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	07/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a facility staff knocked and asked permission prior to entering a resident's room for two of two sampled residents (Resident 18 and 44). This deficient practice violated the residents' rights to be treated with respect and dignity, which had the potential to affect the residents' sense of self-worth and self-esteem.Findings:a. During a review of Resident 18's admission Record, the admission Record indicated the facility admitted the resident on 5/30/2025 with diagnoses including, Alzheimer`s Disease (a progressive disease that destroys memory and other important mental functions) and lack of coordination.During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool) dated 6/6/2025, the MDS indicated the resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses. The MDS indicated that Resident 18 was totally dependent on staff for activities of daily living (ADLs- activities related to personal care). b. During a review of Resident 44's admission Record, the admission Record indicated the facility originally admitted the resident on 4/14/2021 and readmitted the resident on 1/27/2025 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 44's MDS dated [DATE], the MDS indicated the resident had severely impaired cognition. The MDS indicated that Resident 44 was totally dependent on staff for ADLs. During a concurrent observation and interview on 6/30/2025 at 10:01 a.m., with Certified Nurse Assistant 2 (CNA 2), observed CNA 2 entering Resident 18`s room without knocking on the door and asking permission to go in. At this time Resident 18 was in her bed. After CNA 2 exited Resident 18`s room, CNA 2 was observed entering Resident 44`s room without knocking and asking permission to go in the room. At this time Resident 44 was in her bed. Upon exiting the room, CNA 2 stated she (CNA 2) forgot to knock on the residents' rooms and stated that she should have knocked and asked permission to go in since this is the residents' home.During an interview on 7/2/2025 at 10:26 a.m., with the Director of Nursing (DON), the DON stated that anyone entering a resident`s room must knock and ask permission prior to entering the resident`s room. The DON stated resident`s privacy should be respected. The DON stated that residents should be treated with respect and dignity.During a review of the facility`s policy and procedure titled, Dignity, last reviewed on 1/21/2025, the policy indicated, 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 are expected to knock and request permission before entering residents' rooms.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal his/her need for assistance from staff) was within a resident's reach while in bed for one of one sampled resident (Resident 25). This deficient practice had the potential to delay the provision of services and the resident's needs not being met.Findings:During a review of Resident 25's admission Record, the admission Record indicated the facility admitted the resident on 9/23/2024 with diagnoses that included dysphagia (difficulty swallowing) and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2025, the MDS indicated Resident 25's cognition (a mental process of acquitting knowledge and understanding) was impaired. The MDS indicated Resident 25 required supervision with activities of daily living (ADLs - activities related to personal care). During a concurrent observation and interview on 6/30/2025 at 10:07 a.m., with Certified Nurse Assistant 3 (CNA 3), observed Resident 25's call light on the floor and not within reach while the resident was in his bed. CNA 3 stated that call light should be placed behind the pillow to make sure the call light is within reach.During an interview on 7/3/2025 at 8:16 a.m., with the Administrator in Training (AIT), the AIT stated that call light is the primary means of contact when the resident requires assistance from staff. The AIT stated that the call light should be accessible and within easy reach. The AIT stated that if it's not within the resident`s reach, there could be a delay in getting help to the resident and can be frustrating for the resident. During a review of the facility`s policy and procedure titled, Answering the Call Light, last reviewed on 1/21/2025, indicated that the purpose of this policy and 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the resident's Advance Directive (AD- a legal document indicating resident preference on end-of-life treatment decisions) was kept in the resident's medical chart and easily retrievable for two of eight sampled residents (Resident 40 and 81).This deficient practice had the potential to create confusion which could lead to conflict with the resident`s wishes regarding their health care.Findings: a. During a review of Resident 40’s admission Record, the admission Record indicated that the facility admitted the resident on 7/5/2025, with diagnoses including dysphagia (difficulty swallowing), type 2 diabetes (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 40’s Minimum Data Set (MDS – a resident assessment tool) dated 5/1/2025, the MDS indicated that Resident 40 could understand others and make himself understood. The MDS indicated that Resident 40 was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 40’s Advance Directive Acknowledgement form (ADA- a document provided by the facility that indicates whether a resident has an AD, would like information regarding creation of an AD, or refusal to create an AD) dated 3/27/2025, the ADA form indicated that the resident had executed an AD dated 11/28/2012, and the facility received a copy on 3/27/2025. During a concurrent interview and record review on 7/1/2025 at 1:29 p.m., with the Medical Records Director (MRD), reviewed Resident 40`s ADA form dated 3/27/2025. The MRD stated that Resident 40`s ADA form indicated that the resident had executed an AD, and the facility received a copy of Resident 40’s AD on 3/27/2025. The MRD further stated a copy of Resident 40’s AD was not readily present in Resident 40`s chart but it should be there in case of an emergency.  During an interview on 7/3/2025 at 12:33 pm, with the Assistant Director of Nursing (ADON), the ADON stated that if a resident has an AD, a copy of the resident`s AD should be kept in the resident’s active chart to provide guidance to the facility`s staff about the resident’s wishes. The ADON stated that Resident 40`s AD was not present in his chart and the potential outcome is not honoring the resident`s wishes.  During a review of the facility`s policy and procedure (P&P) titled, “Advanced Directives,” last reviewed on 1/21/2025, the P&P indicated that the resident has the right to formulate and AD, including the right to accept or refuse medical or surgical treatment. Advanced Directives are honored in accordance with the state law and facility policy. The resident`s wishes are communicated to the resident`s direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record and discussing the resident`s wishes in care planning meetings. b. During a review of Resident 81’s admission Record, the admission Record indicated that the facility admitted the resident on 1/3/2025 with diagnoses including dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and anemia (a condition where the body does not have enough healthy red blood cells). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 81’s MDS dated [DATE], the MDS indicated that the resident`s cognitive skills (brain’s ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 81 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 81’s ADA dated 6/18/2025, the ADA form indicated that the resident had executed an AD, and the facility received a copy on 1/8/2025. During a review of Resident 81’s Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) form dated 1/8/2025, the POLST form indicated that Resident 81 had an AD. During a concurrent interview and record review on 7/1/2025 at 8:49 a.m., with the Social Service Director (SSD), reviewed Resident 81`s ADA form dated 6/18/2025. The SSD stated that Resident 81`s ADA form indicated that the resident had executed an AD, and the facility received a copy of the AD on 1/8/2025. However, the copy of Resident 81’s AD is not readily present in Resident 81`s chart. The SSD stated that a copy of Resident 81’s AD should be placed in the resident`s active chart to be referenced in case of emergency and to determine the resident`s wishes as far as health care and medical interventions. The SSD stated that there is a potential risk of violating the resident`s healthcare wishes if the AD is not accessible to the staff. During an interview on 7/3/2025 at 12:10 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that if a resident has executed an AD, a copy of the resident`s AD should be kept in the resident’s active chart to provide guidance to the facility`s staff about the resident’s wishes. The ADON stated that Resident 81`s AD was not present in his chart and the potential outcome is not honoring the resident`s wishes. During a review of the facility`s policy and procedure (P&P) titled, “Advanced Directives,” last reviewed on 1/21/2025, the P&P indicated that the resident has the right to formulate and AD, including the right to accept or refuse medical or surgical treatment. Advanced Directives are honored in accordance with the state law and facility policy. The resident`s wishes are communicated to the resident`s direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record and discussing the resident`s wishes in care planning meetings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three (Resident 12, Resident 65, Resident 121) of 6 sampled residents were free from unnecessary medication by failing to:1. Ensure the following conditions existed for Seroquel (brand name for an antipsychotic medication, a drug that affects brain activities associated with mental processes and behavior) to be prescribed: the symptoms are identified as being due to mania (mental state of an extreme highs or depressive lows) or psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) or delusions, (having false or unrealistic beliefs such as paranoia [unjustified mistrust of others]/grandiosity [inflated sense of superiority]; the behavioral symptoms (sudden anger outburst) present a danger to the resident or others; and the symptoms are significant enough that the resident is experiencing inconsolable/persistent distress for Resident 12. There was no documentation ensuring the symptoms are not due to a medical condition that can be expected to resolve/improve as the underlying condition is treated for Resident 12. These failures placed Resident 12 at risk for adverse reactions and side effects related to antipsychotic use with symptoms that included sedation (drowsiness), dizziness, placing the resident at risk for fall.2. Ensure licensed nurses attempted nonpharmacological interventions (treatments or strategies that do not involve the use of medications) prior to administering as needed (PRN) Ativan (primarily used for the short-term treatment of anxiety disorders, including generalized anxiety disorder, panic attacks, and social phobias) for Resident 65. This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects such as delirium, cognitive (the mental processes involved in gaining knowledge and comprehension) impairment and increased risk of falls.3. Ensure staff monitored behaviors prior to administering Clonazepam (medication used to treat symptoms of anxiety [a condition where a person experiences feelings of worry, nervousness or unease]) for Resident 121.This failure had the potential to result in improper use of medication for Resident 121, due to the lack of behavioral assessment. Findings: a. During a review of Resident 12’s admission Record (or face sheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) with mood disturbance (a significant change in a person's emotional state that persists for an extended period). The admission Record indicated Family Member 1 (FM 1) is the primary medical decision maker for Resident 12. During a review of Resident 12’s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 6/17/2025, the MDS indicated Resident 12 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 12 required supervision or touching assistance (helper provides verbal cures and/or touching assistance as resident completes activity) with oral and personal hygiene. The MDS indicated Resident 12 required moderate assistance (helper does less than half the effort) with walking. