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 07/25/2024

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48142

Based on observation, interview, and record review, the facility failed to ensure residents' call lights (a device used by patients to call for assistance from hospital staff) were within reach for two of 30 sampled residents (Resident 27 and 28) .

This deficient practice had the potential to result in the residents not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect the residents' comfort and well-being.

Findings:

a. A review of Resident 27's Admission Record indicated the facility admitted the resident on 1/27/2022 with diagnosis of chronic obstructive pulmonary disease (COPD, a common lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), difficulty in walking, and lack of coordination.

A review of Resident 27's History and Physical (H&P, a comprehensive assessment of a resident and their problem) dated 6/5/2023, indicated that does not have the capacity to understand and make decisions.

A review of Resident 27's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/11/2024, indicated the resident required set up assistance with eating, required supervision in oral hygiene, toileting, upper body dressing, putting on/taking off footwear, and moderate assistance with lower body dressing.

A review of Resident 27's care plan (a written document that summarizes a resident's needs, goals, and care/treatment) on risk for fall, initiated on 1/27/2022 and last revised on 6/5/2024, indicated an intervention to keep call light within reach.

During an observation on 7/22/2024 at 3:26 p.m., in Resident 27's room, observed Resident 27's call light placed on the top edge of the bed and not within reach.

(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

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 07/25/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/22/2024 at 3:30 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 verified by stating Resident 27's call light was placed on the upper top right edge of the bed and stated Resident 27 would not able to reach it. CNA 1 further stated that the call light must be within reach for assistance, emergencies, and to prevent the resident from falling. During an interview on 7/25/2024 at 2:17 p.m., with the Director of Nursing (DON), the DON stated that it is important for the call light to be consistently within reach of the resident. The DON stated this allows the resident to easily call for assistance and prevents them from getting out of bed unassisted, which could lead to a fall. A review of the facility's policy and procedure titled, Answer the Call Light, last reviewed date 1/16/2024, indicated when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 38549 b. A review of Resident 28's Admission Record indicated the facility admitted the resident on 4/29/2022 with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]) and unspecified asthma (a chronic lung disease that can make it difficult to breathe) with (acute) exacerbation. A review of Resident 28's History and Physical (a formal assessment of a resident and their medical problem by a healthcare provider, usually during an initial visit), dated 4/15/2024, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 28's MDS, dated [DATE], the document indicated the resident had moderately impaired cognition (thought processes) and required supervision or touching assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 28's care plan for risk for fall, undated, indicated to ensure the resident's call light is within reach. During a concurrent observation and interview on 7/22/2024 at 9:37 a.m., observed Resident 28 awake in bed. When asked to test the functionality of his call light, Resident 28 looked around for his call light and stated he could not find his call light. Observed Resident 28's call light hanging behind the resident's bed. During a concurrent observation and interview on 7/22/2024 at 10:03 a.m., with Certified Nursing Assistant 3 (CNA 3), CNA 3 confirmed by stating that Resident 28's call light was behind his bed and stated it should have been within reach and easily accessible. During an interview on 7/25/2024 at 2:32 p.m., with the DON, the DON stated it was important for residents' call lights to be within reach and functioning so that they can easily call for staff when needed instead of trying to do things by themselves. The DON stated that having call lights within residents' reach can aid in preventing falls, accidents, and injuries. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Answering the Call Light, last reviewed on 1/16/2024, the document indicated that the purpose of the procedure is to respond to the resident's requests and needs . When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.

