correction is an admission otherwise. SCPA has submitted The inspection was limited to the specific this plan of correction in order to allegations in the complaint and does not comply with its regulatory represent the findings of a full inspection of the obligation and does not waive facility. any objections to the allegations contained herein. Please note One deficiency was issued for complaint number that SCPA may contest the CA00558941. merits and/or from any F 309 PROVIDE CARE/SERVICES FOR HIGHEST F 309 deficiency findings alleged below and may take appropriate WELL BEING SS≂D actions to appeal them." CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the F 309 12/8/17 facility must provide the necessary care and It is the policy of SCPA to services to attain or maintain the highest provide an adequate care and services to prevent infection and practicable physical, mental, and psychosocial a resident's indwelling catheter well-being, consistent with the resident's tubing will be free from potential comprehensive assessment and plan of care. contaminants.

483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of

IMMEDIATE CORRECTIVE ACTION

On 11/15/17 the C.N.A's for Resident #1 was provided a one to one in-service by The Director of Staff Development

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE

PRINTED: 01/30/2018

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.

FORM CMS-2667(02-99) Provious Versions Obsolete

Event ID: J2DY11

Facility ID: CA920000053

If continuation sheet Page 1 of 5

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

TOTAL AND ADDRESS OF THE PROPERTY OF THE PROPE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		055728	B. WING			, ·	24/2018
NAME OF PROVIDER OR SUPPLIER SANTA CLARITA POST-ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321				
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	practice, the completate plan, and the but not limited to the resident with provided to resident with provided to residents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREME by: Based on interview failed to ensure one (Resident 1) was pand services to pretransferr to the acutand found the resident found the resident practice redired feces as were deficient practice redirection. Findings: According to the actange susceptible to infection. Findings: According to the actange of the limited feces as were deficient practice redirection. Findings:	rehensive person-centered residents' choices, including e following:	F	309	on providing adequate care and services when providing catheter care, and having the tubing for the indwelling catheter free of soiled contaminants. RESIDENTS AFFECTED On 11/15/17 the RN Supervisor observed other residents with indwelling catheters to ensure the tubing of the catheters were free of any soiled contaminants. No other residents were affected by this deficient practice. CORRECTIVE MEASURES The Director of Staff Development has given an inservice on 12/8/17 to the nursing staff to provide adequate care and services to prevent infection and to ensure residents with indwelling catheter's tube be free of soiled contaminants during peri-care. MONITORING OF CORRECTIVE ACTION At the direction of the QAA committee, the Director of Staff Development and/or RN Supervisor will conduct weekly QA rounds to ensure residents have adequate care and services to prevent infection and to ensure tubing of indwelling catheters be free of soiled contaminants. The results of the audits will be presented to the QAA		

FORM CMS-2567(02-99) Provious Vorsions Obsolete

Event ID: J2DY11

Facility ID: CA920000053

If continuation sheet Page 2 of 5

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		055728	B. WING		01/24/20	18	
NAME OF PROVIDER OR SUPPLIER SANTA CLARITA POST-ACUTE CARE CENTER SUMMARY STATEMENT OF DESIGNACIES			STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD SE COMPI	(5) LETION AYE	
F 309	weakness. A review of Resid (MDS, an assess dated 10/24/17 in moderately impaid decision-making, person assistanc required extensive the rest of his actindicated the residrainage tube an movements. A review of Resid dated 10/28/17 in returned from the room. The reside tract infection (Uremergency room "was covered in feces noted on the During an interview (DON) on 11/15/7 Resident 1 was a indwelling cathete DON stated the Cexternal part of the when providing company of the providing company incontinence bried to the continence bried to the contine	lent 1's Minimum Data Set ment and care-planning tool) idicated the resident was red cognitive skills for daily required extensive two (2) e with transfers/ambulation, and e one (1) person assistance with divities of daily living. The MDS dent had an indwelling urinary divided was incontinent of bowel dent 1's change of condition form idicated the resident had just a cute hospital emergency in twas found to have a urinary [1]) and it was noted in the that the resident's catheter in dried feces as well as dried he resident's back and shoulder." The with the Director of Nurses are as 3:30 p.m., she stated demitted to the facility with the car and had a history of UTIs. The CNA should have cleaned the ne drainage tubing routinely	F 309	committee at a minimum of quarterly for further action planning and monitoring as necessary.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; J2DY11