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12’s Physician’s Orders, dated 4/03/2025, the Physician Orders indicated an order for Seroquel 25 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give 0.5 tablet by mouth at bedtime for psychosis manifested by sudden anger outburst During a review of Resident 12’s Care Plan for Antipsychotic, initiated 7/02/2025, the Care Plan indicated a goal that the resident will exhibit a therapeutic effect related to the use of the medication, Seroquel. The care plan indicated interventions that included: attempt a gradual dose reduction as condition improves and attempt non-pharmacological approaches prior to medication administration (i.e. provide quiet and dark environment and keep as comfortable as possible). During a review of Resident 12’s Medication Regimen Review (MRR, a monthly review of resident’s records to ensure there is an adequate indication for a prescribed medication), created between 4/24/2025 and 4/25/2025, the MRR indicated the following:- For Seroquel, ensure there is documentation in the chart to show that the symptoms are: not due to a medication condition that can be expected to resolve/improve as the underlying condition is treated; and, persistent or likely to reoccur without continued agreement; and not sufficiently relieved by non-drug interventions; and not due to environmental stressors; and not due to psychological stressors or anxiety/fear stemming from misunderstanding related to the cognitive impairment that can be expected to improve/resolve as the situation is addressed.- For Seroquel, make sure to have evidence in the chart that one of the following conditions exist: the symptoms are identified as being due to mania or psychosis (i.e. auditory/visual/other hallucinations, delusions; the behavioral symptoms (sudden anger outburst) present a danger to the resident or others; the symptoms are significant enough that the resident is experiencing inconsolable/persistent distress, a significant decline in function, or substantial difficulty receiving needed care.-For Seroquel a fasting blood glucose (simple sugar, the body’s primary source of energy from food drawn after a period of fasting), lipid panel (a measurement of the fats in the blood) and electrocardiogram (EKG, measuring the electrical activity of the heart which detects abnormal heart rates) is recommended. Monitor orthostatic hypotension (a sudden drop in blood pressure that occurs when a person stands up after sitting or lying down which can cause dizziness, lightheadedness, and fainting) weekly by taking blood pressure in two different positions, three to five minutes apart (lying, sitting, standing). Notify the physician and psychiatrist if noted decline of 20 millimeters of mercury (mm Hg, a unit of measurement for blood pressure) in systolic blood pressure (SBP, the pressure in the arteries when the heart muscle pumps blood throughout the body) or 10 mm Hg drop in diastolic blood pressure (DBP, the pressure in the arteries when the heart is resting between beats). During a review of Resident 12’s Initial Psychiatric Interview, dated 4/08/2025, the Initial Psychiatric Interview indicated the following: NP 1 consulted with Resident 12. Alert and oriented times one (to name), disorganized and forgetful. (Resident 12) did not provide meaningful feedback. Irritable and aggressive towards staff during patient care. Spoke to FM 1 but refused to make any adjustment. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12’s Nurse Practitioner 1’s (NP 1) Notes, dated 4/09/2025, the notes indicated the following: Psych consulted with Resident 12. Considering gradual dose reduction (GDR, stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) but was not placed due to Resident 12 responsible party’s (FM 1) refusal. Writer provided rationale for GDR and risk versus benefits and why writer recommended GDR recommendation. However, Resident 12/FM 1 refused GDR stating the current dose is needed for the maintenance and did not agree with pharmacist GDR recommendation. Writer discussed current plan of care. No concerning significant behaviors were noted but promptings at times are needed. During a review of Resident 12’s Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) indicated the following behaviors of “sudden anger outburst” for the following months:4/2025 no behaviors5/2025 2 behavioral episodes6/2025 3 behavioral episodes During a concurrent interview and record review with Licensed Vocational Nurse 2 (LVN 2) on 7/01/2025 at 2:26 p.m., reviewed Resident 12’s Physician’s Orders. LVN 2 stated Resident 12 is cooperative, sometimes gets up without asking for help and is “pretty manageable.” During an interview with LVN 1 on 7/01/2025, she stated when Resident 12 does not like noise, he waves his hand and goes back to his room. LVN 1 stated she has not seen behavioral issues with Resident 12. During an interview with LVN 3 on 7/01/2025 at 3:57 p.m., she stated “sudden anger outburst” for her is when Resident 12 is in bed, gets mad and screams until we approach to see what he wants. During an interview with Certified Nursing Assistant 1 (CNA 1) on 7/01/2025 at 4 p.m., she stated Resident 12 sometimes yells but does not hit anyone. During a phone interview with Resident 12’s Family Member 1 (FM 1) who is also Resident 12’s decision maker, on 7/02/2025 at 4:40 p.m., she stated she was notified by the facility of them wanting to discontinue the Seroquel. FM 1 stated she did not want to discontinue the Seroquel because she was afraid his behavioral issues he had before being on the medication, would return. During a phone interview with the facility’s Pharmacist Consultant (Pharm 1) on 7/03/2025 at 10:06 a.m., he stated he made Resident 12’s MRR from 4/2025 to ensure there is adequate justification for giving Seroquel. Pharm 1 stated if there is no adequate indication for giving Seroquel, then a GDR should be conducted. Pharm 1 stated he wanted to make sure the behaviors present a danger to Resident 12 and others. Pharm 1 stated people in general have anger outburst and he wanted to ensure the Seroquel is given for the appropriate behavior. Pharm 1 stated all antipsychotic medications could have side effects and that is why he recommends laboratory values to be conducted (fasting blood glucose, lipid panel, and EKG). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with Resident 12’s Nurse Practitioner 1 (NP 1) on 7/03/2025 at 10:38 a.m., he stated Resident 12 does not have the proper diagnosis for the prescription of Seroquel but Resident 12’s FM 1 did not want to discontinue the medication when he spoke to FM 1. NP 1 stated he explained to FM 1 that Resident 12 could be changed to a non-antipsychotic medication, but FM 1 refused. NP 1 stated Resident 12 could be at risk for the side effects of pseudo-Parkinson symptoms (symptoms that mimic Parkson’s disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]). During a phone interview with Resident 12’s 11 p.m. to 7 a.m. shift LVN 4 on 7/03/2025 at 11:22 a.m., he stated Resident 12’s “sudden anger outburst “behaviors were episodes of screaming. LVN 4 stated he goes to Resident 12 right away to try to address his concerns to calm him and does not disturb any residents who are sleeping. During an interview with the Assistant Director of Nurses (ADON) on 7/03/2025 at 1:24 p.m. she stated the process for GDR is the facility receives monthly recommendations from the consultant pharmacist. The ADON stated if the consultant pharmacist recommends a GDR, they communicate with a resident’s physician, and conduct an interdisciplinary team (IDT, a group of healthcare professionals from different disciplines [i.e. nursing, social services, etc] who collaborate to provide comprehensive and coordinated care for a patient assessment) that includes family. The ADON stated the licensed nurses want to honor the family’s wishes but if the medication is not appropriate, the facility should notify the facility’s medical director to have a discussion with the family about the appropriateness of the medication. The ADON stated that it should have occurred because FM 1 was refusing a GDR for Seroquel. The ADON stated Seroquel could place Resident 12 at risk for orthostatic hypotension and could experience dizziness or fainting. During a review of the facility’s policy and procedure titled, “Psychoactive/Psychotropic Medication Use, last reviewed 1/21/2025, indicated the following:- A psychotropic medication is any drug that affects brain activities associated with mental processes and behavior which includes antipsychotic medications. - Before initiating or increasing a psychotropic medication for enduring conditions, the resident’s symptoms and therapeutic goals must be clearly and specifically identified and documented. Additionally, a resident’s expressions or indication of distress are: not due to a medical condition or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; not due to environmental stressors alone (e.g. unfamiliar care provider, excessive noise for that individual); not due to psychological stressors alone (loneliness, anxiety or fear stemming from misunderstanding related to his or her cognitive impairment); and persistent and that non-pharmacological approaches have been attempted and evaluated in any attempts to discontinue the psychotropic medication. -The diagnosis alone does not necessarily warrant use of an antipsychotic medication. Antipsychotic medication may be indicated if: behavioral symptoms present a danger to the resident or others; expressions or indications of distress are of significant distress to the resident; multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress; and/or GDR was attempted, but clinical symptoms returned. b. During a review of Resident 65's admission Record, the admission Record indicated the facility admitted the resident on 3/21/2022 with diagnoses including lack of coordination (lack of voluntary coordination of muscle movements) and cognitive communication deficit (a communication difficulty caused by a cognitive impairment). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's MDS, the MDS indicated the resident was moderately impaired cognition and required supervision or touching assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 07/02/25 10:29 a.m., with the Director of Nursing (DON) Resident 65`s Order Summary Report (active orders) as of 7/2/2025 and Medication Administration Record (MAR- a legal document used in healthcare settings to track and document medications administered to a patient). The review indicated an order dated 6/28/2025 for Ativan Oral Tablet 1 milligram (mg) to give 1 tablet by mouth every 12 hours as needed for anxiety manifested by agitation as evidenced by verbal aggression. The review also indicated an order to attempt non-pharmacologic approaches prior to anti-anxiety medication such as engaging the resident in preferred activities, minimizing environmental stressors and other approaches. The review of the MAR indicated that on 6/29/2025 at 8:02 a.m., one dose of Ativan 1 mg was administered to Resident 65 and there was no documentation that non-pharmacologic approaches were attempted prior to the administration of the medication as per physician’s order. The DON stated that non-pharmacologic approaches should be attempted prior to administration of Ativan because if the behavior can be managed without medicating the resident it could avoid adverse effects, such as increased risk for falls, associated with this medication. During a review of the facility`s policy and procedure titled “Psychoactive/Psychotropic Medication Use,” last reviewed on 1/21/2025, the policy indicated that “Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication, dose, duration, and adequate monitoring for efficacy and adverse consequences. Management will also include preventing where possible, identifying, and responding to adverse consequences; and identifying person=centered non-pharmacological interventions, unless contraindicated, to meet the individual needs of the resident, and minimize or discontinue the use of Psychotropic medication…” c. During a review of Resident 121’s admission Record, dated 7/2/2025, the admission Record indicated the facility admitted Resident 121 on 6/2/2025, with diagnoses including generalized anxiety disorder (a condition where a person experiences ongoing anxiety and worries that affects day-to-day activities) and bipolar disorder (a condition where a person experiences extreme mood swings). During a review of Resident 121’s Order Summary, dated 7/2/2025, the Order Summary indicated the physician ordered Clonazepam 0.5 milligrams (mg, a unit of measurement) one tablet by mouth at bedtime for anxiety, starting on 6/3/2025. During a concurrent interview and record review on 7/3/2025 at 10:20 a.m., with Registered Nurse 2 (RN 2), Resident 121’s June 2025 MAR, dated 7/2/2025, was reviewed. The MAR did not indicate from 6/3/2025 to 6/25/2025, the licensed nurses conducted a behavioral assessment on Resident 121 prior to administering Clonazepam. RN 2 stated that behavioral monitoring for Clonazepam should have started on 6/3/2025 when the medication was started. RN 2 stated behavioral monitoring for Clonazepam was initiated on 6/26/2025. RN 2 stated that a prolonged administration of the medication without monitoring could affect the Resident’s kidneys and the kidney’s function can decline. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/3/2025 at 11:11 a.m., with the DON, the DON stated that behavioral monitoring on the MAR should have started at the same time Clonazepam was started on 6/3/2025. The DON stated the medication was being administered without any indication due to lack of behavioral monitoring documentation. During a review of the facility’s policy and procedure (P&P) titled, “Psychoactive/ Psychotropic Medication Use”, dated 4/2025, the P&P indicated “Monitoring of a resident receiving Psychotropic medication will include evaluation of the effectiveness of medication, as well as an assessment for possible adverse consequences”.