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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. 38549 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 3 (LVN 3) provided privacy to a resident before administering medications via gastrostomy tube (g-tube - a tube that's surgically inserted through the abdomen and into the stomach used for medication and nutrition) for one of 30 sampled residents (Resident 62). This deficient practice violated the resident's right to privacy. Findings: A review of Resident 62's Admission Record indicated the facility admitted the resident on 11/2/2019 with diagnoses including aphasia (a language disorder that makes it difficult to understand and express language, as well as read and write), hemiplegia (partial or complete paralysis on one side of the body) and hemiparesis (mild loss of strength or paralysis on one side of the body), and encounter for attention to gastrostomy (a surgical procedure that creates an opening in the skin and into the stomach to insert a feeding tube). A review of Resident 62's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/17/2024, indicated the resident had severely impaired cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). During an observation on 7/23/2024 at 8:04 a.m., observed LVN 3 administer medications to Resident 62 via g-tube. LVN 3 did not close Resident 62's privacy curtain all the way around the resident and was still open at the foot of Resident 62's bed. During an interview on 7/23/2024 at 8:51 a.m., with LVN 3, LVN 3 stated she did not close Resident 62's privacy curtain all the way around the resident. During an interview on 7/25/2024 at 2:30 p.m., with the Director of Nursing (DON), the DON stated it was important to provide privacy to residents during care in order to protect their dignity. The DON stated that residents can possibly feel embarrassed if they are not given full privacy during care. A review of the facility's policy and procedure titled, Dignity, last reviewed on 1/16/2024, indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to: 1. Ensure a resident's Minimum Data Set (MDS - a standardized assessment and care screening tool) section regarding falls was accurate for one of 30 sampled residents (Resident 65). 2. Ensure a resident's MDS section regarding the presence of an advance directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was accurate for one of 30 sampled residents (Resident 45). This deficient practice had the potential to delay care and services for the residents. Findings: a. A review of Resident 65's Admission Record indicated the facility admitted the resident on 2/1/2023 with diagnoses including abnormalities of gait and mobility and lack of coordination. A review of Resident 65's MDS, dated [DATE], indicated the resident had severely impaired cognition (thought processes) and required substantial/maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 65's Change in Condition Evaluation (COC - a verbal or written communication tool that helps provide essential, concise information, usually during crucial situations), dated 3/25/2024, the COC indicated the resident had a fall. During a concurrent interview and record review on 7/24/2025 at 2:55 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 65's MDS dated [DATE]. LVN 1 stated it was coded in the MDS that Resident 65 had no falls since admission/entry or reentry or the prior assessment. LVN 1 stated this was incorrect because Resident 65 had a fall on 3/25/2024. Resident 65's prior MDS assessment was done on 2/6/2024. LVN 1 stated it was important for the MDS to accurately reflect Resident 65's fall in order to properly care plan for the resident. During an interview on 7/25/2024 at 2:25 p.m., with the Director of Nursing (DON), the DON stated that MDS assessments affected residents' plan of care, that's why it was important for it to be accurate. A review of the facility's policy and procedure titled, Certifying Accuracy of the Resident Assessment, last reviewed on 1/16/2024, indicated that the information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. (continued on next page)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	b. A review of Resident 45's Admission Record indicated the facility originally admitted the resident on 11/30/2019 and readmitted the resident on 7/26/2020 with diagnoses including type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]) with foot ulcer (an open sore or wound on the foot that doesn't heal or keeps coming back), chronic obstructive pulmonary disease (COPD - a common lung disease that makes it hard to breathe by damaging lung tissue and narrowing airways), and stage three (3) chronic kidney disease (a condition where the kidneys are moderately damaged and have reduced ability to filter waste and fluids from the blood). A review of Resident 45's History and Physical (H&P - a formal assessment of a resident and their medical problem by a healthcare provider, usually during an initial visit), dated 7/2/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 45's MDS, dated [DATE], indicated the resident had intact cognition and required partial/moderate assistance from staff for most ADLs. During a concurrent interview and record review on 7/24/2024 at 10:29 a.m., with LVN 1, reviewed Resident 45's MDS dated [DATE] and Resident 45's Advance Directive/Physician Orders for Life-Sustaining Treatment (POLST - a portable medical order form that records patients' [resident's] treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) Acknowledgement form, dated 6/23/2023. LVN 1 stated the MDS indicated that Resident 45 had an advance directive that was available and reviewed. LVN 1 stated that, according to Resident 45's Advance Directive/Physician Orders for Life-Sustaining Treatment Acknowledgement form, Resident 45 never had an advance directive nor was she interested in creating one. LVN 1 stated Resident 45's MDS had been coded inaccurately. LVN 1 stated it was important for the resident's MDS to be coded accurately because it provided an overview of the status of the resident and directed the resident's care plan. LVN 1 stated it was important to know whether or not the resident had an advance directive because, in the event that the resident was to lose the mental capacity to make decisions, then the facility would know how to care for the resident based on the resident's preferences. During an interview on 7/25/2024 at 2:25 p.m., with the DON, the DON stated that MDS assessments affected residents' plan of care, that's why it was important for it to be accurate. A review of the facility's policy and procedure titled, Certifying Accuracy of the Resident Assessment, last reviewed on 1/16/2024, indicated that the information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.

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	555574	A. Building B. Wing	07/25/2024

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Stoney Point Healthcare Center	21820 Craggy View St. Chatsworth, CA 91311

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38469

Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for seven of 30 sampled residents (Resident 34, 117, 65, 7, 72, 59, and 27) by failing to:

1. Develop a care plan addressing Resident 34, 117, and 65's insulin (hormone that regulates the level of glucose [sugar] in the blood) use.

2. Develop a care plan addressing Resident 7's use of psychotropic medications (medications capable of affecting the mind, emotions, and behavior).

3. Develop a care plan addressing Resident 72's diagnosis of viral hepatitis C (a viral infection that causes liver inflammation (swelling).

4. Develop a care plan addressing Resident 59 and Resident 27's diagnosis of urinary tract infection (UTI, an infection in any part of the urinary system) and antibiotic (medications that fight bacterial infections) use against UTI infection.

These deficient practices had the potential to result in failure to deliver the necessary care and services.

Findings:

1.a. A review of Resident 34's Admission Record indicated the facility admitted the resident on 6/11/2024 with diagnoses including type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]) and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood).

A review of Resident 34's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 5/19/2024, indicated resident had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. The MDS also indicated Resident 34 was dependent on staff for toileting hygiene, shower, dressing and putting on/taking off footwear.