Facility ID: CA920000053

If continuation sheet Page 3 of 5

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	CON	E SURVEY APLETED	
		055728	B. WING			/24/2018	
NAME OF PROVIDER OR SUPPLIER SANTA CLARITA POST-ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
F 309	at 5 p.m., she staindwelling cathete at the beginning used a towel and area with the wat stated she then a and changed the would call the lice should touch the she should clean. Review of the job 2003, included to clean and dry, provide daily independent of the clean and dry, provide daily independent of the clean and the encourage assistance with the assistance to ensure the clean and the encourage assistance to ensure the clean and the encourage assistance to ensure the clean and the encourage assistance to ensure the encourage assistance as a contract the encourage assistance to ensure the encourage assistance to ensure the encourage assistance as a contract the encourage assistance as a contract the encourage as a co	er or tubing. ew with CNA 2 on the same day ated she checked residents er frequently and cleaned them of the shift. She explained she warm water, rinsed the perior and cleaned the resident. She applied any ointment or cream under pads. CNA 2 stated she ensed nurse and check if she catheter. CNA 2 was not sure if					
	The facility's poli	cy and procedure titled "Catheter					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J2DY11

Facility ID: CA920000063

if continuation sheet Page 4 of 5

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVI	EY
		055728	B. WING _		01/24/201	18
	PROVIDER OR SUPPLIER LARITA POST-ACUT	E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 23801 NEWHALL AVENUE NEWHALL, CA 91321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(5) LETION NTE
F 309	Care, Indwelling" re to pour warm wate cleanse the area w outward, taking car advance catheter f	age 4 evised October 2014, indicated of over perineal area and sell from catheter insertion point or not to pull on catheter or surther into urethra. Debris from catheter at insertion site.	F 30	9		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J2DY11

Facility ID: CA920000053

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2133510768

HHA/HOSPICE

03:10:07 p.m.

01-30-2018

8/13

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					: 01/30/2018 APPROVED
		& MEDICAID SERVICES	,				0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	E SURVEY PLETED
		05572B	B, WING	·		i	C 24/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, GITY, STATE, ZIP CODE		Z-WZU 10
SANTA CLARITA POST-ACUTE CARE CENTER					801 NEWHALL AVENUE EWHALL, GA 91321		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 000	INITIAL COMMENT	•	F	000	*This Plan of Correction constitutes Santa Clarita Post- Acute Care Center's written		
F 309 SS=D	Department of Publish Abbreviated survey Complaint number: Representing the Difference Event The inspection was aflegations in the corepresent the finding facility. One deficiency was CA00558941. PROVIDE CARE/SIWELL BEING CFR(s): 483.24, 483	epartment of Public Health: aluator Nurse ID: 25487 limited to the specific emplaint and does not gs of a full inspection of the issued for complaint number ERVICES FOR HIGHEST 3.25(k)(I)	F3	309	credible allegation of compliance. Santa Clarita Post-Acute Care Center (herein referred to SCPA) makes its best effort to operate in full compliance with both federal and state laws. Nothing included in this plan of correction is an admission otherwise. SCPA has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the allegations contained herein. Please note that SCPA may contest the merits and/or from any deficiency findings alleged below and may take appropriate actions to appeal them."		
	applies to all care as residents. Each residents. Each residents. Each residents. Each residents. Each residents of services to attain or practicable physical well-being, consists comprehensive assessmential treatments. Bassessment of a residents received.	ndamental principle that nd services provided to facility ident must receive and the the necessary care and maintain the highest , mental, and psychosocial nt with the resident's essment and plan of care.			F 309 It is the policy of SCPA to provide an adequate care and services to prevent infection and a resident's indwelling catheter tubing, and back and shoulder will be free from potential contaminants. IMMEDIATE CORRECTIVE ACTION On 11/15/17 the C.N.A's for Resident #1 was provided a one to one in-service by The		2/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XII) DATE

2/13/17

Any deficiency statement driding with an esteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined the

Any deficiency statement ériding with an asteriek (*) 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.

