

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056351 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Chatsworth Park Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 10610 Owensmouth Chatsworth, CA 91311 | |

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) |
| <p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49135</p> <p>Based on interview and record review, the facility failed to obtain a written order from a physician to provide Physical Therapy (PT- used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability and that utilizes exercise, physical modalities [uses transmission of energy to or through the resident], assistive devices [tools, products or types of equipment that help a resident perform tasks and activities], and resident education and training) for one of six sampled residents (Resident 1).</p> <p>This deficient practice had the potential to result in negative physical outcome.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 6/25/2024, indicated that Resident 1 is cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and requires supervision or touching assistance on staff for transfer, dressing, toilet use, personal hygiene, and bathing.</p> <p>During a review of Resident 1's Physician Orders for 7/2024, there was no order found to provide Resident 1 PT treatment and services.</p> <p>A review of Resident 1's PT Progress Report and Therapy Plan dated 4/19/2024 indicated Resident 1 was certified to receive PT treatment and services from 4/18/2024 to 7/16/2024, five (5) times a week.</p> <p>During a concurrent interview and record review on 7/18/2024 at 10:25 a.m. with the Director of Rehabilitation (DOR), the DOR stated that Resident 1 received PT treatment and services from 3/21/2024 until 6/13/2024. The DOR further stated the facility provided continuous PT treatment and services to Resident 1 without a written order from Resident 1's physician because Resident 1 wanted it. The DOR stated that a written order from Resident 1's physician should have been obtained prior to providing PT treatment and services.</p> <p>(continued on next page)</p> |

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 |
|---|-----------|--------------------------------------|
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 056351 |
| | | If continuation sheet Page 1 of 2 |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056351 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Chatsworth Park Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 10610 Owensmouth Chatsworth, CA 91311 | |

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) |
|--|---|
| <p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of the facility policy and procedure, titled Specialized Rehabilitative Services, last reviewed on 1/2024, indicated it is the policy of the facility that specialized rehabilitative services are provided only upon the written order of a physician. When specialized rehabilitative services are required, such services must be ordered by a licensed physician.</p> |