A review of Resident 34's physician's orders dated 7/16/2024, included an order for Humulin R (short-acting insulin) injection solution 100 Unit/milliliter (U/ml, a unit of measurement) per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) every six hours related to type 2 diabetes mellitus and hold for blood sugar below 100 milligram per deciliter (mg/dl- unit of measurement).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/2024 at 10:25 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 34's care plans from 6/11/2024 to 7/24/2024. The ADON confirmed by stating that there is no care plan developed for Resident 34's insulin use. The ADON stated that there must be a care plan for insulin use wherein goals of treatment are identified, interventions are specified, and determine an evaluation date to see if the goals of treatment are achieved or met. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 1.b. A review of Resident 117's Admission Record indicated the facility admitted the resident on 5/3/2024 with diagnoses including chronic pulmonary disease (a common lung disease causing restricted airflow and breathing problems) and difficulty in walking. A review of Resident 117's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was moderately impaired. The MDS further indicated that Resident 117 required maximal assistance with toileting hygiene, shower, lower body dressing, and putting on and taking off footwear. A review of Resident 117's physician's orders dated 5/4/2024, included an order for insulin Lispro (rapid-acting insulin) injection solution 100 Unit/milliliter per sliding scale subcutaneously before meals and at bedtime and call physician if blood sugar is above 401 mg/dl and hold for blood sugar below 70 mg/dl. During a concurrent interview and record review on 7/24/2024 at 1:40 p.m., with the ADON, reviewed Resident 117's care plans dated 5/3/2024 to 7/24/2024. The ADON confirmed by stating that there was no care plan developed for Resident 117's insulin use. The ADON stated that there must be a care plan for insulin use wherein goals of treatment are identified, interventions are specified and determine an evaluation date to see if the goals of treatment are achieved or met. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. 38549 1.c. A review of Resident 65's Admission Record indicated the facility admitted the resident on 2/1/2023 with diagnoses including type 2 diabetes mellitus. A review of Resident 65's MDS, dated [DATE], indicated the resident had severely impaired cognition and required substantial/maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 65's physician's orders, indicated the following orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Humalog (Insulin Lispro) 100 units/milliliter sliding scale, ordered on 2/1/2023. - Insulin glargine (long-acting insulin) 100 units/ml, inject 25 units subcutaneously at bedtime for type 2 diabetes mellitus, ordered on 3/1/2024. During a concurrent interview and record review on 7/24/2024 at 2:34 p.m., with the ADON, reviewed Resident 65's care plans dated 2/1/2023 to 7/24/2024. The ADON stated Resident 65 did not have a care plan addressing his insulin use. During an interview on 7/25/2024 at 2:25 p.m., with the Director of Nursing (DON), the DON stated that the purpose of care plans was to identify the type of care residents need. The DON stated Resident 65 should have had a care plan addressing his insulin use, so that nurses knew what interventions needed to be done, such as monitoring for adverse side effects (undesired harmful effect resulting from a medication or other intervention) and rotating injection sites. The DON stated if Resident 65 did not have a specific care plan addressing his insulin use, then nurses may not know what interventions need to be done. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 49252 2. A review of Resident 7's Admission Record indicated the facility readmitted the resident on 4/30/2024 with diagnoses that included bipolar disorder (a mental illness that causes severe changes in mood, energy, and activity levels) and unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) not due to a substance or known physiological condition. A review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severely impaired cognition. A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated the following orders: - Latuda (medication to treat psychosis) oral tablet 40 milligrams (mg, a unit of measurement), give one tablet orally one time a day related to unspecified psychosis not due to a substance or known physiological condition manifested by aggressive behavior towards staff during care, ordered on 5/6/2024. - Seroquel (medication used to treat certain mental/mood disorders) oral tablet 50 mg, give one tablet orally two times a day for bipolar disorder (mood disorder that causes intense shifts in mood, energy levels, and behavior) manifested by angry outbursts, ordered on 5/6/2024. - Trazodone hydrochloride (medication used to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) oral tablet 50 mg, give one tablet orally at bedtime related to major depressive disorder manifested by inability to sleep, ordered on 5/6/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/2024 at 11:33 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 7's care plans dated 4/30/2024 to 7/24/2024. RN 1 stated there were no care plans in place for Resident 7's use of Latuda, Trazodone, and Seroquel. RN 1 stated the care plans were necessary because they allowed the facility to check if Resident 7's goals were being reached, ensured Resident 7 was getting the care that she needed, and made the staff aware of monitoring for specific drug risks. During an interview on 7/25/2024 at 1:57 p.m., with the DON, the DON stated care planning provided important knowledge to care for a resident's specific needs and requests. The DON further stated that Latuda, Trazodone, and Seroquel should be care planned as part of Resident 7's care. The DON further stated without care planning for those medications, the staff would not recognize the right interventions for the specific medications and would risk not being able to stabilize and manage Resident 7's behaviors. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/16/2024, indicated, a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and was developed and implemented for each resident. The comprehensive, person-centered care plan included measurable objectives and timeframes, described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and would reflect currently recognized standards of practice for problem areas and conditions. 48678 3. A review of Resident 72's Admission Record indicated the facility admitted the resident on 6/24/2024 with diagnosis of viral hepatitis C. A review of Resident 72's History and Physical (H&P, a comprehensive assessment of a resident and their problem) dated 6/25/2024, indicated Resident 72 did not have the capacity to understand and make decisions. A review of Resident 72's MDS, dated [DATE], indicated Resident 72 required partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for activities of daily living. During a concurrent interview and record review on 7/24/2024 at 12:03 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 72's care plans dated 6/24/2024 to 7/24/2024. LVN 1 stated there was no care plan developed for Resident 72's diagnosis of viral hepatitis C. LVN 1 stated a care plan for viral hepatitis C is important to have as a basis for interventions and goals for that particular problem, such as, ensure Resident 72 is well hydrated, has a consult with the Registered Dietician, and has laboratory results scheduled. LVN 1 stated the facility has 14 days to complete the care plan, after the initial admission assessment, and stated Resident 72 should have a care plan developed for his medical condition of hepatitis C. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 7/25/2024 at 1:57 p.m., with DON, the DON stated the purpose of a care plan is to list interventions residents need and to determine plan of care for the resident. The DON stated care plans are developed for a resident once the facility identifies medications and diagnosis. The DON stated the licensed nurses are responsible for developing a care plan, and should include every single diagnosis and all the medications that residents have and are taking. The DON stated the time frame in which care plans are developed are with 48 hours upon admission, seven days after the MDS closes for comprehensive care plans, and right away for any changes of condition. The DON stated if a resident has hepatitis C, it should have a care plan developed because if a care plan does not exist the facility would not know if the hepatitis is active, or not active, if treatment is needed, and to alert the staff of what precautions to take such as what personal protective equipment (PPE- specialized clothing or equipment worn by an employee for protection against infectious materials) to wear.