FORM CMS-2567(02-69) Previous Versions Obsolete

Event ID: J2DY11

Facility ID: CAB20000053

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03:10:25 p.m.

01-30-2018

9/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

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		D. WING			01/2	2 <u>4/2018</u>
RITA POST-ACUTI				FREET ADDRESS, CITY, STATE, ZIP CODE		
	SANTA CLARITA POST-ACUTE CARE CENTER			3801 NEWHALL AVENUE		
· · · · · · · · · · · · · · · · · · ·			N	EWHALL, CA 91321		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPE DEFICIENCY)	36	(XS) COMPLETION DATE
ntinued From participe, the comprete plan, and the restrict to the Pain Management of facility must ensistent with profesional the residents' good playsis. The facility size of the comprehensive of the residents' good plan, and the resident of the plan and the plan and the resident of the plan and the plan a	ge 1 ehensive person-centered esidents' choices, including e following: ent. sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, peals and preferences. cility must ensure that me dialysis receive such t with professional standards exprehensive person-centered esidents' goals and esidents' goals and with is not met as evidenced or and record review, the facility e of three sample residents ovided with adequate care event infection. Resident 1 was the hospital emergency room ent's indwelling urinary tube which is highly tion) tubing was solled with his back and shoulder. This		<u> </u> 	Director of Staff Development on providing adequate care and services when providing care and having the tubing for the indwelling catheter and back and shoulder free of soiled contaminants RESIDENTS AFFECTED On 11/15/17 the RN Supervisor observed other residents with indwelling catheters to ensure the tubing of the catheters were free of any soiled contaminants as well as the residents back and shoulder area. No other residents were affected by this deficient practice. CORRECTIVE MEASURES The Director of Staff Development has given an inservice on 12/8/17 to the nursing staff to provide adequate care and services to prevent infection and to ensure residents with indwelling catheter's tube be free of soiled contaminants during peri-care. On 2/12/18, the Director of Staff Development provided an inservice to the nursing staff on	RIATE	DATE
dings:	•			cleansing and grooming to the		
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vas originally adn h diagnoses that esence of urogen rgery or Genitou	nitted to the facility on 8/07/17 included a history of falls, ital implants (Urogenital finary Surgery is a specialty			MONITORING OF CORRECTIVE ACTION At the direction of the QAA committee, the Director of Staff Development and/or RN Supervisor will conduct weekly		
THE REPORT OF THE PARTY OF THE PARTY.	retice, the compres plan, and the resident practice is resident in the residen	is REQUIREMENT is not met as evidenced used on interview and record review, the facility sed to ensure one of three sample residents esident 1) was provided with adequate care of services to prevent infection. Resident 1 was inster to the acute hospital emergency room of found the resident's indwelling urinary theter (drainage tube which is highly sceptible to infection) tubing was solled with sed faces as were his back and shoulder. This ficient practice resulted in the potential for ection. Idings: Coording to the admission face sheet, Resident was originally admitted to the facility on 8/07/17 in diagnoses that included a history of falls, esence of urogenital implants (Urogenital regery or Genitourinary Surgery is a specialty at involves surgical procedures to reproductive	rectice, the comprehensive person-centered re plan, and the residents' choices, including a not limited to the following: Pain Management. Be facility must ensure that pain management is exided to residents who require such services, insistent with professional standards of practice, incomprehensive person-centered care plan, in the residents' goals and preferences. Dialysis. The facility must ensure that idents who require dialysis receive such vices, consistent with professional standards practice, the comprehensive person-centered replan, and the