

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0687 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide proper foot care and treatment to maintain good foot health for one of two sampled residents (Resident 10) by failing to: 1. Inspect Resident 10's skin during daily provisions (everyday care, services, and basic necessities provided to the resident to keep them safe, comfortable, and health) on 6/15/2026 to 6/28/2026 and on 7/1/2026 to 7/15/2026 as indicated in Resident 10's care plan (a document that summarizes a person's health conditions, specific care needs, and current treatments) titled, At Risk for Skin Breakdown related to Braden Risk (a scoring tool used to predict resident's risk of developing a pressure ulcer, total score ranges from zero to 18) score (Resident 10's Braden Risk score is 13 - indicates moderate risk for developing pressure ulcers/injuries [also known as pressure sores and decubitus ulcers, localized damage to skin and/or underlying tissue caused by prolonged pressure or friction, often over bony areas) and fragile skin condition 2. Provide skin and foot care to Resident 10, who had an admitting diagnosis of type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a condition in which a person's peripheral nerves [network of cable-like nerve fibers outside the brain and spinal cord] are damaged) upon admission of Resident 10 to the facility on 5/27/2026 to 6/28/2026 and on 7/1/2026 to 7/16/2026 in accordance with the facility's policy and procedure (P&P) titled, Nursing Care of the Older Adult with Diabetes Mellitus, last reviewed on 1/20/2026, which indicated to provide skin and foot care to residents with DM. 3. Conduct daily foot inspections and washing of feet every day for Resident 10 on 6/26/2026 to 6/28/2026 and on 7/1/2026 to 7/16/2026 in accordance with the Podiatry (a medical specialty focused on the diagnosis, treatment, and prevention of conditions affecting the feet, ankles, and lower legs) Nurse Practitioner's (NP's) recommendations, dated 6/26/2026. 4. Offload (to reduce or remove pressure on the affected area to promote healing and prevent further damage) Resident 10's heels using a pillow when in bed in accordance with Resident 10's care plan titled, Skin: Resident has a diabetic ulcer (open sore or wound on the foot that fails to heal properly, often associated with condition like diabetes and poor circulation) on left lateral (outer side) foot and is at risk for complications related to delayed healing, initiated on 6/26/2026. These failures resulted in Resident 10 developing two facility-acquired diabetic foot ulcers. Resident 10 developed on 6/26/2026 a left lateral diabetic foot ulcer measuring 0.9 centimeters (cm-unit of measurement) in length x (by) 0.9 cm in width x 0.1 cm in depth and, on 7/9/2026, it (left lateral diabetic foot ulcer) increased in size to 1.8 cm x 1.8 cm x UTD (unable to determine). Resident 10 developed, on 7/9/2026, another ulcer on Resident 10's right great toe measuring 0.8 cm in length x 0.8 cm in width x 0.2 cm in depth with necrotic (dead) tissue on wound bed (the base or bottom part of a wound, where new skin and tissue grow as the wound heals), and was tender (painful) to palpation (touched or pressed during examination). Findings: During a review of Resident 10's undated admission Record, the admission (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555574 If continuation sheet Page 1 of 53

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents (menu tickets) containing protected information ([PHI]- any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were shredded prior to disposing in the waste container. This failure had the potential to violate 125 of 126 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 7/14/2026 at 9:25 a.m., of the dishwashing process in the dishmachine area, observed Dietary Aide 3 (DA 3) throwing the leftover foods, plastic and menu tickets into the grey trash can. During an observation on 7/14/2026 at 9:27 a.m., of DA 3 dishwashing, observed DA 3 threw the meal ticket in the trash can. During a concurrent observation on 7/14/2026 at 9:28 a.m., of DA 3 dishwashing with the Dietary Supervisor (DS), observed DA 3 continue to throw meal tickets in the trash from the soiled trays. The DS stated their process of dishwashing starts by throwing all the trash in the garbage can including the meal tickets. The DS stated DA 3 came from the sister facility and he did not provide training before starting to work and help in their facility. During an interview on 7/14/2026 at 9:34 a.m., with the DS, the DS stated after dishwashing is done, the staff take the trash to the outside dumpster. The DS further stated the first step of dishwashing is to dispose of the meal tickets in the trash during stripping of the trays (removing trays from the cart and clearing from the solid waste and food leftovers). The DS stated the meal tickets contained residents' food likes and dislikes, food allergies, name of the residents, ID number (medical record), diet order, and room number. The DS stated throwing meal tickets in the trash is not good practice because the meal tickets contained PHI, including name and picture of the resident. The DS further stated they needed to separate the menu tickets and shred it before disposing due to Health Insurance Portability and Accountability Act (HIPPA, a federal law designed to protect sensitive patient health information from being disclosed without the resident's consent). The DS stated throwing the meal tickets in the trash is not protecting residents' health information and other people could get the residents information and use them as a potential outcome. During an interview on 7/14/2026 at 3:48 p.m., with the Director of Nursing (DON), the DON stated the menu ticket contained name, room number, age, gender, allergies, diet preferences, diet order, diet order, ID number which is the residents medical record number, and the picture of the residents. The DON stated they should have shredded the menu tickets before throwing it in the trash because it contained PHI and needed to be protected. The DON stated they violated HIPPA by throwing it in trash and the information was exposed to other people. During a review