A review of the facility's policy and procedure titled, Care Plans Comprehensive Person-Centered last reviewed 1/16/2024, indicated, the comprehensive person-centered care plan is developed within seven days of the completion of the MDS assessment, includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychological well-being, and reflects currently recognized standards of practice for problem areas and conditions.

48142

4.a. A review of Resident 59's Admission Record indicated the facility admitted the resident on 4/26/2024, with a diagnosis of UTI.

A review of Resident 59's MDS, dated [DATE], indicated Resident 59 had the ability to make self-understood and understand others.

A review of Resident 59's Order Summary Report, indicated an order for sulfamethoxazole-trimethoprim (antibiotic) oral tablet 800-160 mg, give one tablet by mouth two times a day for UTI for seven days, ordered on 4/26/2024.

During a concurrent interview and record review on 7/24/2024 at 2:07 p.m., with LVN 1, reviewed Resident 59's care plans dated 4/26/2024 to 7/24/2024. LVN 1 stated Resident 59 did not have a care plan for sulfamethoxazole-trimethoprim use and a care plan for UTI. LVN 1 stated that these care plans are important for outlining interventions and target goals, as well as for communicating with the care team provider.

During an interview on 7/25/2024 at 1:57 p.m., with the DON, the DON stated a care plan is a personalized guide for a resident's care, detailing necessary interventions and treatments. The DON stated a care plan is developed by licensed nurses based on the resident's medications, diagnoses, and individual needs. The DON stated the care plan is crucial for ensuring the resident receives appropriate care and helps the care team communicate effectively.

A review of facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, last reviewed date on 1/16/2024, indicated the comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions.

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NAME OF PROVIDER OR SUPPLIER: Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 21820 Craggy View St. Chatsworth, CA 91311	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.b. A review of Resident 27's Admission Record indicate the facility admitted the resident on 1/27/2022 with diagnosis of UTI. A review of Resident 27's History and Physical (H&P) dated 6/5/2023, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 27's Order Summary Report, indicated an order for ceftriaxone sodium (antibiotic) inject one dose intramuscularly (injection of a substance into a muscle) one time a day for UTI for five days, ordered on 6/4/2024. During a concurrent interview and record review on 7/24/2024 at 2:10 p.m., with LVN 1, reviewed Resident 27's care plans dated 6/4/2024 to 7/24/2024. LVN 1 stated Resident 27 did not have a care plan for ceftriaxone sodium use and a care plan for UTI. LVN 1 stated that these care plans are important for outlining interventions and target goals, as well as for communicating with the care team provider. During an interview on 7/25/2024 at 1:57 p.m., with the DON, the DON stated a care plan is a personalized guide for a resident's care, detailing necessary interventions and treatments. The DON stated a care plan is developed by licensed nurses based on the resident's medications, diagnoses, and individual needs. The DON stated the care plan is crucial for ensuring the resident receives appropriate care and helps the care team communicate effectively. A review of facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed date on 1/16/2024, indicated the comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49252

Based on observation, interview, and record review the facility failed to:

1. Ensure medication administration was supervised and medications were not left at bedside for one of 30 sampled residents (Resident 7).

This deficient practice had the potential to allow Resident 7 to miss a dose of medications and allow other residents to consume the medications.

2. Ensure a resident's bed was positioned in the lowest position while the resident was in bed, as ordered by the physician, for one of 30 sampled residents (Resident 22).

This deficient practice had the potential to place the resident at increased risk of sustaining a fall with injuries.

3. Ensure one of one resident (Resident 118), who was at high risk for falls, had bilateral landing mats placed in her room next to her bed as ordered by physician.

This deficient practice had the potential to place the resident at increased risk of sustaining an injury.

Findings:

1. A review of Resident 7's Admission Record indicated the facility readmitted the resident on 4/30/2024 with diagnoses that included end stage renal disease (ESRD- a condition in which the kidneys [organs that remove waste products from the blood and produce urine] no longer function normally).

A review of Resident 7's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) assessment dated [DATE], indicated Resident 7 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses).

