

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, that facility failed to ensure residents' Preadmission Screening and Resident Review Level II (PASRR- an in-depth, mandatory assessment conducted when a PASRR Level I screen [a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care]) indicates a potential serious mental illness [SMI], intellectual disability, or related condition) recommendations were provided to two of three sampled residents (Resident 2 and Resident 3). This deficient practice resulted in the facility not arranging specialized services per PASRR Level II recommendations for Resident 2 and Resident 3. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 4/16/2021 with diagnoses that included unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 2's Minimum Data Set (MDS -a resident assessment tool) dated 6/5/2026, the MDS indicated Resident 2's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 2 required setup or clean up assistance from staff with eating, required supervision or touching assistance from staff with oral hygiene, toileting hygiene, and personal hygiene. During a concurrent interview and record review on 7/30/2026 at 10:40 a.m., with the MDS Nurse (MDSN), reviewed Resident 2's PASRR Level I screening dated 4/16/2021. The MDSN stated that Resident 2's PASRR Level I screening was positive. The MDSN stated that Resident 2 required a PASRR Level II mental health evaluation referral. During a concurrent interview and record review on 7/30/2026 at 12:38 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's PASRR Level II personalized care recommendations dated 5/3/2021 and Resident 2's progress notes. The ADON stated that there was no documented evidence that Resident 2's PASRR II personalized recommendations for a referral for a neuropsychology (scientific study of how the human brain relates to thinking, behavior, and emotion) consultation and a sleep specialist consultation were implemented. The ADON stated that social services department should have referred Resident 2 to neuropsychology and sleep specialist per the recommendations of PASRR Level II. b. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 6/23/2025 with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, unspecified dementia (a progressive state of decline in mental abilities), depression (common mental health condition that causes a lasting feeling of deep sadness, emptiness, and a loss of interest in things you normally enjoy), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 3's MDS dated (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], the MDS indicated Resident 3's cognition was moderately impaired. The MDS indicated Resident 3 required setup or clean up assistance from staff with eating and oral hygiene, required supervision or touching assistance from staff with personal hygiene, and required partial/moderate assistance from staff with toileting hygiene. During a concurrent interview and record review on 7/30/2026 at 10:50 a.m., with the MDSN, reviewed Resident 3's PASRR Level I screening dated 10/12/2023. The MDSN stated that Resident 3's PASRR Level I screening was positive. The MSDN stated that Resident 3 required a PASRR Level II mental health evaluation referral. During a concurrent interview and record review on 7/30/2026 at 12:52 p.m., with the ADON, reviewed Resident 3's PASRR Individualized Determination Report dated 10/16/2023 and Resident 3's progress notes. The ADON stated that Resident 3 is a smoker. The ADON stated that there was no documented evidence that Resident 3's PASRR II personalized recommendation of a smoking cessation program was implemented. The ADON stated that is the responsibility of the MDSN to coordinate with social services. The ADON stated any PASRR II recommendations should have been relayed to the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) and to residents' physicians for proper coordination of care. The ADON stated that potential negative outcomes that may occur from not referring to the recommended recommendations could be worsening of mental health behaviors and potential for decline in residents' physical and mental wellbeing. During a review of the facility's policy and procedures (P&P) titled, PASRR, last reviewed on 1/20/2026, the P&P indicated all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASRR) process. A. the facility conducted a Level I PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the Level 1 screen indicated that the individual may meet the criteria for a MD, ID, RD, he or she is referred to the state PASRR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. The Interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation.		