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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** Based on interview and record review, the facility failed to accurately assess the Minimum Data Set (MDS - a resident assessment tool) of two of seven sampled residents (Resident 123 and 7) by failing to: 1. Accurately document Resident 123's discharge to reflect the correct disposition. 2. Accurately document Resident 7's current active diagnoses to reflect a diagnosis of anxiety (intense, excessive, and persistent worry and fear about everyday situations). These deficient practices had the potential to negatively affect the residents' plan of care and the delivery of necessary care and services. Findings: a. During a review of Resident 123’s admission Record, the admission Record indicated that the facility admitted the resident on 2/25/2025 with diagnoses including type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]), dysphagia (difficulty swallowing) and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 123`s History and Physical (H&P) dated 3/2/2025, the H&P indicated that the resident did not have the capacity to make decisions or make his needs known. During a review of Resident 123’s Minimum Data Set (MDS – a resident assessment tool) dated 5/24/2025, the MDS indicated that the resident was discharged to a short-term general hospital. The MDS indicated that Resident 123`s cognitive skills (brain’s ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions).  During a review of Resident 123`s physician order dated 5/24/2025, the order indicated to discharge the resident to Skilled Nursing Facility 1 (SNF 1) on 5/24/2025. During a review of Resident 123`s Nursing Progress Notes dated 5/24/2025 at 1:10 p.m., the progress notes indicated that Resident 123 was transferred to SNF 1 with all his belongings.  During a review of Resident 123`s Discharge Summary form dated 5/24/2025, the Discharge Summary form indicated that the resident`s discharge disposition was SNF 1.  During a concurrent interview and record review on 7/3/2025 at 10:09 a.m., with MDS Nurse 1 (MDSN 1), reviewed Resident 123`s physician orders and MDS assessment dated [DATE]. MDSN1 stated that Resident 123`s physician ordered to discharge the resident to SNF 1 on 5/24/2025. However, Resident 123’s discharge MDS assessment dated [DATE] indicated that the resident was transferred to a short-term general hospital. MDSN 1 stated he (MDSN 1) completed the MDS assessment on 5/24/2025 and mistakenly chose short term general hospital instead of skilled nursing facility as Resident 123`s discharge disposition. MDSN 1 stated that this was a mistake from his part. MDSN 1 stated the potential outcome of an incorrect discharge MDS assessment is having an inaccurate medical record. During an interview on 7/3/2025 at 12:15 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that the facility`s MDS Nurse is required to accurately complete each portion of the MDS assessment to reflect the resident’s status at the time of the assessment. The ADON stated that Resident 123`s MDS assessment dated [DATE] was completed incorrectly and did not indicate the resident`s correct discharge disposition. The ADON stated that the potential outcome of an inaccurate MDS assessment for discharge is confusion and inaccurate medical record. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility`s policy and procedure (P&P) titled, “Resident Assessments,” last reviewed on 1/21/2025, the P&P indicated that the resident assessment coordinator is responsible for ensuring that the Interdisciplinary Team (IDT) conducts timely and appropriate resident assessments. The IDT uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. Assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident`s strengths and areas of decline. All persons who have completed any portion of MDS resident assessment form must sign the document attesting to the accuracy of such information. The results of the assessments are used to develop, review and revise the resident`s comprehensive care plan. b. During a review of Resident 7’s admission Record, the admission Record indicated the facility admitted the resident on 7/20/2020 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood), unspecified mood disorder (a mental health condition characterized by significant and persistent disruptions in a person's emotional state, impacting their ability to function normally), mild cognitive impairment (a decline in mental abilities, including thinking, learning, remembering, and decision-making) of unknown etiology (the cause of a disease or abnormal condition), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 7’s History and Physical (H&P), dated 10/21/2024, the H&P indicated Resident 7 had the capacity to understand and make decisions. The H&P further indicated Resident 7 had anxiety and was stable on their current regimen (a systematic plan [as of diet, therapy, and/or medication] designed to improve or maintain health). During a review of Resident 7’s MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS further indicated Resident 7 required substantial assistance for dressing and toileting and was completely dependent on staff for bathing. The MDS did not indicate the resident had an anxiety disorder under active diagnoses. During a review of Resident 7’s care plan (a document that summarizes a resident’s needs, goals, and care/treatment) titled, “The resident uses anti-anxiety medication Ativan (a medication used to treat anxiety disorders) related to anxiety…,” dated 10/14/2024, the care plan indicated Resident 7 yells, screams, and is combative when receiving care for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The care plan indicated the goal that the resident will show decreased episodes of the signs and symptoms of anxiety. During a review of Resident 7’s psychiatric progress note dated 3/4/2025, the psychiatric progress note indicated the resident was taking the medication Ativan two times a day for anxiety. The psychiatric progress note indicated Resident 7 reported having anxiety. During a concurrent interview and record review on 7/3/2025 at 11:17 a.m., with Minimum Data Set Nurse 1 (MDSN 1), reviewed Resident 7’s MDS dated [DATE]. MDSN 1 stated since Resident 7’s indication for taking Ativan is anxiety, anxiety should have been included as a diagnosis in Resident 7’s MDS. MDSN 1 stated the diagnosis should be in the MDS so the resident’s medications and diagnoses are correctly documented. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/3/2025 at 1:06 p.m., with the Director of Nursing (DON), the DON stated Resident 7’s anxiety diagnosis should be in the MDS for accuracy. During a review of the facility's policy and procedure (P&P) titled, “Resident Assessments,” last reviewed on 1/21/2025, the policy and procedure indicated information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a complete baseline 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) within 48 hours of a resident`s admission to the facility by failing to address the resident`s indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) for one of two sampled residents (Resident 81). This deficient practice had the potential for Resident 81 to not receive appropriate care and treatment in the facility. Findings:During a review of Resident 81's admission Record, the admission Record indicated that the facility originally admitted the resident on 1/3/2025 and readmitted the resident on 6/17/2025, with diagnoses including dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), obstructive uropathy (a blockage in the urinary tract that prevents urine from draining normally), and reflux uropathy (when urine flows backward into the kidneys).During a review of Resident 81`s Nursing-Admission/readmission Evaluation/Assessment form dated 1/3/2025, the assessment form indicated that the resident had an indwelling catheter.During a review of Resident 81's Minimum Data Set (MDS - a resident assessment tool) dated 5/2/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 81 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 81 had an indwelling catheter. During a review of Resident 81's Order Summary Report dated 6/19/2025, the Order Summary Report indicated an order for an indwelling catheter due to obstructive and reflux uropathy diagnosis. During a concurrent interview and record review on 7/1/2025 at 2:09 p.m., with MDS Nurse 1 (MDSN 1), reviewed Resident 81`s baseline care plan. MDSN 1 stated that Resident 81 was admitted to the facility on [DATE] with an indwelling catheter. MDSN 1 stated that Resident 81`s baseline care plan initiated on 1/3/2025, did not indicate that the resident had an indwelling catheter. MDSN 1 stated that residents` baseline care plans must be completed thoroughly reflecting all the necessary information regarding residents` care. MDSN 1 stated that the potential outcome of not thoroughly completing a resident`s baseline care plan is the inability to meet the resident`s immediate care needs and lack of his/her care.During an interview on 7/3/2025 at 12:13 p.m., with the Assistant Director of Nursing (ADON), the ADON stated a resident`s baseline care plan is required to be completed within 48 hours of the resident`s admission to the facility. The ADON stated that upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident indicating all care areas, required nursing interventions and monitoring. The ADON stated Resident 81`s baseline care plan developed on 1/3/2025 was not completed thoroughly and it did not indicate anything regarding the resident`s indwelling catheter. The ADON stated the potential outcome is the inability to meet the resident`s immediate care needs for the indwelling catheter and the delivery of necessary services to the resident.During review of the facility`s policy and procedure (P&P) titled, Care Plans-Baseline, last reviewed on 1/21/2025, the P&P indicated that a baseline plan of care should be developed for each resident within 48 hours of admission. The baseline care plan should include instructions needed to provide effective, person-centered care of the residents, which may include the following: Initial goals based on admission orders and discussion with the resident/representative, physician orders, dietary orders, therapy orders and social services. The baseline care plan should be used until an interdisciplinary person-centered comprehensive care plan can be developed. The resident and/pr representative should be provided a written summary of the baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 two of four sampled residents (Resident 75 and 114) by failing to: 1. Develop a care plan addressing Resident 75's use of olanzapine (medication used to treat schizophrenia (mental disorder in which people interpret reality abnormally) and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). 