A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated the following physician orders:

- Divalproex sodium (medication used to treat seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]) extended release oral tablet 24 hour 500 milligrams (mg, unit of measurement), give one tablet orally one time a day for seizure disorder, ordered on 5/6/2024.

- Latuda oral (medication to treat psychosis [severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality]) tablet 40 mg, give one tablet orally one time a day related to unspecified psychosis not due to a substance or known physiological condition manifested by aggressive behavior towards staff during care, ordered on 5/6/2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Mirapex (medication used to treat restless leg syndrome [condition that causes a very strong urge to move the legs]) oral tablet 0.5 mg, give one tablet by mouth three times a day for restless leg syndrome, ordered on 6/2/2024. - Seroquel (medication used to treat certain mental/mood disorders) oral tablet 50 mg, give one tablet orally two times a day for bipolar disorder (mood disorder that causes intense shifts in mood, energy levels, and behavior) manifested by angry outbursts, ordered on 5/6/2024. - Benztropine mesylate (medication used to treat symptoms of Parkinson's Disease [progressive disorder that affects the nervous system and the parts of the body controlled by the nerve]) oral tablet 1 mg, give one tablet orally two times a day for Parkinson's Disease, ordered on 5/6/2024. - Carvedilol (medication used to treat hypertension [high blood pressure, the force of the blood pushing on the blood vessel walls is too high]) oral tablet 12.5 mg, give one tablet orally two times a day for hypertension, ordered on 5/6/2024. During an observation on 7/22/2024 at 10:19 a.m., in Resident 7's room, observed Resident 7 lying in bed with several medications in a medication cup on Resident 7's bedside table. During a concurrent observation and interview on 7/22/2024 at 10:20 a.m., in Resident 7's room with Registered Nurse 1 (RN 1), observed a cup of medications filled with various pills on Resident 7's bedside table. RN 1 stated they were probably from the 9 a.m. medication administration. RN 1 further stated, they shouldn't have been left on the bedside table and the nurse should have watched Resident 7 take the pills. RN 1 stated if Resident 7 isn't administered her pills this would result in her conditions not being treated. During a concurrent interview and record review on 7/22/2024 at 3:28 p.m., with Licensed Vocational Nurse 5 (LVN 5), reviewed Resident 7's Medication Administration Record (MAR, report that serves as a legal record of the drugs administered to a resident by a health care professional) dated 7/2024 and Resident 7's morning bubble packs (plastic packaging in which a medication is stored until ready for use). LVN 5 stated she left the following six medications at Resident 7's bedside in the medication cup: 1. Divalproex sodium extended release oral tablet 24 hour 500 mg 2. Latuda oral tablet 40 mg 3. Mirapex oral tablet 0.5 mg 4. Seroquel oral tablet 50 mg 5. Benztropine mesylate oral tablet 1 mg 6. Carvedilol oral tablet 12.5 mg (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated she became distracted when another resident needed assistance and made a mistake leaving the medications at the bedside without witnessing Resident 7 take the 9 a.m. medications. LVN 5 further stated she should have watched Resident 7 swallow the medications to ensure resident safety. LVN 5 stated it was important to ensure another resident wouldn't have the opportunity to take the medications. During an interview on 7/24/2024 at 11:11 a.m., with RN 1, RN 1 stated Resident 7 cannot self-administer her medications and the nurse who administers the medications should stay there and watch the resident take them. A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated there were no physician orders for self-administration of medications. During an interview on 7/25/2024 at 2:09 p.m., with the Director of Nursing (DON), the DON stated that medications for residents who cannot self-administer should not be left at the bedside. The DON stated the nurse observes that the resident swallows the medication before leaving the room to know the medications are being taken. The DON stated improper medication administration could cause harm to the resident because the resident may not take the medications, the resident could potentially throw the medications out, or another confused resident could take Resident 7's medications. A review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures - IIB2: Oral Medication Administration, last reviewed 1/16/2024, indicated, the purpose was to administer oral medications in a safe, accurate, and effective manner. The procedure indicated to administer medications and remain with the resident while the medications were swallowed. A review of the facility's P&P titled, Preparation and General Guidelines - IIA1: Equipment and Supplies for Administering Medications, last reviewed 1/16/2024, indicated medications are administered at the time they are prepared, without unnecessary interruptions by the person who prepared the dose. The P&P indicated medications are administered within (60 minutes) of schedule time and resident is always observed after administration to ensure that the dose was completely ingested. 