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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. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by failing to administer Resident 1's Abilify Maintena injection (prescription medicine given as a once-monthly injection to treat schizophrenia [a mental illness that can affect thoughts, mood, and behavior] in adults and bipolar [mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks]) as prescribed by the physician. This deficient practice resulted in Abilify Maintena injection not being administered on 6/2/2026 and could have resulted in worsening symptoms such as agitation or aggression. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/25/2026 with diagnoses that included unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 1's Minimum Data Set (MDS - "a resident assessment" tool) dated 5/27/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff with eating, oral hygiene, and personal hygiene and required substantial/maximal assistance from staff with toileting hygiene and showering/bathing self. During a review of Resident 1's physician order dated 6/1/2026, the physician order indicated an order for Abilify intramuscular (medicine delivered directly into a muscle) prefilled syringe 300 milligram (mg- unit of measurement), inject 300 mg intramuscularly one time a day every 30 day (s) for psychosis, manifested by calm to aggressive behavior towards staff as evidence by trying to hit staff during activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 7/28/2026 at 12:59 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 6/2026. The ADON stated that Resident 1's Abilify intramuscular injection was not administered on 6/2/2026 as ordered. During a concurrent interview and record review on 7/28/2026 at 1:23 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 6/2/2026, LVN 1 was Resident 1's charge nurse. LVN 1 stated that on 6/2/2026 she did not administer Resident 1's Abilify intramuscular injection because the medication was not delivered and the medication was not available in the facility. LVN 1 stated that she called the pharmacy to ask about the medication and was waiting for the medication to be delivered. LVN 1 further stated that by the end of her shift on 6/2/2026, Resident 1's Abilify intramuscular injection was still not delivered. During a follow-up interview on 7/28/2026 at 2:38 p.m., with the ADON, the ADON stated that Resident 1's Abilify intramuscular injection should have been administered. The ADON stated that nursing staff should have followed up with the pharmacy regarding the delivery of the medication and should have made Resident 1's physician aware. The ADON stated that potential negative outcomes that could have occurred by not administering Abilify intramuscular injection could be exacerbation of symptoms such as aggressiveness towards staff and others which is what the medication was prescribed to treat. During an interview on 7/30/2026 at 2:33 p.m., with the Director of Nursing (DON), the DON stated that Resident 1's Abilify intramuscular injection should have been administered. The DON stated that nursing staff should have followed up with the pharmacy and should have documented their efforts in (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolving the medication delivery issue. The DON further stated that nursing staff should have also informed the prescribing provider that Resident 1's Abilify intramuscular injection was not administered and was not delivered for their awareness. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed on 1/20/2026, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to ensure an electrocardiogram (EKG- a test that measures the electrical activity of the heart) that was ordered by a physician on 6/20/2026 was completed for one of three sampled residents (Resident 1). This deficient practice resulted in the delay of necessary care and services for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/25/2026 with diagnoses that included heart disease (a general term for conditions that affect the heart) and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/27/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff with eating, oral hygiene, and personal hygiene and required substantial/maximal assistance from staff with toileting hygiene and showering/bathing self. During a review of Resident 1's physician order dated 6/20/2026 timed at 12:07 p.m., the physician order indicated an order for EKG every day shift every 12 months starting on the 22nd for one day for the use of Abilify (used to treat schizophrenia [a mental illness that can affect thoughts, mood, and behavior] in adults and bipolar [mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks]) per pharmacy recommendation. During a concurrent interview and record review on 7/28/2026 at 2:28 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's physician's orders. The ADON stated that Resident 1 is currently taking Abilify and Resident 1 has a physician's order for an EKG to be done per pharmacy recommendations. The ADON reviewed Resident 1's nursing progress notes and stated that Resident 1's EKG was not done per physician's order. The ADON stated that Resident 1 should have had an EKG done on 6/22/2026 per physician's order. The ADON continued to state that it is important for the EKG to be done because it was a pharmacy recommendation based on Resident 1's use of Abilify. The ADON further stated that negative outcomes related to Resident 1's EKG not being done could be worsening of Resident 1's heart disease. When asked why Resident 1's EKG was not done, the ADON stated that there was no documented evidence that indicated the reason why Resident 1's EKG was not done. During a review of the facility's policy and procedure (P&P) titled, Availability of Services, Diagnostic, last reviewed on 1/20/2026, the P&P indicated clinical laboratory and radiology services of our residents are provided by our facility. The following diagnostic services are available twenty-four (24) hours a day, seven (7) days a week, including holidays; h. Electrocardiography.		