2. Develop a care plan addressing Resident 114's use of amphetamine-dextroamphetamine (medication used to treat attention-deficit/hyperactivity disorder [ADHD - a chronic condition including attention difficulty, hyperactivity, and impulsiveness]). These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: During a review of Resident 75's admission Record, the admission Record indicated the facility admitted the resident on 5/31/2025 with diagnoses that included generalized anxiety disorder (a group of mental health conditions characterized by excessive, persistent fear and worry that can significantly interfere with daily life) and dementia (a general term for a decline in mental ability severe enough to interfere with daily life). During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool) dated 6/7/2025, the MDS indicated Resident 75's cognition (a mental process of acquitting knowledge and understanding) was impaired. The MDS indicated Resident 75 required moderate to maximal assistance with activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 7/2/2025 at 1:58 p.m., with the Director of Nursing (DON), reviewed Resident 75`s Order Summary Report and Resident 75`s care plans from 6/26/2025 to 7/2/2025. Resident 75’s Order Summary Report indicated an order for olanzapine oral tablet 7.5 milligrams (mg- unit of measurement), give one (1) tablet by mouth two times a day for psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), manifested by agitation as evidenced by throwing stuff to others, dated 6/26/2025. Resident 75`s care plans indicated there was no care plan developed for the use of olanzapine. The DON stated that they should have developed a care plan for the use of olanzapine to include interventions to prevent or manage any adverse effects (undesired harmful effect resulting from a medication or other intervention) from the medications. The DON stated that without a care plan, the staff caring for the resident would have no set interventions in managing the adverse effects of olanzapine which can increase the risk for falls. During a review of the facility`s policy and procedure (P&P) titled, “Care Plans, Comprehensive Person-Centered,” last reviewed on 1/21/2025, the policy indicated, “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…” (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 114’s admission Record, the admission Record indicated the facility admitted Resident 114 on 4/15/2025 with diagnoses that included but not limited to major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), and unspecified atrial fibrillation (an irregular and often very rapid heart rate). During a review of Resident 114’s History and Physical (H&P) dated 6/27/2025, the H&P indicated Resident 114 had the capacity to understand and make decisions. During a review of Resident 114’s MDS dated [DATE], the MDS indicated Resident 114 was able to be understood and understand others. The MDS indicated Resident 114 was independent for activities such as hygiene, dressing, toileting, bathing and all movements such as rolling left to right. During a review of Resident 114’s physician orders, the physician orders indicated an order for amphetamine-dextroamphetamine oral tablet 5 mg, dated 4/15/2025. During a concurrent interview and record review on 7/3/2025 at 10:26 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 114’s care plans from 4/15/2025 to 7/3/2025. RN 2 stated that she could not locate a care plan for Resident 114’s ADHD medication. RN 2 stated when there is a medication prescribed that can alter the way a resident thinks/feels there must be a care plan with goals and interventions. RN 2 stated ADHD is not a common diagnosis that she has encountered with the geriatric (older) population, and it is extremely important to have a care plan to make sure Resident 114 is receiving the right care and monitored appropriately. During an interview on 7/3/2025 at 2:32 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the nursing staff must write a care plan according to policy for all psychotropics (a drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) but did not write one for Resident 114’s ADHD medication and they should have. The ADON stated a care plan is necessary for staff to know what goals, interventions and side effects to look for to provide the proper care for Resident 114. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/21/2025, the policy indicated the purpose of the P&P was to provide comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs for each resident. During a review of the facility's P&P titled, Psychoactive/Psychotropic Medication Use,” last reviewed on 1/21/2025, the policy indicated behavioral intervention, unless contraindicated, will be used to meet the individual needs of the resident. The P&P further indicated monitoring of a resident receiving psychotropic medication will include effectiveness of the medication, as well as assessment for possible adverse consequences.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update and revise a resident`s dental care plan (a document that summarizes a resident's needs, goals, and care/treatment) after the resident`s upper dentures went missing for one of three sampled residents (Resident 69). This deficient practice had the potential to result in Resident 69 receiving inadequate care and services. Findings:During a review of Resident 69's admission Record, the admission Record indicated that the facility originally admitted the resident on 5/12/2022 and readmitted the resident on 12/3/2024, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type two diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 4/30/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 69 required staff partial/moderate assistance (helper does less than half the effort) for showering and bathing. The MDS indicated that Resident 69 require staff supervision for oral hygiene, toileting hygiene, lower body dressing, and personal hygiene.During a review of Resident 69's care plan for risk/potential for dental problem, initiated on 5/26/2022, the care plan indicated a goal that the resident will maintain good oral hygiene and will have adequate oral care. The care plan interventions were to provide daily and as needed oral care and to refer the resident for dental consultation as needed.During a review of Resident 69`s Theft and Loss Record dated 8/12/2024, the Theft and Loss Record indicated that the resident reported that her top dentures went missing. The Theft and Loss Report further indicated that on 8/20/2024, Resident 69 was evaluated by a dentist who recommended teeth extractions (removing something) in order to prepare dentures. However, Resident 69 declined to have teeth extractions and dentures.During a concurrent interview and record review on 7/2/2025 at 2:07 p.m., with the Social Service Director (SSD), reviewed Resident 69`s care plans. The SSD stated that Resident 69`s risk/potential for dental problem care plan initiated on 5/26/2022, indicated that the resident was wearing full top dentures and had her own bottom teeth. The SSD stated that Resident 69`s risk/potential for dental problem care plan was not reviewed and revised after 8/12/2024 when the resident reported that her top dentures were missing. The SSD stated residents' care plans are required to be reviewed or revised quarterly, after a change of condition, and as needed. The SSD stated that the purpose of reviewing and re-evaluating the care plans is to check the effectiveness and accuracy of the care plan interventions and make sure all the pertinent information and intervention regarding residents` care are included. The SSD stated that the potential outcome of not reviewing/revising a resident`s care plan quarterly is inadequate care and supervision of the resident.During an interview on 7/3/2025 at 12:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that residents` care plans are required to be reviewed and revised quarterly and after residents` change of condition. The ADON stated Resident 69`s dental care plan was not revised or updated after the resident`s upper dentures went missing on 8/12/2024. The ADON stated that the potential outcome of not updating/revising a resident`s care plan is the inability to provide appropriate care and services to the resident.During a review of the facility`s policy and procedure (P&P) titled, Care Plans- Comprehensive Person-Centered, last reviewed on 1/21/2025, the P&P indicated that the interdisciplinary team reviews and updates the care plan when there has been significant change in the resident`s condition, when the desire outcome is not met, when the resident has been readmitted to the facility from hospital stay and at least quarterly, in conjunctions with the required quarterly MDS assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of seven sampled residents (Residents 7, 79, and 85) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) by failing to:1a. For Resident 7, provide Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment for passive range of motion (PROM, movement at a given joint with full assistance from another person) to both lower extremities (BLE, hip, knee, ankle, foot) seven times a week in May 2025 and June 2025 as ordered by a physician and in accordance with Resident 7's care plan.1b. For Resident 7, complete a quarterly joint mobility screen timely.2. For Resident 79, complete a quarterly joint mobility screen timely.3. For Resident 85, complete a quarterly joint mobility screen timely.These deficient practices had the potential to cause stiffness and pain for Resident 7 and decline in ROM for Residents 7, 79, and 85. Findings:1. During a record review of Resident 7's admission Record (AR), the AR indicated the facility admitted the resident on 7/20/2020 with diagnoses including but not limited to, metabolic encephalopathy (any damage or disease that affects the brain), bilateral (both sides) primary osteoarthritis of knee (a progressive disorder of the knee joint, caused by a gradual loss of cartilage).During a review of Resident 7's Minimum Data Set (MDS, resident assessment tool) dated 4/3/2025, the MDS indicated Resident 7 had moderate impairment in cognition (mental processes involved in gaining knowledge and comprehension, include thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 7 required supervision from staff for eating, moderate assistance for oral hygiene, substantial assistance for dressing and rolling left to right, and dependent assistance for bed to chair transfers. The MDS indicated Resident 7 did not have any functional limitations in ROM in the upper extremities (shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the LE.During a review of Resident 7's Order Summary Report (OSR) dated 7/1/2025, the OSR indicated an order dated 5/22/2025 for RNA to provide PROM exercises to BLE on all planes once a day seven times a week as tolerated, pain medications as needed.During a review of Resident 7's care plan (CP- a document that summarizes a resident's needs, goals, and care/treatment) initiated on 5/22/2025, the CP indicated Resident 7 was at risk for decline and/or complications with ROM in joints, decreased mobility and movement, decreased muscle strength, decreased functional use of extremity, pain, deformity, contracture, and/or skin breakdown and required a RNA ROM program to LE. The CP goal indicated to maintain ROM in BLE. The CP intervention indicated RNA to provide PROM exercises to BLE on all planes once a day, seven times a week as tolerated, pain medications as needed.During a review of Resident 7's Rehab Joint Mobility Screen (JMS), the JMS indicated JMS were completed on 10/22/2024, 1/9/2025, and 4/3/2025. The JMS dated 4/3/2025 indicated the JMS was completed and signed on 7/1/2025 (three months later). The JMS dated 4/3/2025 indicated Resident 7 had minimal ROM impairment in both shoulders, normal ROM in both elbows, wrists, fingers/hand, right hip and minimal ROM impairment in the left hip, both knees, and both ankles.During a review of Resident 7's Documentation Survey Report (DSR) for RNA dated May 2025, the DSR indicated Resident 7 did not receive RNA treatment for PROM for BLE seven times a week on 5/24/2025, 5/25/2025, and 5/31/2025 (3 days).During a review of Resident 7's DSR for RNA dated June 2025, the DSR indicated Resident 7 did not receive RNA treatment for PROM for BLE seven times a week on 6/1/2025, 6/7/2025, 6/8/2025, 6/14/2025, and 6/15/2025 (5 days).During an interview on 7/1/2025 at 8:32 a.m., with Restorative Nursing Aide 1 (RNA 1), RNA 1 stated Resident 7 was on an RNA treatment program for PROM for BLE seven times a week.During an interview on 7/1/2025 at 8:53 a.m., with co-Director of Rehabilitation 1 (DOR 1) and co-Director of Rehabilitation 2 (DOR 2), DOR 2 stated the rehabilitation department completed quarterly screenings on all residents based on the MDS calendar. DOR 2 stated the quarterly screenings included joint mobility screens. DOR 2 stated joint mobility screens were completed to detect any functional declines in residents and to ensure the residents were on the appropriate maintenance program. DOR 2 stated if therapists noticed any changes, then it would be communicated to nursing staff and to the physicians.During a concurrent observation and interview on 7/1/2025 at 10:41 a.m., in Resident 7's room, observed RNA 1 perform RNA treatment to Resident 7. Resident 7 was lying in bed and RNA 1 performed PROM exercises to Resident 7's left ankle, knee, and hip and Resident 7's right ankle, knee, and hip. Resident 7's left ankle was pointed away from the body, left knee was straight and could bend a little, and left hip could move a little away from the body. Resident 7's right ankle could move forward and back;