38549 2. A review of Resident 22's Admission Record indicated the facility admitted the resident on 3/22/2024 with diagnoses including lack of coordination, abnormalities of gait (a person's manner of walking) and mobility, and a history of falling. A review of Resident 22's MDS, dated [DATE], indicated the resident had severely impaired cognition (thought processes) and required partial/moderate assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 22's physician's orders indicated to implement fall precaution by placing the bed in the lowest position when the resident is in bed, ordered on 3/22/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/23/2024 at 10:01 a.m., with Certified Nursing Assistant 5 (CNA 5), observed Resident 22 awake in bed with their bed not placed in the lowest position. When asked if Resident 22's bed was in its lowest position, CNA 5 lowered the bed until it was in the lowest position. CNA 5 stated she did not like to keep Resident 22's bed in the lowest position because it was harder for the resident to stand up to go to the bathroom when she tried to assist him. CNA 5 stated if the bed was positioned higher, then the resident was able to stand up better. During an interview on 7/25/2024 at 2:36 p.m., with the DON, the DON stated that if the physician ordered for a resident's bed to be placed in the lowest position for fall precaution, then the nurses should be following the order because it could possibly lessen the severity of an injury if the resident were to have a fall. A review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, last reviewed on 1/16/2024, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .Environmental factors that contribute to the risk of falls include incorrect bed height or width .In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 48678 3. A review of Resident 118's Admission Record indicated the facility admitted the resident on 6/7/2024 with diagnosis of encephalopathy (disease of the brain that alters brain function or structure) and difficulty walking. A review of Resident 118's History and Physical (H&P, a comprehensive assessment of a resident and their problem) dated 6/7/2024 indicated Resident 118 had fluctuating (changing frequently and uncertainly) capacity (ability to make decisions). A review of Resident 118's MDS, dated [DATE] indicated Resident 118 required partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) with activities of daily living (ADLs) and mobility. A review of Resident 118's Order Summary dated 7/4/2024, indicated Resident 118 was on fall precautions, and bed should be on lowest position when Resident 118 is in bed, as well as place bilateral landing mattress. During a concurrent observation and interview on 7/23/2024 at 10:33 a.m., with Certified Nursing Assistant 2 (CNA 2), in Resident 118's room, CNA 2 visually verified that Resident 118 did not have landing matts in her room, next to her bed. CNA 2 stated that residents who are at high risk for falls are attended to more frequently by providing residents frequent visual checks, removing clutter from resident's rooms, keeping the floor clean, and attend to resident's needs as fast as possible. CNA 2 stated, landing matts are also provided to residents who are at risk for falls, and believed Resident 118 should have one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/23/2024 at 10:36 a.m., with the Director of Staff Development (DSD), reviewed Resident 118's Fall Risk Observation/assessment dated [DATE]. The Fall Risk Observation/Assessment indicated Resident 118 had a score of 18 (was at high risk for experiencing falls based on the assessment tool implemented by the facility). The DSD stated if the resident has an order for a landing matt, then a landing matt should be provided. The DSD stated Resident 118 did not have landing matts in her room and no other interventions were currently in place to prevent Resident 118 from falling and sustaining an injury. The DSD stated Resident 118 should have the landing matts since there was a physician order, and not having the landing matts placed Resident 118 at risk for falls and injury. A review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, dated 5/2024, indicated the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the risk of falls for each resident at risk or with a history of falls. In conjunction with the attending physician, staff will identify and implement relevant interventions [hip padding or treatment of osteoporosis (bone disease where bone density decreases), as applicable] to try to minimize serious consequences of falling.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 38549 Based on interview and record review, the facility failed to ensure licensed nurses documented that they attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (prn) opioid medications (medication used to treat moderate to severe pain) on multiple days for one of 30 sampled residents (Resident 29). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from opioid pain medication. Findings: A review of Resident 29's Admission Record indicated the facility admitted the resident on 5/3/2024 with diagnoses including polyneuropathy (disease or dysfunction of one or more peripheral nerves [nerves located outside of the brain and spinal cord], typically causing numbness or weakness) and chronic pulmonary edema (a condition that occurs when fluid builds up in the lungs over time, making it difficult to breathe). A review of Resident 29's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/10/2024, indicated the resident had moderately impaired cognition (thought processes) and required partial/moderate assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 29's physician's orders indicated an order for hydrocodone-acetaminophen (opioid pain medicine) 5-325 milligrams (mg - unit of measurement), give one tablet by mouth every eight hours as needed for moderate pain 4-7/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 7/1/2024 and discontinued on 7/15/2024. During a concurrent interview and record review on 7/24/2024 at 2:45 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 29's Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) dated 7/2024. LVN 1 stated he could not find any documentation indicating the licensed nurses provided the resident with nonpharmacological interventions prior to administering hydrocodone-acetaminophen 5-325 mg on the following dates/times: - 7/4/2024 at 8:26 a.m. -7/5/2024 at 8 a.m. -7/8/2024 at 8:27 a.m. -7/9/2024 at 7:30 p.m. -7/11/2024 at 8:31 a.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7/12/2024 at 8:32 a.m. -7/13/2024 at 8:18 a.m. -7/15/2024 at 8:30 a.m. During an interview on 7/25/2024 at 2:33 p.m., with the Director of Nursing (DON), the DON stated that nurses should be attempting nonpharmacological interventions prior to administering prn opioid pain medications because, sometimes, residents might just need some comfort measures or to be repositioned. The DON stated the resident may not even need the medication. The DON stated it was important it was important to not rely on opiate pain medication to relieve residents' pain because it can cause adverse side effects such as increased risk for falls and sedation (sleepiness caused by certain drugs). A review of the facility's policy and procedure titled, Pain Assessment and Management, last reviewed on 1/16/2024, indicated that non-pharmacological interventions may be appropriate alone or in conjunction with medications.