STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056351	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatsworth Park Health Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39550 Based on interview and record review, the facility failed to implement the facility's theft and loss policy by failing to document a resident's lost jewelry on the facility's theft and loss report form for one of three sampled residents (Resident 1). This deficient practice violated the resident's right to have Resident 1's property protected and conserved. Findings: During review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 2/27/2014 with diagnoses of major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and essential hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of the facility's Theft and Loss Log, the document indicated no theft and loss reports were documented on the facility's Theft and Loss Log for Resident 1 for 5/2024. During a concurrent interview and record review on 1/2/2025 at 1:10 p.m., with Social Services Assistant 1 (SSA 1), reviewed social services notes for 5/2024. SSA 1 stated that Resident 1 made SSA 1 aware that Resident 1 was missing seven (7) pieces of jewelry in 5/2024. SSA 1 reviewed social services notes for 5/2024 and stated that on 5/12/2024 at 1:20 p.m., SSA 1 documented that Resident 1 reported to SSA 1 that Resident 1 verbalized, she is missing seven (7) pieces of jewelry from her box. During an interview on 1/2/2025 at 1:31p.m., with SSA 1, SSA 1 stated that when a resident or family member reports a lost item, anyone can take the report and a Theft and Loss Report form should be completed. SSA 1 stated that the administrator is made aware, and the facility will begin to look for the item. SSA 1 continued to state that she did not make the Administrator aware when Resident 1 reported her missing jewelry in 5/2024. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/2/2025 at 2:00 p.m., with SSA 1, reviewed the Theft and Lost Log for 5/2024. SSA 1 stated that SSA 1 stated that there was no documented evidence that Resident 1 reported a theft and loss in 5/2024 according to the Theft and Lost Log. SSA 1 stated that she (SSA 1) should have documented Resident 1's report on the Theft and Loss Log and documented on the Theft and Loss Report form. SSA 1 continued to state that SSA 1 did not document on the Theft and Loss Log and the Theft and Lost Report form because the psychologist stated that Resident 1 was forgetful. During an interview on 1/2/2025 at 2:56 p.m., with the Administrator (ADM), the ADM stated that SSA 1 should have documented Resident 1's missing jewelry on the Theft and Loss Log and the Theft and Loss Report form so that proper follow up could have been conducted. The ADM continued to state that the facility should have searched for the missing items and if not found should have discussed with Resident 1. During a review of the facility's policy and procedure titled, Theft and Loss, undated, the policy indicated it is the policy of this facility to provide a theft and loss program which protects and conserves resident's, facility, visitor, and employee property. Loss or theft of resident or visitor property worth more than $25.00 will be documented on Resident Theft and Loss Report. Each report will be submitted to the Administrator for investigation, police reporting or other appropriate action. Complete Resident Property Loss Report forms will be filed in a binder which will be retained in the Social Service Department office. If property greater than $100 has been stolen it will be reported to local law enforcement within 24 hours of the discovery and copies of the report will be available to the Department.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 39739 Based on interview and record review, the facility failed to ensure the Discharge Summary was accurate and complete for one of three sampled residents (Resident 2). This deficient practice had the potential to lead to confusion about Resident 2's discharge status and a delay in attaining services needed for Resident 2 after discharge. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 12/7/2024 with diagnoses of, but not limited to, fracture (break in the bone) of the right femur (thigh bone), presence of right artificial hip joint, and pneumonitis (swelling of the lung tissue). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 2's Progress Note dated 12/12/2024 at 2:48 p.m., the progress note indicated Resident 2 was adamant about leaving the facility and being discharged home. During a review of Resident 2's Progress Note dated 12/15/2024 at 10:35 a.m., the progress note indicated Resident 2 was requesting to be discharged home. The progress notes further indicated the risks of the discharge were explained to Resident 2. During a review of Resident 2's Discharge Summary and Post-Discharge Plan of Care dated 12/15/2024, the documents indicated the reason for discharge was due to Resident 2's health improving sufficiently that the resident no longer needing the services of the facility. Resident 2's Discharge Summary was also noted to be missing the address, phone number, and contact person for the Home Health agency (type of medical care that's delivered to a patient's home) assigned to complete the post-discharge care of the resident. During a concurrent interview and record review on 1/16/2025 at 1:08 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's Discharge Summary and Post Discharge Plan of Care dated 12/15/2024. The ADON stated Resident 2's Discharge Summary was inaccurate and the reason for discharge should have been marked as other, with the explanation that it was Resident 2's request to be discharged . The ADON also stated the area on the Discharge Summary for the address, phone number, and contact person of the Home Health agency was left blank. The ADON stated it is important to have the complete contact information for the Home Health agency just in case Resident 2 has questions or needs to schedule or reschedule services. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Documentation in Long Term Care Record Policies and Procedures, undated, the policy indicated the facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 39739 Based on interview and record review, the facility failed to provide pain medication as ordered by the physician and follow the physician's order for pain medication parameters (a set of defined limits) for one (1) of three (3) sampled residents (Resident 2). This deficient practice had the potential to result in Resident 2 being overmedicated and experience an adverse reaction (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 12/7/2024 with diagnoses of, but not limited to, fracture (break in the bone) of the right femur (thigh bone), presence of right artificial hip joint, and pneumonitis (swelling of the lung tissue). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the following physician's orders: - Acetaminophen (medication used to treat minor aches and pain and reduces fever) 500 milligrams (mg - unit of measurement), give one tablet by mouth every six (6) hours as needed for mild pain (1-3/10, numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), dated 12/7/2024. - Acetaminophen 325 mg, give two tablets by mouth every six (6) hours as needed for moderate pain (4-6/10), dated 12/7/2024. During a review of Resident 2's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by the licensed nurse in the facility) dated 12/2024, the MAR indicated Resident 2 received two tablets of acetaminophen 325 mg on 12/10/2024 after reporting a pain level of three (3), a pain level lower than the 4-6/10 parameter indicated on the physician's order. During a concurrent interview and record review on 1/16/2025 at 2:05 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's MAR for 12/2024. The ADON stated if Resident 2 reported a pain level of three (3), then according to the physician's orders, Resident 2 should have been medicated with one tablet of acetaminophen 500 mg and not two tablets of acetaminophen 325 mg. The ADON stated by not getting the appropriate physician ordered dose of pain medication, Resident 2 received more medication than she was supposed to. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Recognition and Management of Pain, last revised 7/2017, the policy and procedure indicated it is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with profession standards of practice, the comprehensive per-centered care plan, and the resident's goals and preferences. During a review of the facility's policy and procedure titled, Medication Administration - Oral, last revised 1/2024, the policy and procedure indicated it is the policy of the facility to accurately prepare, administer and document oral medications.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to ensure residents' attending physician documented residents' History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) in a timely manner per the facility's policy and procedure for three out of three sampled residents (Resident 2, Resident 4, and Resident 5). This deficient practice had the potential for inconsistent care coordination due to incomplete records for Resident 2, Resident 4, and Resident 5. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 12/7/2024 with diagnoses of, but not limited to, fracture (break in the bone) of the right femur (thigh bone), presence of right artificial hip joint, and pneumonitis (swelling of the lung tissue). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a concurrent interview and record review on 12/31/2024 at 11:27 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's Admission Record and Resident 2's H&P dated 12/12/2024. The ADON stated that residents' H&P should be completed and documented within 72 hours of admission. The ADON reviewed Resident 2's Admission Record and stated Resident 2 was admitted on [DATE]. The ADON reviewed Resident 2's H&P document and stated that Resident 2's H&P was documented on 12/12/2024, five (5) days after Resident 2's admission. The ADON stated that the H&P of Resident 2 was not completed per facility policy. b. During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 12/5/2024 with diagnoses of, but not limited to, acute respiratory failure (when the lungs can't release enough oxygen into your blood), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During a review of Resident 4's MDS dated [DATE], the MDS indicated the resident's speech was clear, able to make self-understood, and had the ability to understand others. During a concurrent interview and record review on 12/31/2024 at 11:30 a.m., with the ADON, reviewed Resident 4's Admission Record and Resident 4's H&P dated 12/10/2024. The ADON stated Resident 4 was admitted on [DATE]. The ADON reviewed the H&P document and stated that Resident 4's H&P was documented on 12/10/2024, five (5) days after Resident 4's admission. The ADON stated that the H&P of Resident 4 was not completed per facility policy. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted the resident on 12/6/2024 with diagnoses of, but not limited to, chronic kidney disease (gradual loss of kidney function), syncope (fainting) and collapse, and unspecified injury of head. During a review of Resident 5's MDS dated [DATE], the MDS indicated the resident had intact cognition. During a concurrent interview and record review on 12/31/2024 at 11:35 a.m., with the ADON, reviewed Resident 5's Admission Record and Resident 5's H&P dated 12/12/2024. The ADON stated Resident 5 was admitted on [DATE]. The ADON reviewed the H&P document and stated that Resident 5's H&P was documented on 12/12/2024, six (6) days after Resident 5's admission. The ADON stated that the H&P of Resident 5 was not completed per facility policy. The ADON stated residents' H&P should be done within 72 hours of admission so that nursing staff will know what is going on with the resident. The ADON stated the physician must evaluate the resident timely so that the residents' plan of care can be created. During a review of the facility's policy and procedure titled, Physician Documentation, undated, the policy indicated a current History and Physical is to be provided by the attending physician with 72 hours of admission.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to ensure that a resident received their prescribed amoxicillin-pot clavulanate (antibiotic- used to treat many different infections caused by bacteria) in a timely manner as ordered by the physician for one of three sampled residents (Resident 2). This deficient practice resulted in the delay of medication administration of an antibiotic which had the potential to cause bacteria to reproduce. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 12/7/2024 with diagnoses of, but not limited to, fracture (break in the bone) of the right femur (thigh bone), presence of right artificial hip joint, and pneumonitis (swelling of the lung tissue). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 2's physician's orders, the physician's orders indicated an order for amoxicillin-pot clavulanate tablet 875-125 milligrams (mg- unit of measurement), give one (1) tablet by mouth every 12 hours for aspiration pneumonia (lung infection that occurs when food, liquid, or vomit is inhaled into the lungs), with an order date of 12/7/2024 and start date of 12/7/2024. During a concurrent interview and record review on 12/31/2024 at 12:20 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by the licensed nurse in the facility) dated 12/2024 and Resident 2's progress note dated 12/7/2024. The ADON stated that Resident 2 did not receive Resident 2's amoxicillin-pot clavulanate tablet 875-125 mg on 12/7/2024 at 9:00 p.m. as ordered. The ADON reviewed Resident 2's progress note dated 12/7/2024 at 8:29 p.m. and stated that Resident 2 did not receive her scheduled antibiotic because the facility was waiting for the delivery of the medication. The ADON stated that amoxicillin-pot clavulanate tablet 875-125 mg is available in the facility's medication emergency kit (e-kit - a small supply of medications that can be used when pharmacy services are unavailable) and should have been removed from the facility's medication e-kit. During a concurrent interview and record review on 12/31/2024 at 2:19 p.m., with the ADON, reviewed the facility's medication delivery manifest (refers to detailed document listing of all medications delivered to a facility) dated 12/7/2024. The ADON stated that Resident 2's amoxicillin-pot clavulanate tablet 875-125 mg was delivered on 12/7/2024 at 9:37 p.m. The ADON stated that Licensed Vocational Nurse 1 (LVN 1) should have administered Resident 2's amoxicillin-pot clavulanate tablet 875-125 mg when the medication was delivered because the medication was delivered within the medication administration time frame. The ADON continued to state that all medications should be administered because it is a physician's order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/31/2024 at 3:23 p.m., with LVN 1, reviewed Resident 2's MAR dated 12/2024 and progress note dated 12/7/2024. LVN 1 stated that Resident 2 was newly admitted to the facility on [DATE]. LVN 1 stated that Resident 2 did not receive his amoxicillin-pot clavulanate tablet 875-125 mg because the medication was not delivered to the facility. LVN 1 continued to state that she did not check the e-kit to see if amoxicillin-pot clavulanate tablet 875-125 mg was available. LVN 1 stated that she should have checked the medication e-kit to see if amoxicillin-pot clavulanate tablet 875-125 mg was available, but LVN 1 stated she did not. When asked why LVN 1 did not check the medication e-kit, LVN 1 did not respond. LVN 1 reviewed the facility's medication delivery manifest dated 12/7/2024 and stated that she was not aware that Resident 2's medication was delivered on 12/7/2024. LVN 1 continued to state that if she knew Resident 2's medication was delivered on 12/7/2024, she would have administered Resident 2's amoxicillin-pot clavulanate tablet 875-125 mg. During a review of the facility's policy and procedure titled, Medication Orders, undated, the policy indicated medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribed. Verbal orders are received only by authorized personnel and confirmed in writing by the prescriber within 5 days.