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to:1. Ensure fall risk assessments were completed accurately for one of ten sampled residents (Resident 7).This deficient practice had the potential to place Resident 7 at an increased risk of falling.2. Ensure a fall risk assessment was completed for one of ten sampled residents (Resident 119) after the resident`s fall on 6/25/2025. This deficient practice placed Resident 119 at an increased risk for recurrent falls and injuries. Findings: a. During a review of Resident 7’s admission Record, the admission Record indicated the facility admitted the resident on 7/20/2020 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood), lack of coordination, and mild cognitive impairment (a decline in mental abilities, including thinking, learning, remembering, and decision-making) of unknown etiology (the cause of a disease or abnormal condition). During a review of Resident 7’s History and Physical (H&P) dated 10/21/2024, the H&P indicated Resident 7 had the capacity to understand and make decisions. The H&P indicated Resident 7 had cognitive impairment and to monitor for safety. The H&P further indicated Resident 7 had muscle weakness and gait (manner of walking) instability. During a review of Resident 7’s Minimum Data Set (MDS – a resident assessment tool) dated 4/3/2025, the MDS indicated the resident had moderate cognitive impairment. The MDS further indicated Resident 7 required substantial assistance for dressing and toileting and was completely dependent on staff for bathing. During a review of Resident 7’s Change in Condition Evaluation dated 12/7/2024, the Change in Condition Evaluation indicated staff found Resident 7 on the floor next to her bed. The Change in Condition Evaluation further indicated per Resident 7’s roommate, Resident 7 was dangling her legs off the side of the bed then slid down to the floor. During a concurrent interview and record review on 7/3/2025 at 11:52 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 7’s Fall Risk Observation/Assessments dated 12/7/2024 and 1/7/2025. Resident 7’s Fall Risk Observation/Assessments dated 12/7/2024 and 1/7/2025 indicated the resident had not fallen in the last 90 days. RN 2 stated both assessments were incorrect as Resident 7’s fall on 12/7/2024 should have been included. RN 2 stated when completing a fall risk assessment, you should look back in the record for the last 90 days to see if the resident had previously fallen. RN 2 stated if the fall risk assessment is not accurate, it won’t show if a resident has a pattern of falls, and staff might not be able to do everything that should be done to prevent further falls. During an interview on 7/3/2025 at 1:06 p.m., with the Director of Nursing (DON), the DON stated if the fall risk assessment does not correctly indicate a previous fall, the severity of the fall risk score (the assessment of an individual's likelihood of falling) could be affected. The DON stated the purpose of having a fall risk assessment is to prevent or minimize falls for the residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedure (P&P) titled, “Falls and Fall Risk, Managing,” last revised 1/21/2025, the P&P indicated based on previous evaluations and current data, staff will identify interventions related to the resident’s specific risks and causes to try to prevent the resident from falling. During a review of the facility`s P&P titled, “Assessing Falls and Their Causes,” last reviewed on 1/21/2025, the P&P indicated that the purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. When a resident falls, the following information should be recorded in the resident`s medical record: completion of a fall risk assessment, appropriate interventions taken to prevent future falls, notification of the physician and family as indicated, interventions, first aid, or treatment administered and assessment data including vital signs and any obvious injuries. b. During a review of Resident 119's admission Record, the admission Record indicated that the facility admitted the resident on 5/22/2025, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), and lack of coordination. During a review of Resident 119’s MDS dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was severely impaired. The MDS indicated that Resident 119 was dependent on staff (staff does all of the effort) for toileting hygiene and showering/bathing. The MDS indicated that Resident 119 required staff substantial/maximal assistance (helper does more than half the effort) for lower body dressing, and putting on/taking off footwear. During a review of Resident 119`s Change in Condition Evaluation form dated 6/25/2025, the assessment form indicated that the resident was witnessed by a Registered Nurse (RN) sliding off his wheelchair and on to the floor. During a concurrent interview and record review on 7/2/2025 at 12:00 p.m., with MDS Nurse 1 (MDSN 1), reviewed Resident 119`s fall risk assessments. MDSN 1 stated that Resident 119 had a fall on 6/25/2025, however, licensed staff did not develop a fall risk assessment after Resident 119&rsquo;s fall. MDSN 1 stated that licensed staff are required to develop a fall risk assessment upon a resident`s admission and after a fall. MDSN 1 stated that the potential outcome of not developing a fall risk assessment after a resident`s fall is lack of care and risk for recurrent falls.  During a concurrent interview and record review on 7/3/2025 at 11:54 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 119`s fall risk assessments. The ADON stated that licensed staff are required to complete a fall risk assessment upon a resident`s admission, readmission, and after a fall. The ADON stated that Resident 119 had a fall on 6/25/2025, however, licensed staff did not complete a fall risk assessment after Resident 119`s fall. The ADON stated the potential outcome is insufficient care and recurring fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s P&P titled, “Assessing Falls and Their Causes,” last reviewed on 1/21/2025, the P&P indicated that the purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. When a resident falls, the following information should be recorded in the resident`s medical record: completion of a fall risk assessment, appropriate interventions taken to prevent future falls, notification of the physician and family as indicated, interventions, first aid, or treatment administered and assessment data including vital signs and any obvious injuries.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) center completed a post-dialysis assessment (evaluation done after hemodialysis by the hemodialysis licensed nurses) by failing to ensure the dialysis center recorded a resident's post dialysis weight (the weight after fluid is removed during the dialysis treatment) on 6/25/2025.This deficient practice had the potential for Resident 46 to have unidentified complications after dialysis treatment such as abnormal vital signs (pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions). Findings:During a review of Resident 46's admission Record (or face sheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the patient was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, irreversible kidney failure) and dependence on renal dialysis (also known as hemodialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).During a review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/21/2025, the MDS indicated Resident 46 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 46 required supervision or touching assistance (helper provides verbal cures and/or touching assistance as resident completes activity) with oral and personal hygiene. The MDS indicated Resident 46 receives dialysis treatments.During a review of Resident 46's Care Plan for Hemodialysis, initiated 11/29/2022, the care plan indicated a goal that Resident 46 will follow fluid restriction (drinking no more than an amount set by nursing to ensure the body does not retain too much fluid). The care plan indicated an intervention to monitor weight as indicated and report significant weight gain/loss to the physician.During a review of Resident 46's Dialysis Communication Record, dated 6/25/2025, the document indicated there was a blank space for the post-dialysis weight.During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 7/02/2025 at 12:51 p.m. reviewed Resident 46's Dialysis Communication Record for 6/2025. LVN 1 verified that there was not a post-dialysis weight recorded by the dialysis center for 6/25/2025. LVN 1 stated the licensed nurses should call the dialysis center if there is no post-dialysis weight recorded. LVN 1 stated this is important to ensure enough fluid was removed during the dialysis treatment.During a concurrent interview and record review with the Assistant Director of Nurses (ADON) on 7/03/2025 at 1:24 p.m., reviewed Resident 46's Dialysis Communication Record for 6/25/2025. The ADON verified there was no post-dialysis weight for 6/25/2025. The ADON stated the licensed nurses should have called the dialysis center to find out what the weight is. The ADON stated it is important to see how much fluid was removed during dialysis. The ADON stated if fluid is removed, indicated by a lower post-dialysis weight than the pre-dialysis weight that indicates the dialysis procedure was completed. During a review of the facility's Policy and Procedure titled, Hemodialysis Catheters - Access and Care Of, last reviewed 1/21/2025, indicated the licensed nurses should document in the resident's medical record if dialysis was done during their shift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR- review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) was acted upon for three of six sampled residents (Resident 116, Resident 12, and Resident 121 by failing to: Complete an EKG (electrocardiogram - a simple, painless test that measures the heart's electrical activity) for the usage of Quetiapine (antipsychotic medication) for Resident 116. This deficient practice could have resulted in missed dangerous heart rhythms that Quetiapine can cause in high-risk populations such as the elderly. 2. Follow the pharmacist consultant's recommendation to have documentation to support the use of Seroquel (brand name for an antipsychotic medication, a drug that affects brain activities associated with mental processes and behavior) for by failing to:a. Ensure the following conditions existed for Seroquel to be prescribed: the symptoms are identified as being due to mania (mental state of an extreme highs or depressive lows) or psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) or delusions, (having false or unrealistic beliefs such as paranoia [unjustified mistrust of others]/grandiosity [inflated sense of superiority]; the behavioral symptoms (sudden anger outburst) present a danger to the resident or others; and the symptoms are significant enough that the resident is experiencing inconsolable/persistent distress.b. Monitor orthostatic hypotension (a sudden drop in blood pressure that occurs when a person stands up after sitting or lying down which can cause dizziness, lightheadedness, and fainting) for Resident 12 by failing to take orthostatic blood pressure (taking the blood pressure in lying, sitting, and standing position three to five minutes apart to see if there are large gaps between the readings). These failures placed Resident 12 at risk for adverse reactions and side effects related to antipsychotic use with symptoms that included dizziness, fainting, and risk for fall.3. Ensure the physician documented a progress note (a written entry in the resident's chart documenting actions) to support the use of Klonopin (medication used to treat symptoms of anxiety [a condition where a person experiences feelings of worry, nervousness or unease]) for Resident 121.This failure had the potential to subject Resident 121 to unnecessary side effects of Klonopin. Findings: During a review of Resident 116’s admission Record, the admission Record indicated the facility admitted Resident 116 on 5/10/2025 with diagnoses that included but not limited to acute (sudden) and chronic (repeatedly or over long time) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues), hypertension (HTN-high blood pressure), and a history of falling. During a review of Resident 116’s History and Physical (H&P) dated 5/16/2025, the H&P indicated Resident 116 had the capacity to understand and make decisions. During a review of Resident 116’s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/17/2025, the MDS indicated Resident 116 was able to be understood and understand others. The MDS indicated Resident 116 needed substantial assistance from staff for activities such as lower body dressing, toileting, and bathing. The MDS further indicated Resident 116 was taking a high-risk antipsychotic drug. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 116’s Physician’s Orders the Physician’s Orders indicated:-6/7/2025 EKG per pharmacy recommendation r/t (related to) Seroquel (brand name for Quetiapine) use every shift every 12 month(s) starting on the 9th for 1 day(s) for Seroquel use.