residents' goals and inferences. Is REQUIREMENT is not met as evidenced assed on interview and record review, the facility resident 1) was provided with adequate care of services to prevent infection. Resident 1 was insferr to the acute hospital emergency room of found the resident's indwelling urinary theter (drainage tube which is highly sceptible to infection) tubing was solled with red feces as were his back and shoulder. This ficient practice resulted in the potential for action. dings: cording to the admission face sheet, Resident was originally admitted to the facility on 8/07/17 in diagnoses that included a history of falls, issence of urogenital implants (Urogenital rigery or Genitourinary Surgery is a specialty it involves surgical procedures to reproductive	retice, the comprehensive person-centered re plan, and the residents' choices, including and limited to the following: Pain Management. Be facility must ensure that pain management is wided to residents who require such services, resistent with professional standards of practice, a comprehensive person-centered care plan, at the residents' goals and preferences. Dialysis. The facility must ensure that eldents who require dialysis receive such vices, consistent with professional standards oractice, the comprehensive person-centered re plan, and the residents' goals and inferences. BREQUIREMENT is not met as evidenced used on interview and record review, the facility red to ensure one of three sample residents esident 1) was provided with adequate care of services to prevent infection. Resident 1 was resident infection. Resident 1 was resident infection, building urinary the heart (drainage tube which is highly beceptible to infection) tubing was solled with red faces as were his back and shoulder. This ficient practice resulted in the potential for action. dings: cording to the admission face sheet, Resident was originally admitted to the facility on 8/07/17 in diagnoses that included a history of falls, resence of urogenital implants (Urogenital regery or Genitourinary Surgery is a specialty it involves surgical procedures to reproductive	ntinued From page 1 citice, the comprehensive person-centered e plan, and the residents' choices, including and the residents' choices, including and the residents' choices, including and timited to the following: Pain Management. a facility must ensure that pain management is wided to residents who require such services, comprehensive person-centered care plan, at the residents' goals and preferences. Dialysis. The facility must ensure that idents who require dialysis receive such idents who require dialysis receive such depths who require dialysis receive such services, consistent with professional standards oractice, the comprehensive person-centered e plan, and the residents' goals and farences. Braculirement is not met as evidenced used to ensure one of three sample residents esident 1) was provided with adequate care is services to prevent infection. Resident 1 was nester to the acute hospital emergency room at found the resident's indwelling urthary theter (drainage tube which is highly sceptible to infection) tubing was solled with at discess as were his back and shoulder. This facilent practice resulted in the potential for action. dings: coording to the admission face sheet, Resident as originally admitted to the facility on 8/07/17 in diagnoses that included a history of falls, seence of urogenital implants (Urogenital seed of the provided and includer area.) MONITORING OF CORRECTIVE ACTION At the direction of the QAA committee, the Director of Staff Development and/or RN Supervisor will conduct weekly	intinued From page 1 decice, the comprehensive person-centered to plan, and the residents choices, including and the residents choices, including and the residents choices, including and the residents who require such services, sistent with professional standards of practice, or comprehensive person-centered care plan, at the residents goals and preferences. Dialysis. The facility must ensure that idents who require dialysis receive such vices, consistent with professional standards vices of standards vices of standards vices, consistent with professional standards

