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	06/24/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were released in a timely manner to Resident 1's Responsible Party 1 (RP 1) after receiving a valid request for the medical records from RP 1 on 5/27/2026. This deficient practice resulted in a delay in RP 1's ability to review Resident 1's medical records. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 5/27/2026 with diagnoses that include dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), bipolar disorder (a mental health condition that causes extreme, uncontrollable shifts in mood, energy, activity levels, and concentration) and schizophrenia (a mental illness that affects a person's ability to think, feel and behave clearly). During a review of Resident 1's History and Physical (H&P- a comprehensive assessment of a resident's medical condition) dated 5/30/2011, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of RP 1's Request for Medical Records dated 5/27/2026, the Request for Medical Records indicated RP 1 requested a copy of Resident 1's medical records during Resident 1's stay at the facility. During a concurrent interview and record review on 6/23/2026 at 11:30 a.m., with the Medical Records Director (MRD), the Request for Medical Records dated 5/27/2026 submitted by RP 1 was reviewed. The MRD stated that MRD did receive the Request for Medical Records on 5/27/2026. The MRD stated that the facility had received Resident 1's medical records from 2011 through 2017 but had not sent those records to RP 1. The MRD stated that MRD was waiting to receive Resident 1's medical records from 2017 through 2021 before sending the medical records to RP 1. The MRD further stated that he (MRD) did not have any contact with RP 1 after receiving the Request for Medical Records. During a concurrent interview and record review on 6/24/2026 at 4:00 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Policy on Release of Records dated 1/20/2026, was reviewed. The P&P indicated any resident or resident's representative is entitled to inspect or obtain copies of a resident's records. The facility will release records about a resident only if the facility receives a properly completed Authorization for Release of Records.Any resident or resident's representative will be provided access to inspect the resident's during business hours within 24 hours of the facility's Administrator or Director of Nursing receipt of a completed Authorization for those records.Any resident or resident's representative will be provided copies of the resident records within two working business days of the facility's Administrator or Director of Nurses receipt of the completed Authorization for those records and upon payment of estimated or actual copying costs. The DON stated that the facility received the Request for Medical Records for Resident 1 on 5/27/2026 and confirmed that the facility should have communicated with RP 1 in a timely manner and should have provided the requested medical records to RP 1 in a timely manner. During a phone interview on 7/7/2026 at 11:00 a.m. with the DON, the DON stated that the medical records requested by RP 1 were provided to RP 1 on 7/7/2026 (41 days after the facility received the request on 5/27/2026).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview and record review the facility failed to ensure that the medical record for one of three sampled residents (Resident 2) was complete and accurately documented after Resident 2 reported to Licensed Vocational Nurse (LVN) 1 that Resident 2 had hit Resident 2's left eye on the bedside table (a table positioned at the bedside of resident to assist with meals). This deficient practice had the potential to result in delays in care and services, compromise the continuity of care, and negatively affect Resident 2's overall health status.During a review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on 5/2/2025 with diagnoses that include pneumonia (an infection/inflammation in the lungs), type 2 diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), dementia (a progressive state of decline in mental abilities), and history of falling. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 2's cognition (ability to think and make decisions) was moderately impaired. The MDS further indicated Resident 2 required set up assistance with eating, supervision with oral hygiene and personal hygiene and moderate assistance with toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 6/23/2026 at 10:20 a.m., with Resident 2, Resident 2 was observed to have discoloration (any patch, spot, or uneven area of skin that differs from your natural skin tone) on the left eye. Resident 2 stated that Resident 2 hit the left eye on the bedside table the evening prior. Resident 2 stated that the privacy curtain was closed and felt that the roommate's bedside table hit his (Resident 2) left eye. Resident 2 stated that the nursing staff spoke to Resident 2 about the left eye at the time the incident occurred. During an interview on 6/23/2026 at 12:40 p.m., with LVN 2, LVN 2 stated that during LVN 2's morning medication administration on 6/23/2026, LVN 2 noticed discoloration of Resident 2's left eye. LVN 2 stated that the Medical Doctor (MD) was informed, and the MD ordered staff to monitor Resident 2 for any changes in condition. During an interview on 6/23/2026 at 1:50 p.m., with LVN 1, LVN 1 stated that LVN 1 worked the evening shift (3 p.m. to 11 p.m.) on 6/22/2026. LVN 1 stated that Resident 2 notified LVN 1 that the bedside table had hit Resident 2's left eye. LVN 1 stated that Resident 2 did not have any discoloration at the time LVN 1 completed an assessment of Resident 2's left eye. LVN 1 stated that LVN 1 notified Resident 2's MD, and the MD instructed staff to continue monitoring Resident 2 for any changes in condition. LVN 1 stated that LVN 1 did not document in Resident 2's medical record that Resident 2 had hit the left eye on the bedside table. LVN 1 confirmed that LVN 1 should have documented in Resident 2's medical chart the incident involving Resident 2 hitting the left eye on the bedside table, the assessment of Resident 2's left eye, and the notification of the MD. During an interview on 6/23/2026 at 2:45 p.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated that RNS 1 worked the evening shift on 6/22/2026. RNS 1 stated that LVN 1 informed RNS 1 that Resident 2 had reported hitting the left eye on the bedside table. RNS 1 stated that RNS 1 and LVN 1 assessed Resident 2's left eye, observed no discoloration and Resident 2 denied any pain at that time. RNS 1 stated that the incident should have been documented in Resident 2's medical record. During an interview on 6/24/2026 at 4:00 p.m., with the Director of Nursing (DON), the DON stated that the DON was not informed that Resident 2 had hit the left eye on the bedside table. The DON stated that once informed, the facility immediately began an investigation into the incident. The DON stated that LVN 1 and RNS 1 should have documented that Resident 2 hit the left eye on the bedside table, along with the assessment that was completed and the notification of the MD. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed on 1/20/2026, the P&P indicated that all services provided to the resident, progress towards 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 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical records should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.The following information is to be documented in the resident's medical record, objective observations.treatments or services performed, changes in the resident's condition, events, incidents or accident involving the resident and progress toward or changes in the care plan goals and objectives.documentation in the medical record will be objective, complete, and accurate.