- 5/10/2025 Quetiapine Fumarate oral tablet 25mg (milligram – a unit of measurement). Give 1 tablet by mouth two times a day for psychosis, m/b (manifested by) agitation AEB (as evidence by) sudden angry outburst. During a concurrent interview and record review on 7/2/2025 at 1:43 pm with Registered Nurse 3 (RN 3) reviewed Resident 116’s physician’s orders and results (where the results of blood work, radiology and EKG would be) section of Resident 116’s electronic medical record. RN 3 stated Resident 116 was supposed to have an EKG on 6/9/2025 but did not because it would have shown up in the results of Resident 116’s electronic record. RN 3 then looked in Resident 116’s physical chart and did not find evidence that an EKG was completed. RN 3 stated Resident 116 should have had an EKG according to pharmacy recommendation to ensure the Quetiapine did not affect the cardiac (heart) rhythm. During an interview 7/3/2025 at 2:38 pm with the Assistant Director of Nursing (ADON), the ADON stated the nursing staff missed the Resident 116’s EKG order and should have followed up. The ADON stated the EKG is important to get a baseline heart rhythm and to ensure the Quetiapine does not cause changes to that rhythm. During a review of the facility's policy and procedure (P&P) titled, Medication Regien Reviews, last reviewed on 1/21/2025, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly and provides the director of nursing services with a written, signed and dated copy of all medication regimen reports and the findings must be sent to physician for review/changes. During a review of the facility's P&P titled, Psychoactive/Psychotropic Medication Use” last reviewed on 1/21/2025, indicated management will also include preventing (where possible) identifying, and responding to adverse consequences. 2. During a review of Resident 12’s admission Record the admission Record indicated the patient was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) with mood disturbance (a significant change in a person's emotional state that persists for an extended period). The admission Record indicated Family Member 1 (FM 1) is the primary medical decision maker for Resident 12.During a review of Resident 12’s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 6/17/2025, the MDS indicated Resident 12 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 12 required supervision or touching assistance (helper provides verbal cures and/or touching assistance as resident completes activity) with oral and personal hygiene. The MDS indicated Resident 12 required moderate assistance (helper does less than half the effort) with walking. During a review of Resident 12’s Physician’s Orders, dated 4/03/2025, indicated an order for Seroquel 25 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give 0. 5 tablet by mouth at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by sudden anger outburst. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12’s Care Plan for Antipsychotic, initiated 7/02/2025, indicated a goal that the resident will exhibit a therapeutic effect related to the use of the medication, Seroquel. The care plan indicated interventions that included: attempt a gradual dose reduction as condition improves and attempt non-pharmacological approaches prior to medication administration (i.e. provide quiet and dark environment and keep as comfortable as possible). During a review of Resident 12’s Medication Regimen Review (MRR, a monthly review of resident’s records to ensure there is an adequate indication for a prescribed medication), created between 4/24/2025 and 4/25/2025, the MRR indicated the following: -For Seroquel, ensure there is documentation in the chart to show that the symptoms are: not due to a medication condition that can be expected to resolve/improve as the underlying condition is treated; and, persistent or likely to reoccur without continued agreement; and not sufficiently relieved by non-drug interventions; and not due to environmental stressors; and not due to psychological stressors or anxiety/fear stemming from misunderstanding related to the cognitive impairment that can be expected to improve/resolve as the situation is addressed. -For Seroquel, make sure to have evidence in the chart that one of the following conditions exist: the symptoms are identified as being due to mania or psychosis (i.e. auditory/visual/other hallucinations, delusions; the behavioral symptoms (sudden anger outburst) present a danger to the resident or others; the symptoms are significant enough that the resident is experiencing inconsolable/persistent distress, a significant decline in function, or substantial difficulty receiving needed care. -For Seroquel a fasting blood glucose (simple sugar, the body’s primary source of energy from food drawn after a period of fasting), lipid panel (a measurement of the fats in the blood) and electrocardiogram (EKG, measuring the electrical activity of the heart which detects abnormal heart rates) is recommended. Monitor orthostatic hypotension weekly by taking blood pressure in two different positions, three to five minutes apart (lying, sitting, standing). Notify the physician and psychiatrist if noted decline of 20 millimeters of mercury (mm Hg, a unit of measurement for blood pressure) in systolic blood pressure (SBP, the pressure in the arteries when the heart muscle pumps blood throughout the body) or 10 mm Hg drop in diastolic blood pressure (DBP, the pressure in the arteries when the heart is resting between beats) from lying to sitting or sitting to standing positions. During a review of Resident 12’s Initial Psychiatric Interview, dated 4/08/2025, the Initial Psychiatric Interview indicated the following: NP 1 consulted with Resident 12. Alert and oriented times one (to name), disorganized and forgetful. (Resident 12) Did not provide meaningful feedback. Irritable and aggressive towards staff during patient care. Spoke to FM 1 but refused to make any adjustment. During a review of Resident 12’s Nurse Practitioner 1’s (NP 1) Notes, dated 4/09/2025, the notes indicated the following: Psych consulted with Resident 12. Considering gradual dose reduction (GDR, stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) but was not placed due to Resident 12 responsible party’s (FM 1 who makes Resident 12’s medical decisions) refusal. Writer provided rationale for GDR and risk versus benefits and why writer recommended GDR recommendation. However, Resident 12’s FM 1 refused GDR stating the current dose is needed for the maintenance and did not agree with pharmacist GDR recommendation. Writer discussed current plan of care. No concerning significant behaviors were noted but promptings at times are needed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12’s Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) indicated the following behaviors of “sudden anger outburst” for the following months:4/2025 no behaviors5/2025 2 behavioral episodes6/2025 3 behavioral episodes During a phone interview with Resident 12’s Family Member 1 (FM 1) who is also Resident 12’s decision maker, on 7/02/2025 at 4:40 p.m., she stated she was notified by the facility of them wanting to discontinue the Seroquel. FM 1 stated she did not want to discontinue the Seroquel because she was afraid his behavioral issues he had before being on the medication, would return. During a phone interview with the facility’s Pharmacist Consultant (Pharm 1) on 7/03/2025 at 10:06 a.m., he stated he made Resident 12’s MRR from 4/2025 to ensure there is documentation indicating there is an adequate justification for giving Seroquel. Pharm 1 stated if there is no adequate indication for giving Seroquel then a GDR should be conducted. Pharm 1 stated he wanted to make sure the behaviors present a danger to Resident 12 and others. Pharm 1 stated people in general have anger outburst and he wanted to ensure the Seroquel is given for the appropriate behavior. Pharm 1 stated all antipsychotic medications could have side effects and that is why he recommended laboratory values to be conducted (fasting blood glucose, lipid panel, and EKG). During a phone interview with Resident 12’s Nurse Practitioner 1 (NP 1) on 7/03/2025 at 10:38 a.m., he stated Resident 12 does not have the proper diagnosis for the prescription of Seroquel but Resident 12’s FM 1 did not want to discontinue the medication when he spoke to FM 1. NP 1 stated he explained to FM 1 that Resident 12 could be changed to a non-antipsychotic medication, but FM 1 refused. NP 1 stated Resident 12 could be at risk for the side effects of pseudo-Parkinson symptoms (symptoms that mimic Parkson’s disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements)]. During an interview with the Assistant Director of Nurses (ADON) on 7/03/2025 at 1:24 p.m. she stated the process for GDR is the facility receives monthly recommendations from the consultant pharmacist. The ADON stated if the consultant pharmacist recommends a GDR, they communicate with a resident’s physician, and conduct an interdisciplinary team (IDT, a group of healthcare professionals from different disciplines [i.e. nursing, social services, etc] who collaborate to provide comprehensive and coordinated care for a patient assessment) that includes family. The ADON stated the licensed nurses want to honor the family’s wishes but if the medication is not appropriate, the facility should notify the facility’s medical director to have a discussion with the family about the appropriateness of the medication. The ADON stated that it should have occurred because FM 1 was refusing a GDR for Seroquel since there is no documentation of adequate indication for use of Seroquel. The ADON stated Resident 12’s MRR, dated between 4/24/2025 and 4/25/2025, the orthostatic blood pressure recommendation should have been acted upon sooner than two months when it was brought to the facility’s attention by the survey team, because Seroquel puts Resident 12 at risk for orthostatic hypotension and he could experience dizziness or fainting. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure titled, “Psychoactive/Psychotropic Medication Use, last reviewed 1/21/2025, indicated the following:-A psychotropic medication is any drug that affects brain activities associated with mental processes and behavior which includes antipsychotic medications. -A resident’s expressions or indication of distress are: not due to a medical condition or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; not due to environmental stressors alone (e.g. unfamiliar care provider, excessive noise for that individual); not due to psychological stressors alone (loneliness, anxiety or fear stemming from misunderstanding related to his or her cognitive impairment); and persistent and that non-pharmacological approaches have been attempted and evaluated in any attempts to discontinue the psychotropic medication. -The diagnosis alone does not necessarily warrant use of an antipsychotic medication. Antipsychotic medication may be indicated if: behavioral symptoms present a danger to the resident or others; expressions or indications of distress are of significant distress to the resident; multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress; and/or GDR was attempted, but clinical symptoms returned. During a review of the facility’s policy and procedure titled, “Tapering Medications and Gradual Dose Reduction,” last reviewed 1/21/20225, indicated the following:-All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions.-Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. -For any individual who is receiving a psychotropic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident’s target symptoms returned or worsened after the most recent GDR within the facility; and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident’s function or increase distressed behavior. During a review of the facility’s policy and procedure titled, “Psychoactive/Psychotropic Medication Use, last reviewed 1/21/2025, indicated the following:-A psychotropic medication is any drug that affects brain activities associated with mental processes and behavior which includes antipsychotic medications. -Before initiating or increasing a psychotropic medication for enduring conditions, the resident’s symptoms and therapeutic goals must be clearly and specifically identified and documented. Additionally, a resident’s expressions or indication of distress are: not due to a medical condition or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; not due to environmental stressors alone (e.g. unfamiliar care provider, excessive noise for that individual); not due to psychological stressors alone (loneliness, anxiety or fear stemming from misunderstanding related to his or her cognitive impairment); and persistent and that non-pharmacological approaches have been attempted and evaluated in any attempts to discontinue the psychotropic medication. -The diagnosis alone does not necessarily warrant use of an antipsychotic medication. Antipsychotic medication may be indicated if: behavioral symptoms present a danger to the resident or others; expressions or indications of distress are of significant distress to the resident; multiple non-pharmacological approaches have been attempted but did not relieve the symptoms which are presenting a danger or significant distress; and/or GDR was attempted, but clinical symptoms returned. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 121’s admission Record, the admission Record indicated the facility admitted the resident on 6/2/2025, with diagnosis that including generalized anxiety disorder (a condition where a person experiences ongoing anxiety and worries that affects day-to-day activities) and bipolar disorder (a condition where a person experiences extreme mood swings). During a review of the Consultant Pharmacist’s Medication Regimen Review (MRR), dated 6/14/2025 to 6/15/2025, the MRR indicated the following: • “Klonopin is being given for behavioral control, but without a progress note from you to show why this long acting benzodiazepine [medication used to help calm down anxious feelings] is best suited for the resident…If a change to a shorter acting agent (Xanax, Ativan, Serax [medications used to help calm down anxious feelings]) is not feasible, could you please update your progress note so the center may remain compliant?” During a review of nurse practitioner’s “Progress Note”, dated 6/30/2025, the Progress Note did not indicate why Klonopin was best suited for Resident 121. During a concurrent interview and record review on 7/3/2025 at 12:19 p.m., with the Director of Nursing (DON), the “Note to Attending Physician/Prescriber,” dated 6/14/2025, was reviewed. The “Note to Attending Physician/Prescriber” did not indicate the physician documented the need for Resident 121 to continue taking Klonopin. The DON stated it did not indicate the need for continued use of Klonopin and the resident could be receiving medication without an indication. During a review of the facility’s Policy and Procedure (P&P) titled, “Psychoactive/Psychotropic Medication Use”, dated 4/2025, the P&P indicated, “The attending physician will identify, evaluate, and document with input from other disciplines and consultants as needed, medical symptoms that may warrant the use of Psychotropic medications”.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed ensure resident's drug regimen was free from unnecessary drugs by failing to adequately monitor potential adverse effects of amphetamine-dextroamphetamine (stimulant medication to treat ADHD [differences in how the brain develops and works causing problems with a person's attention, ability to sit still, and practice self-control]) for one of one sampled resident (Resident 114). This deficient practice had the potential for adverse effects including psychosis (hallucinations, delusions, paranoia, aggression, hostility) and heart issues such as fast heartbeat and hypertension.Findings:During a review of Resident 114's admission Record, the admission Record indicated the facility admitted Resident 114 on 4/15/2025 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN-high blood pressure), and unspecified atrial fibrillation (an irregular and often very rapid heart rhythm in the upper part of the heart). During a review of Resident 114's History and Physical (H&P) dated 6/27/2025, the H&P indicated Resident 114 had the capacity to understand and make decisions. During a review of Resident 114's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/8/2025, the MDS indicated Resident 114 was able to be understood and understand others. The MDS indicated Resident 114 was independent for activities such as hygiene, dressing, toileting, bathing and all movements such as rolling left to right. The MDS further indicated Resident 114 did not have an ADHD diagnosis.During a review of Resident 114's Physician's Orders, the Physician's Orders indicated an order dated 4/14/2025 for Amphetamine-Dextroamphetamine (medication to treat ADHD) oral tablet 5mg (milligram - a unit of measurement)During a concurrent interview and record review on 7/3/2025 at 10:26 am with Registered Nurse 2 (RN 2), reviewed Resident 114's Physician's Orders and Care Plans (CP). RN 2 stated that she could not locate an order or CP to monitor the adverse effects or effectiveness of Resident 114 using an ADHD medication. RN 2 stated when there is a medication prescribed that can alter the way a resident thinks/feels there must be a CP with goals and interventions including looking out for adverse effects and an order to monitor effectiveness and behavior. RN 2 stated ADHD is not a common diagnosis that she has encountered with the geriatric (older) population, and it is extremely important to make sure Resident 114 is receiving the right care and is monitored appropriately. During an interview 7/3/2025 at 2:32 pm with the Assistant Director of Nursing (ADON), the ADON stated the nursing staff must write a CP according to policy for all psychotropics (a drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) but did not write one for the ADHD medication and they should have. The ADON stated nursing staff should have asked for an order to monitor Resident 114's behavior and possible adverse effects while on the ADHD medication, and without doing so, Resident 114 could not have received the proper care necessary. The ADON further stated monitoring the ADHD medication can help determine the need and effectiveness. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/21/2025, indicated the purpose of the P&P was to provide comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs for each resident. During a review of the facility's P&P titled, Psychoactive/Psychotropic Medication Use last reviewed on 1/21/2025, indicated behavioral intervention, unless contraindicated, will be used to meet the individual needs of the resident. The P&P further indicated monitoring of a resident receiving psychotropic medication will include effectiveness of the medication, as well as assessment for possible adverse consequences.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to accommodate a resident's food allergies and preferences for one of six residents (Resident 7) investigated under nutrition by:1. Failing to document Resident 7's allergy to eggs on the tray ticket (a document that accompanies a meal tray with essential information about the meal and the resident receiving it).2. Failing to ensure Resident 7 received a substitution for breakfast when eggs were not served.These failures placed Resident 7 at risk of:1. Being served eggs and having a reaction such as a rash, hives, diarrhea, vomiting, dehydration (occurs when your body loses too much water and other fluids), and/or anaphylactic shock (severe allergic reaction including closure of airways). 2. Not receiving the needed nutrition, they require. Findings: 1. During a review of Resident 7’s admission Record, the admission Record indicated the facility admitted the resident on 7/20/2020 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record indicated Resident 7 had an allergy to eggs. During a review of Resident 7’s History and Physical (H&P), dated 10/21/2024, the H&P indicated Resident 7 had the capacity to understand and make decisions. The H&P further indicated Resident 7 had an allergy to eggs. During a review of Resident 7’s Minimum Data Set (MDS – a resident assessment tool), dated 4/3/2025, the MDS indicated the resident had moderate cognitive impairment (problems with the ability to think, learn, remember, use judgement, and make decisions). The MDS further indicated Resident 7 required substantial assistance for dressing and toileting and was completely dependent on staff for bathing. During a review of Resident 7’s Dietary Interview/Pre-Screen, dated 10/11/2023, the Dietary Interview/Pre-Screen indicated Resident 7 had an allergy to eggs. During a review of Resident 7’s care plan (a personalized document that outlines an individual's specific health needs, treatments, and goals to ensure they receive appropriate care and support) titled, “ALLERGY CARE PLAN,” dated 7/22/2022, the care plan indicated Resident 7 had an allergy to eggs. The care plan indicated, “Document allergies in chart, face sheet, medication sheets, treatment sheets, diet slips etc.” During an observation on 6/30/2025 at 12:57 p.m. at Resident 7’s bedside, Resident 7 was eating lunch in bed. Resident 7’s lunch was on a tray on her bedside table. Resident 7’s tray ticket did not indicate any allergies. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/1/2025 at 2:13 p.m. with the Dietary Supervisor (DS), Resident 7’s tray ticket was reviewed and did not indicate the resident had any allergies. Resident 7’s tray ticket indicated dislikes of juice, eggs, beans, and corn. The DS stated since Resident 7 has an egg allergy, eggs should be included on the tray ticket as an allergy. The DS stated he will update the resident’s tray ticket to include the egg allergy. The DS stated Resident 7 could get sick or have a reaction if given a food she is allergic to. During a concurrent interview and record review on 7/1/2025 at 2:41 p.m. with Registered Nurse (RN) 2, Resident 7’s medical record indicated the resident was allergic to eggs. RN 2 stated there was not documentation of the type of reaction or how severe the reaction was to eggs. RN 2 stated the egg allergy should be printed on the tray ticket. RN 2 stated if Resident 7 was served eggs she could possibly have an allergic reaction like redness, bloating in the face, or difficulty breathing. During an interview on 7/1/2025 at 4:01 p.m. with Resident 7, Resident 7 stated she is allergic to eggs. Resident 7 stated if she eats eggs, she experiences nausea, diarrhea, vomiting, and bumps on her arms. During an interview on 7/2/2025 at 11:48 a.m. with the Registered Dietician (RD), the RD stated she verified Resident 7 is allergic to eggs. The RD stated the egg allergy should be on the tray ticket. The RD stated the resident could potentially get eggs if it is not on the tray ticket as an allergy. The RD stated the resident might have a reaction if given eggs. The RD stated Resident 7’s response to eggs was unknown but the reaction could be many things like a rash up to a very serious reaction like anaphylactic shock. During an interview on 7/3/2025 at 1:06 p.m. with the Director of Nursing (DON), the DON stated Resident 7’s food allergies should be printed on the tray ticket, so she will not be given eggs. The DON stated Resident 7 could have an allergic reaction to eggs. The DON stated Resident 7’s specific reaction to eggs is unknown but staff would look for rashes, shortness of breath, nausea, and vomiting. During a review of the facility's policy and procedure (P&P) titled, “Food Allergies and Intolerances, ” last reviewed on 1/21/2025, the P&P indicated residents with food allergies are identified on admission and steps are taken to prevent resident exposure to the allergens. The P&P indicated all resident reported food allergies are documented in the assessment notes and incorporated into the resident’s care plan. 2. During a review of Resident 7’s Care Plan for Malnutrition, initiated 10/31/2024, the Care Plan indicated a goal that Resident 7 will maintain adequate nutritional status as evidenced by stable weight. The care plan indicated an intervention to provide a diet as ordered. A review of Resident 7’s updated Dietary Tray Card, the Dietary Tray Card indicated Resident 7 was allergic to eggs. During an observation of Resident 7’s breakfast tray on 7/02/2025 in her room, observed there were no eggs on Resident 7’s plate or anywhere on the tray. There was no food that was substituted in place of the egg. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation with the Dietary Supervisor (DS) on 7/02/2025 at 7:50 a.m., observed Resident 7’s breakfast tray in her room which included toast, apple sauce, oatmeal and drinks. The DS stated there should be a protein in place of the egg and placed a yogurt container on her tray. Resident 7 stated she likes yogurt. The DS stated it is important for residents to have protein in their diet for their bodily needs. During a review of the facility’s policy and procedure titled, “Food Allergies and Intolerances, ” last reviewed 1/21/2025, indicated residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure leftover food brought from outside by residents' family and visitors were labeled with a resident identifier and use-by-date in one of one resident refrigerator (Refrigerator 1).This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) for the residents.Findings:During a concurrent observation and interview on 6/30/2025 at 8:44 a.m., with the Administrator in Training (AIT), observed the residents' refrigerator in the nurse's station. Observed in the refrigerator, two plastic bags of undetermined leftover food with no name, date or resident identifier. The AIT stated that this refrigerator is used to store resident's food and when placing resident's leftover food, the leftover food must be labeled with an identifier and date. During an interview on 7/3/2025 at 8:16 a.m., with the AIT, the AIT stated that residents are informed that leftover food will be refrigerated and will be discarded after 48 hours. The AIT stated that if the leftover food is inadvertently given to the resident beyond the use by date, it has the potential to cause foodborne illnesses. During a review of the facility's policy and procedure titled, Food Brought by Family/Visitors, last reviewed on 1/21/2025, the policy indicated that perishable (foods likely to spoil, decay, or become unsafe to consume if not kept refrigerated) foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date .the nursing staff will discard perishable foods on or before the use by date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for four (Resident 7, Resident 79, Resident 85, and Resident 12) of 32 sampled residents by failing to:1.a. Ensure therapy staff did not accurately document a late Rehab Joint Mobility Screen, for Resident 7, dated 4/3/2025 and completed on 7/1/2025.b. Ensure therapy staff did not accurately document a late Rehab Joint Mobility Screen, for Resident 79, dated 4/30/2025 and completed on 7/1/2025.c. Ensure therapy staff did not accurately document a late Rehab Joint Mobility Screen, for Resident 85, dated 4/9/2025 and completed on 7/1/2025.These deficient practices resulted in inaccurate medical documentation and had the potential for a decline in range of motion (ROM, full movement potential of a joint) in Residents 7, 79, and 85.2. Ensure Resident 7's diagnosis of anxiety was included in the diagnosis list in the resident's medical record.This deficient practice placed Resident 7 at risk of not receiving the care and services necessary for a diagnosis of anxiety. Findings: 1.a. During a record review of Resident 7’s admission Record (AR), the AR indicated the facility admitted the resident on 7/20/2020 with diagnoses including but not limited to, metabolic encephalopathy (any damage or disease that affects the brain), bilateral (both sides) primary osteoarthritis of knee (a progressive disorder of the knee joint, caused by a gradual loss of cartilage). During a review of Resident 7’s Minimum Data Set (MDS, resident assessment tool) dated 4/3/2025, the MDS indicated Resident 7 had moderate impairment in cognition (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 7 required supervision from staff for eating, moderate assistance for oral hygiene, substantial assistance for dressing and rolling left to right, and dependent assistance for bed to chair transfers. The MDS indicated Resident 7 did not have any functional limitations in ROM in the upper extremities (shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities (LE, hip, knee, ankle/foot). During a review of Resident 7’s Rehab Joint Mobility Screen (JMS), the JMS indicated JMS were completed on 10/22/2024, 1/9/2025, and 4/3/2025. The JMS dated 4/3/2025 indicated the JMS was completed and signed on 7/1/2025 (three months later). The JMS dated 4/3/2025 indicated Resident 7 had minimal ROM impairment in both shoulders, normal ROM in both elbows, wrists, fingers/hand, right hip and minimal ROM impairment in the left hip, both knees, and both ankles. During a concurrent interview and record review on 7/2/2025 at 9:21 a.m., with the co-Director of Rehabilitation (DOR 1), reviewed Resident 7’s JMS dated 4/3/2025. DOR 1 stated the JMS were completed quarterly based on the MDS schedule. DOR 1 reviewed Resident 7’s JMS and stated JMS dated 4/3/2025 was completed on 7/1/2025 and was late. DOR 1 stated therapy staff should have completed it before 4/3/2025. DOR 1 stated the JMS dated 4/3/2025, but completed on 7/1/2025 should have been entered as a late entry and should have indicated how the therapist obtained the ROM measurements if it was completed three months after 4/3/2025. DOR 1 stated the JMS was not documented accurately and it was important to maintain accurate records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/2025 at 10:05 a.m., with the Assistant Director of Nursing (ADON), the ADON stated joint mobility screens were completed quarterly by the therapy staff. The ADON stated it was important to document the actual date the JMS was completed, specify that the document was a late entry, indicate why it was not completed earlier, and indicate how the resident was assessed to ensure accuracy in the document. During a review of the facility’s policy and procedure (P&P) titled, “Charting and Documentation,” reviewed 1/21/2025, the P&P indicated all services provided to the resident shall be documented in the resident’s medical record. 1.b. During a review of Resident 79’s admission Record (AR), the AR indicated the facility initially admitted the resident on 11/2/2022 and readmitted the resident on 5/6/2024 with diagnoses including but not limited to schizophrenia (a mental health disorder that is characterized by disturbances in thought), difficulty in walking, muscle wasting and atrophy (gradual decline). During a review of Resident 79’s MDS dated [DATE], the MDS indicated Resident 79 was moderately impaired in cognitive skills for daily decision making. The MDS indicated Resident 79 required supervision for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 79 required moderate assistance walking 10 feet. The MDS indicated Resident 79 required substantial assistance in bed to chair transfers. During a review of Resident 79’s Rehab Joint Mobility Screen (JMS), the JMS indicated JMS were completed on 11/5/2024, 1/31/2025, and 4/30/2025. The JMS dated 4/30/2025 indicated the JMS was completed and signed on 7/1/2025 (two months later). The JMS dated 4/30/2025 indicated Resident 79 had normal or within normal limits ROM in all joints. During a concurrent interview and record review on 7/2/2025 at 9:21 a.m., with DOR 1, reviewed Resident 79’s JMS dated 4/30/2025. DOR 1 stated the JMS were completed quarterly based on the MDS schedule. DOR 1 reviewed Resident 79’s JMS and stated the JMS dated 4/30/2025 was completed on 7/1/2025 and was late. DOR 1 stated therapy staff should have completed the JMS before 4/30/2025. DOR 1 stated the JMS dated 4/30/2025, but completed on 7/1/2025 should have been entered as a late entry and should have indicated how the therapist obtained the ROM measurements if it was completed two months after 4/30/2025. DOR 1 stated the JMS was not documented accurately and it was important to maintain accurate records. During an interview on 7/2/2025 at 10:05 a.m., with the ADON, the ADON stated joint mobility screens were completed quarterly by the therapy staff. The ADON stated it was important to document the actual date the JMS was completed, specify that the document was a late entry, indicate why it was not completed earlier, and indicate how the resident was assessed to ensure accuracy in the document. During a review of the facility’s P&P titled, “Charting and Documentation,” reviewed 1/21/2025, the P&P indicated all services provided to the resident shall be documented in the resident’s medical record. 1.c. During a review of Resident 85’s admission Record (AR), the AR indicated the facility admitted the resident on 1/11/2023 with diagnoses including but not limited to, schizophrenia (a mental health disorder that is characterized by disturbances in thought), difficulty in walking, and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). (continued on next page)

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	07/03/2025

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 85’s MDS dated [DATE], the MDS indicated Resident 85 was moderately impaired in cognitive skills for daily decision making. The MDS indicated Resident 85 was independent with eating and upper body dressing, required setup assistance for oral hygiene. The MDS indicated Resident 85 required supervision for bed to chair transfers and walking 150 feet. During a review of Resident 85’s Rehab Joint Mobility Screen (JMS), the JMS indicated JMS were completed on 10/12/2024, 1/9/2025, and 4/9/2025. The JMS dated 4/9/2025 indicated the JMS was completed and signed on 7/1/2025 (three months later). The JMS dated 4/9/2025 indicated Resident 79 had normal or within normal limits ROM in all joints. During a concurrent interview and record review on 7/2/2025 at 9:21 a.m., with DOR 1, reviewed Resident 85’s JMS dated 4/9/2025. DOR 1 stated the JMS were completed quarterly based on the MDS schedule. DOR 1 reviewed Resident 85’s JMS and stated JMS dated 4/9/2025 was completed on 7/1/2025 and was late. DOR 1 stated therapy staff should have completed it before 4/9/2025. DOR 1 stated the JMS dated 4/9/2025, but completed on 7/1/2025 should have been entered as a late entry and should have indicated how the therapist obtained the ROM measurements if it was completed two months after 4/9/2025. DOR 1 stated the JMS was not documented accurately and it was important to maintain accurate records. During an interview on 7/2/2025 at 10:05 a.m., with the ADON, the ADON stated joint mobility screens were completed quarterly by the therapy staff. The ADON stated it was important to document the actual date the JMS was completed, specify that the document was a late entry, indicate why it was not completed earlier, and indicate how the resident was assessed to ensure accuracy in the document. During a review of the facility’s P&P titled, “Charting and Documentation,” reviewed 1/21/2025, the P&P indicated all services provided to the resident shall be documented in the resident’s medical record. 2. During a review of Resident 7’s admission Record, the admission Record indicated the facility admitted the resident on 7/20/2020 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood), unspecified mood disorder (a mental health condition characterized by significant and persistent disruptions in a person's emotional state, impacting their ability to function normally), mild cognitive impairment of unknown etiology (the cause of a disease or abnormal condition), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record did not indicate a diagnosis of anxiety. During a review of Resident 7’s History and Physical (H&P), dated 10/21/2024, the H&P indicated Resident 7 had the capacity to understand and make decisions. The H&P further indicated Resident 7 had anxiety and was stable on her current regimen (a systematic plan [as of diet, therapy, and/or medication] designed to improve or maintain health). During a review of Resident 7’s MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS further indicated Resident 7 required substantial assistance for dressing and toileting and was completely dependent on staff for bathing. (continued on next page)

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	07/03/2025

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7’s care plan (a document that summarizes a resident’s needs, goals, and care/treatment) titled, “The resident uses anti-anxiety medication Ativan (a medication used to treat anxiety disorders) related to anxiety…,” dated 10/14/2024, the care plan indicated Resident 7 yells, screams, and is combative when receiving care for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The care plan indicated the goal that Resident 7 will show decreased episodes of the signs and symptoms of anxiety. During a review of Resident 7’s psychiatric progress note dated 3/4/2025, the psychiatric progress note indicated the resident was taking the medication Ativan two times a day for anxiety. The psychiatric progress note indicated Resident 7 reported having anxiety. During a concurrent interview and record review on 7/3/2025 at 11:00 a.m., with the Quality Assurance Nurse (QAN), reviewed Resident 7’s diagnoses in Resident 7’s medical record. The QAN stated anxiety should be included in Resident 7’s diagnosis list. The QAN stated Resident 7 is taking Ativan for anxiety, so anxiety should be in the medical record under Resident 7’s diagnoses to accurately reflect why she is taking that medication. During an interview on 7/3/2025 at 11:17 a.m., with Minimum Data Set Nurse 1 (MDSN 1), MDSN 1 stated since Resident 7’s indication for taking Ativan is anxiety, anxiety should be included under Resident 7’s diagnosis list in the medical record. MDSN 1 it is important to include the anxiety diagnosis so staff who are looking at Resident 7’s medical record will be aware of the diagnosis and carry out the plan of care necessary for the resident. During an interview on 7/3/2025 at 1:06 p.m., with the Director of Nursing (DON), the DON stated Resident 7’s anxiety diagnosis should be in the resident’s diagnosis list in the medical record so staff will be aware of her anxiety. During a review of the facility's P&P titled, “Charting and Documentation,” last reviewed on 1/21/2025, the P&P indicated all services provided to the resident and any changes in the resident’s medical or mental condition will be documented in the resident’s medical record.