03: 10:40 p.m.

01-30-2018

10/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		0 5 5728	B. WING	;		ľ	
	PROVIDER OR SUPPLIER CLARITA POST-ACUT			S 2	TREET ADDRESS, CITY, STATE, ZIP CODE 3801 NEWHALL AVENUE IEWHALL, CA 91321	<u>. 177.</u>	<u>24/2018</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	ĖE	(X5) COMPLETION DATE
F 309	and urinary organs) weakness. A review of Resider (MDS, an assessmedated 10/24/17 Indimoderately impaire decision-making, reperson assistance or required extensive the rest of his activitindicated the resided drainage tube and organized extensive and organized extensive the rest of his activitindicated the resided drainage tube and organized movements. A review of Resider dated 10/28/17 indireturned from the aroom. The resident tract infection (UTI) emergency room the "was covered in different notation of the covered in different 1 was admindwelling catheter DON stated the CN external part of the when providing care light side lying after incontinence brief, cloths and apply a stated he would errors.	and generalized muscle at 1's Minimum Data Set ent and care-planning tool) cated the resident was d cognitive skills for daily equired extensive two (2) with transfers/ambulation, and one (1) person assistance with ties of daily living. The MDS ent had an indwelling urinary was incontinent of bowel at 1's change of condition form cated the resident had just cute hospital emergency was found to have a urinary and it was noted in the at the resident's catheter ried feces as well as dried resident's back and shoulder." with the Director of Nurses at 3:30 p.m., she stated nitted to the facility with the and had a history of UTIs. The A should have cleaned the drainage tubing routinely	F	309	QA rounds to ensure residents have adequate care and services to prevent infection and to ensure tubing of indwelling catheters be free of soiled contaminants as well as the back and shoulder area. The results of the audits will be presented to the QAA committee at a minimum of quarterly for further action planning and monitoring as necessary.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J2DY11

Fectity ID: CA920000053

If continuation sheet Page 3 of 5

HHA/HOSPICE

03:10:56 p.m. 01-30-2018 11/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SANTA CLARITA POST-ACUTE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL, PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		
NAME OF PROVIDER OR SUPPLIER SANTA CLARITA POST-ACUTE CARE CENTER SANTA CLARITA POST-ACUTE CARE CENTER (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DAY DEFICIENCY)		C 01/24/2018	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DAY DEFICIENCY)	SANTA CLARITA POST-ACUTE CARE CENTER		
F 309 Continued From page 3	PREFIX		
clean the catheter or tubing. During an interview with CNA2 on the same day at 5 p.m., she stated she checked residents indwelling catheter frequenty and cleaned them at the beginning of the shift. She explained she used a towel and warm water, rinsed the pari area with the water and cleaned the resident. She stated she then applied any ointment or cream and changed the under pade. CNA2 stated she would call the licensed nurse and check if she should buch the catheter. CNA2 was not sure if she should clean the catheter. Review of the job responsibilities for CNAs dated 2003, included to keep incontinent residents clean and dry, provide daily perineal care, and to provide daily indwelling catheter care. Review of a care plan titled "Tolleting Care Plan" initiated 8/21/17, indicated to monitor resident's skin throughout care and keep skin clean and dry, and to encourage resident to seek immediate assistance with tolleting needs and provide assistance to ensure toleting care is provided. Review of a care plan titled "Indwelling Catheter" initiated 8/07/17 indicated the care plan falled to address catheter care and included an intervention of "Perineal care means washing the genitals and ranal area, Peri care can be done during a bath or as a separate procedure. Perineal care means washing the genitals and ranal area, Peri care can be done during a bath or as a separate procedure. The facility's policy and procedure titled "Catheter" infections. The care plan did not address cleaning/maintaining the catheter tubing.			

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: J2DY11

Facility ID: CA920000053

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03:11:11 p.m. 01-30-2018

12/13

PRINTED: 01/30/2018 FORM APPROVED

CENC	& MEDICAID SERVICES	OMB NO. 0						
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		055728	B. WING	3		•	C 24/2018	
NAME OF I	PROVIDER OR SUPPLIER		V	S	TREET ADDRESS, CITY, STAYE, ZIP CODE			
SANTA C	LARITA POST-ACUT	F CARE CENTER		2	3801 NEWHALL AVENUE			
				N	IEWHALL, CA 91321			
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency Must be preceded by Full REGULATORY OR LEG IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		D RE COMPLETION			
F 309	to pour warm water cleanse the area wo cutward, taking can advance catheter fi	ge 4 rvised October 2014, indicated over perineal area and ell from catheter insertion point e not to pull on catheter or orther into urethra. Debris rom catheter at insertion site.	F	309				
	·					1		
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FORM CMS-2567(02-99) Previous Versium Obsoleto

Event ID: J2DY11

Facility ID: CA920005053

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