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview, and record review the facility failed to ensure a resident was free from significant medication error by failing to administer several medications as ordered by the physician for one of 30 sampled residents (Resident 7). This deficient practice resulted in Resident 7 receiving her medications late and had the potential to result in Resident 7 missing a dose of her medications. Findings: A review of Resident 7's Admission Record indicated the facility readmitted the resident on 4/30/2024 with diagnoses that included end stage renal disease (ESRD- a condition in which the kidneys [organs that remove waste products from the blood and produce urine] no longer function normally). A review of Resident 7's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) assessment dated [DATE], indicated Resident 7 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated the following physician orders: - Divalproex sodium (medication used to treat seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]) extended release oral tablet 24 hour 500 milligrams (mg, unit of measurement), give one tablet orally one time a day for seizure disorder, ordered on 5/6/2024. - Latuda oral (medication to treat psychosis [severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality]) tablet 40 mg, give one tablet orally one time a day related to unspecified psychosis not due to a substance or known physiological condition manifested by aggressive behavior towards staff during care, ordered on 5/6/2024. - Mirapex (medication used to treat restless leg syndrome [condition that causes a very strong urge to move the legs]) oral tablet 0.5 mg, give one tablet by mouth three times a day for restless leg syndrome, ordered on 6/2/2024. - Seroquel (medication used to treat certain mental/mood disorders) oral tablet 50 mg, give one tablet orally two times a day for bipolar disorder (mood disorder that causes intense shifts in mood, energy levels, and behavior) manifested by angry outbursts, ordered on 5/6/2024. - Benztropine mesylate (medication used to treat symptoms of Parkinson's Disease [progressive disorder that affects the nervous system and the parts of the body controlled by the nerve]) oral tablet 1 mg, give one tablet orally two times a day for Parkinson's Disease, ordered on 5/6/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Carvedilol (medication used to treat hypertension [high blood pressure, the force of the blood pushing on the blood vessel walls is too high]) oral tablet 12.5 mg, give one tablet orally two times a day for hypertension, ordered on 5/6/2024. During an observation on 7/22/2024 at 10:19 a.m., in Resident 7's room, observed Resident 7 lying in bed with several medications in a medication cup on Resident 7's bedside table. During a concurrent observation and interview on 7/22/2024 at 10:20 a.m., in Resident 7's room with Registered Nurse 1 (RN 1), observed a cup of medications filled with various pills on Resident 7's bedside table. RN 1 stated they were probably from the 9 a.m. medication administration. RN 1 further stated, they shouldn't have been left on the bedside table and the nurse should have watched Resident 7 take the pills. RN 1 stated if Resident 7 isn't administered her pills this would result in her conditions not being treated. During a concurrent interview and record review on 7/22/2024 at 3:28 p.m., with Licensed Vocational Nurse 5 (LVN 5), reviewed Resident 7's Medication Administration Record (MAR, report that serves as a legal record of the drugs administered to a resident by a health care professional) dated 7/2024 and Resident 7's morning bubble packs (plastic packaging in which a medication is stored until ready for use). LVN 5 stated she left the following six medications at Resident 7's bedside in the medication cup: 1. Divalproex sodium extended release oral tablet 24 hour 500 mg 2. Latuda oral tablet 40 mg 3. Mirapex oral tablet 0.5 mg 4. Seroquel oral tablet 50 mg 5. Benztropine mesylate oral tablet one (1) mg 6. Carvedilol oral tablet 12.5 mg LVN 5 stated she became distracted when another resident needed assistance and made a mistake leaving the medications at the bedside without witnessing Resident 7 take the 9 a.m. medications. LVN 5 further stated she should have watched Resident 7 swallow the medications to ensure resident safety. LVN 5 stated if the resident missed these medications or did not take them on time, she could experience blood pressure issues, behavioral or other negative physical effects. During an interview on 7/24/2024 at 11:11 a.m., with RN 1, RN 1 stated Resident 7 cannot self-administer her medications and the nurse who administers the medications should stay there and watch the resident take them. A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated there were no physician orders for self-administration of medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/2024 at 2:15 p.m., with the Director of Nursing (DON), the DON stated standard protocol for medication administration is for 9 a.m. medications to be given from 8 a.m. to 10 a.m. The DON further stated, Resident 7's 9 a.m. medications were given late. The DON further stated there are risks to Resident 7 not receiving her medications or in a timely manner. A review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures - IIB2: Oral Medication Administration, last reviewed 1/16/2024, indicated, the purpose was to administer oral medications in a safe, accurate, and effective manner. The procedure indicated to administer medications and remain with the resident while the medications were swallowed. A review of the facility's P&P titled, Preparation and General Guidelines - IIA1: Equipment and Supplies for Administering Medications, last reviewed 1/16/2024, indicated medications are administered at the time they are prepared, without unnecessary interruptions by the person who prepared the dose. The P&P indicated medications are administered within (60 minutes) of schedule time and resident is always observed after administration to ensure that the dose was completely ingested.

