STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555574	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stoney Point Healthcare Center	21820 Craggy View St. 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. Based on interviews and record review, the facility failed to ensure one of three sampled residents' (Resident 1) rights were respected by not changing Resident 1's room assignment as requested by Resident 1's Responsible Party (RP) 1 in a timely manner. This deficient practice violated the resident's right to be treated with respect and dignity, which had the potential to affect the resident's sense of self-worth and self-esteem.Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted the resident on 1/7/2026 with diagnoses that included encephalopathy (a syndrome of general brain dysfunction causing confusion and memory loss), depression, and dementia (a progressive state of decline in mental status). During a review of Resident 1's History and Physical (H&P) dated 1/8/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 1 required moderate assistance from staff with eating, oral hygiene and upper body dressing, and maximal assistance with toileting, lower body dressing, and putting on/taking off footwear. During an interview on 1/21/2026 at 10:00 a.m. with Responsible Party (RP) 1, RP 1 stated that RP 1 requested a room change for Resident 1 from Social Services (SS) 1 on 1/8/2026, due to Resident 1 feeling uncomfortable in the current room assignment. RP 1 stated that there was a room available, and SS 1 agreed to the room change. RP 1 stated that SS 1 called RP 1 on 1/9/2026 and stated that Resident 1 had not been transferred to the new room yet and was unsure why. During an interview on 1/22/2026 at 12:35 p.m. with SS 1, SS 1 stated that RP 1 requested a room change for Resident 1 on 1/8/2026 and that there was a room available for Resident 1 to transfer to. SS 1 stated that SS 1 informed the Registered Nurse Supervisor (RNS) 1 on 1/8/2026 but was unsure why the room change was not completed. During an interview on 1/22/2026 at 1:15 p.m. with RNS 1, RNS 1 stated that RNS 1 was informed of the request for a room change for Resident 1 but was not able to complete the room change because it was very busy during change of shift. RNS 1 stated that the room change should have been completed as soon as possible for Resident 1. During an interview on 1/22/2026 at 3:00 p.m. with the Director of Nursing (DON), the DON stated that when a room change is requested by a resident, it is discussed with the social services staff, the DON and the admission coordinator. The DON stated that RP 1 had requested a room change on 1/8/2026 and there was a room available for Resident 1 at that time. The DON further stated that the room change should happen as soon as possible. During a review of the facility policy and procedure (P&P) titled Resident Rights with a review date of 1/20/2026, the P&P indicated employees shall treat all residents with kindness, respect and dignity.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, to be treated with resident, kindness and dignity.be supported by the facility in exercising his or her rights. During a review of the facility P&P titled Room (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	Change/Roommate Assignment dated 1/20/2026 the P&P indicated, changes in room or roommate assignment shall be made when the facility deems it necessary or when the resident requests the change. The facility reserves the right to make resident room changes or roommate assignments when the facility deems necessary or when the resident requests the change.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain privacy and confidentiality of personal and medical records for one of three sampled residents (Resident 2) when Resident 2's personal and medical records were provided to Resident 1's responsible party (RP 1). This deficient practice violated Resident 2's right to personal privacy and confidentiality of the resident's personal and medical records.Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 1/8/2026 with diagnoses that included a fracture (a break in the bone) of the fifth lumbar vertebra (a bone in the low back), type 2 diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and dementia (a progress state of decline in mental status).During a review of Resident 2's History and Physical (H&P) dated 1/9/2026, the H&P indicated that Resident 2 does not have the capacity to make decisions.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 1/15/2026, the MDS indicated Resident 2's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 2 required maximal assistance with eating, and dependent on staff with oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing and putting on/taking off footwear.During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted the resident on 1/7/2026 with diagnoses that included encephalopathy (a syndrome of general brain dysfunction causing confusion and memory loss), depression, and dementia (a progressive state of decline in mental status).During a review of Resident 1's History and Physical (H&P) dated 1/8/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 1 required moderate assistance from staff with eating, oral hygiene and upper body dressing, and maximal assistance with toileting, lower body dressing, and putting on/taking off footwear.During an interview on 1/21/2026 at 10:00 a.m. with Responsible Party 1 (RP 1), RP 1 stated she requested Resident 1's medical records, however, the facility provided her records belonging to another resident (Resident 2) instead. RP 1 stated that she notified the facility that the medical records she received were for a different resident.During an interview on 1/22/2026 at 12:50 p.m. with the Social Services Director (SSD), the SSD stated that during a meeting with RP 1, RP 1 requested the medical records for Resident 1. The SSD stated that she printed the medical records and handed them to RP 1. The SSD stated that RP 1 later returned to the facility and informed her (SSD) that the medical records provided belonged to Resident 2. The SSD stated that she removed the medical records from the printer and provided them to RP 1 without verifying they were for the correct resident.During an interview on 1/22/2026 at 1:45 p.m. with the Medical Records Director (MRD), the MRD stated that per facility policy, any individual requesting medical records must first complete the Authorization for Release of Records. This request is then reviewed by the MRD, the Director of Nursing (DON) and the Administrator (ADM). After the authorization has been reviewed and the MRD has received approval to release the medical records, the medical records department will release the medical records to the requester. The MRD further stated that the SSD should not have provided Resident 2's medical records to RP 1.During an interview on 1/22/2026 at 3:00 p.m. with the DON, the DON stated that when a request for medical records is made, the requester must complete the Authorization for Release of Records. This form is reviewed by the MRD, the DON, and the ADM. The DON stated that this process is to ensure that (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical records and personal information are not disclosed to the wrong recipient. The DON further stated that the SSD should not have given the Resident 2's medical records to RP 1.During a review of the facility policy and procedure (P&P) titled Policy of Release of Records with a review date of 1/20/2026, the P&P indicated that any resident, or responsible party is entitled to inspect or obtain copies of a resident's records. [NAME] Point Healthcare Center will release records about a resident only if the facility receives a properly completed Authorization for Release of Records.The signature on the Authorization must be the resident's or resident's representative requesting records. Completed authorization must be given to the facility's ADM or DON.During a review of the facility policy titled, Resident Rights, with a review date of 1/10/2026, the policy indicated federal and state laws guarantee certain basic right of this facility. These rights include the resident's right to privacy and confidentiality.