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 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stoney Point Healthcare Center	21820 Craggy View St. Chatsworth, CA 91311

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38469 Based on observation, interview, and record review, the facility failed to follow safe food handling practices by failing to discard two bags of hotdog buns 12 days past their best by date. This deficient practice had the potential to place 24 out of 121 residents living in the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a kitchen observation on 7/22/2024 at 8:11 a.m., with Kitchen Supervisor 1 (KS1), observed two bags of hotdog buns containing 12 buns in each bag with a Best By date of 7/10/2024. KS 1 stated he is going to discard the hotdog buns. KS 1 further stated that the hotdog buns are no longer safe for the residents to consume if past its Best By date. KS 1 stated that hotdog buns may already have mold and if eaten could result to foodborne illnesses. A review of the facility's policy and procedure titled, Food Receiving and Storage, last reviewed on 1/16/2024, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices .

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NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident's indwelling catheter (a flexible tube that drains urine from the bladder) was not touching the floor for one of one sampled resident (Resident 279). 2. Ensure a resident's oxygen tubing and oxygen humidifier were labeled and stored properly for one of 30 sampled residents (Resident 7). 3. Ensure a resident's nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) oxygen tubing was not touching the inside of the trashcan for one of one sampled resident (Resident 117). These deficient practices had the potential to result in contamination of the resident's care equipment and placed the residents at risk for infection. Findings: 1. A review of Resident 279's Admission Record indicated the facility admitted the resident on 5/20/2024 with a diagnosis of obstructive and reflux uropathy (a condition in which the flow of urine is blocked). A review of Resident 279's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/16/2024, indicated Resident 279 has severe cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment. A review of Resident 279's physician's orders, indicated an order to change indwelling catheter 16 French (Fr, a universal system used to measure the size of catheters) 10 cubic centimeter (cc, unit of measurement) bulb attached to gravity drainage bag every month on Sunday and as needed plugged, leaking, or dislodged, ordered on 7/9/2024. During a concurrent observation and interview on 7/23/2024 at 2:59 p.m., with Certified Nursing Assistant (CNA 2) in Resident 279's room, observed Resident 279's indwelling catheter tubing touching the floor. CNA 2 stated the indwelling catheter tubing should not be touching the floor because the floor was dirty and Resident 279 could possibly get an infection. During an interview on 7/25/2024 at 9:38 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated that an indwelling catheter tube should never touch the floor. The IPN stated if it does, it can pick up germs that could cause an infection in the resident. A record review of facility's policy and procedure titled, Catheter Care, last reviewed date on 1/16/2024, indicated to be sure the catheter tubing and drainage bag are kept off the floor. 49252 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 21820 Craggy View St. Chatsworth, CA 91311	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 7's Admission Record indicated the facility readmitted the resident on 4/30/2024 with diagnoses that included end stage renal disease (ESRD- a condition in which the kidneys [organs that remove waste products from the blood and produce urine] no longer function normally). A review of Resident 7's MDS dated [DATE], indicated Resident 7 had severely impaired cognition. A review of Resident 7's Order Summary Report, dated 7/25/2024, indicated an order for oxygen inhalation at two (2) liters per min (LPM, unit of measurement) via nasal cannula as need for shortness of breath and comfort with a titration (adjusting the dose of a medication) of three (3) to five (5) liters as needed, ordered 5/8/2024. During a concurrent observation and interview on 7/22/2024 at 10:25 a.m., with Registered Nurse 1 (RN 1) in Resident 7's room, observed Resident 7's oxygen concentrator (medical device that gives oxygen) humidifier and nasal cannula were both unlabeled with the nasal cannula around the oxygen concentrator and touching the floor. RN 1 stated the humidifier and nasal cannula should both be labeled with a date, and the nasal cannula should be stored in a plastic bag and labeled with a date, time and the nurse's initials. RN 1 stated this should be done to prevent the spread of infection to the resident. During an interview on 7/25/2024 at 2:03 p.m., with the Director of Nursing (DON), the DON stated the nurses are responsible for labeling the oxygen equipment and the nasal cannula should be kept in a labeled plastic bag when not in use. The DON stated labeling and proper storage were done for infection control measures and when it wasn't done the staff would not know when the humidifier or nasal cannula should be changed, which could cause infection to the resident when used. A review of the facility's policy and procedure titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated 1/16/2024, indicated the purpose was to guide prevention of infection associated with respiratory therapy tasks and equipment among residents. Infection control considerations related to oxygen administration stated to mark the humidifier bottle with the date and keep the oxygen cannula and tubing used as needed in a plastic bag when not in use. 38469 3. A review of Resident 117's Admission Record indicated the facility admitted the resident on 5/3/2024 with diagnoses including chronic pulmonary disease (a common lung disease causing restricted airflow and breathing problems) and difficulty in walking. A review of Resident 117's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was moderately impaired. The MDS further indicated that Resident 117 required maximal assistance with toileting hygiene, shower, lower body dressing, and putting on and taking off footwear. A review of Resident 117's physician's orders dated 5/3/2024, indicated an order to administer oxygen at two (2) LPM via nasal cannula, may titrate up to 5 LPM as needed to keep oxygen saturation (the amount of oxygen that's circulating in the blood) above 90%. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/22/2024 at 10:47 a.m., with the Assistant Director of Nursing (ADON), observed Resident 117 lying in bed and a portion of the length of their nasal cannula tubing inside the trash bin. The ADON stated trash cans and floors are contaminated and Resident117's tubing must be replaced to prevent inadvertently introducing infectious agents to the resident which can lead to sickness. A review of the facility's policy and procedure titled, Policies and Practices- Infection Control, last reviewed date on 1/16/2024, indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. A review of the Centers for Disease Control and Prevention (CDC) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.