of the facility's policy and procedure (P&P) titled, Protected Health Information (PHI) Management and Protection of, dated 1/20/2026, the P&P indicated, Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws. 1. It is the responsibility of all personnel who have access to resident and facility information to ensure such information is managed and protected to prevent unauthorized release or disclosure.10. Health information may be considered not to be individually identifiable in the following circumstances: a. A person with appropriate knowledge and experience with generally acceptable statistical and scientific principles and methods determines that the risk is very small that the information could be used, alone, or with other reasonably available information, to identify the resident who is the subject of the information; or b. The following identifiers of the resident (and relatives, employers or household members) are removed: Names Medical record numbers Full face photographic images Any other unique identifying number, or characteristic code. During a review of the facility's P&P titled, HIPPA Training Program, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: Kitchen and storage areas were not free from dirt and food debris. Reach-in freezer vent had dust and dirt buildup. Meat reach-in freezer bottom shelves had dirt, crumbs and other food debris. Walk-in refrigerator floors had food particles, debris and milk spills. Four (4) of 4 vents in the walk-in refrigerator contained dust and dirt buildup. Walk-in refrigerator shelves had food debris Dry storage floor had noodles, oatmeal and dirt debris. Dry foods and condiment container covers had oatmeal, sugar and flour debris. Hot water dispenser spout contained hard water buildup. Trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] roof contained food splatters and was not cleaned before lunch trayline started. Utensil drawer had dirt debris and silverware was wrapped in a dirty paper towel. Two (2) of 2 fans on the trayline area had dust and dirt buildup. Residents' refrigerator by the Director of Nursing's office contained fruit residue and debris. Kitchen equipment and surfaces are not cleanable surface One (1) metal rack was corroded with rust and 1 black rack had paint coming off and had chips. [NAME] chopping board had scratches and knife marks. Mislabeled and expired trays cheese sandwiches dated 6/30/2026, ham and cheese sandwiches labeled 7/7/2026 and 6/25/2026 in the walk-in refrigerator. Sliced lemon was wrapped in a paper towel and prepared food such as hamburger patty and sliced zucchini were stored in a plastic bag. Four (4) of 4 dented cans (a packaged metal food container that have been physically deformed or crushed) were found with non-dented cans. Personal staff beverage containers were on the mixer table and on top of the dishwashing countertops. Dietary staff were wearing bracelets, rings, and a watch during meal preparation and dishwashing. Four (4) of 4 dietary staff did not wash their hands during food preparation, dishwashing and other kitchen tasks. Dietary Aide 1 (DA 1): held a soiled towel and wiped the countertop surfaces then started putting way clean pans in the storage area then proceeded to touch the lid of the trash. moved the gray trash can using his hands, drinking Gatorade (a brand of drink) and touching a clean cart containing residents' beverages and thickener then went back to the storage area to store the thickener. threw the paper liner in the trash, touched the trash can lid then went to handwashing station and washed and rinsed his hands for 5 seconds (timing using a wristwatch). DA 1 placed his hand in his mouth and proceeded to check and held meal trays without handwashing. held the trash lid, [NAME] his gloves away then held the milk carton and went into the walk-in refrigerator. DA 1 touched his face then proceeded to label the beverage cup and placed it back in the walk-in refrigerator. Dietary Aide 2 (DA 2) wiped his hands on his pants then put gloves on and started dishing out corn coleslaw. DA 2 then held the lid of the trash can then went back to dishing out corn coleslaw. dipped and washed his hands in the red sanitizing bucket and touched the clean dishes. Cross-Reference F802 [NAME] 1 washed the green bell pepper, removed her gloves and opened the trash lid with her bare hands then proceeded chopping the green bell pepper and tofu. [NAME] 1 removed her gloves and threw it in the trash can after peeling the onions then proceeded to cook. [NAME] 1 then wiped her hands using a paper towel then changed her gloves. [NAME] 1 did not wash hands after cleaning the preparation area and before touching the onion. [NAME] 1 only rinsed her hands when changing tasks. [NAME] 2 did not wash her hands after cleaning and wiping surfaces and before putting away clean pots and pans. Cross-Reference F802. DA 1 was drinking Gatorade in the dishwashing area and chewing gum during trayline, food preparation (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bracelet and a leather bracelet while dishwashing and cleaning surfaces. During an observation on 7/13/2026 at 12:14 a.m., of trayline lunch service, observed DA 2 was wearing a wristwatch while scooping corn coleslaw from the pan to the disposable wares. During an interview on 7/13/2026 at 1:53 p.m. with the DS and the RD, the RD stated dietary staff should not wear big hoops earrings, but small stud earrings are okay and minimal jewelry if possible. The DS stated dietary staff should not wear studs, rings with stones, watches and bracelets but plain bracelets are allowed and matrimonial rings with no diamonds. The DS further stated diamonds could go to the resident's food and could cause choking, and the watches and bracelet could touch the food causing cross-contamination. During a review of the facility's P&P titled, Dress Code dated 1/20/2026, the P&P indicated, 9. No excessive jewelry, just wedding ring on hand, non-dangling earrings on ears, and wristwatch. Wristwatch and wedding rings needed to be covered with gloves when food handling. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. 8. a. i. During an observation on 7/13/2026 at 11:34 a.m., of the dishwashing area, observed DA 1 went from dirty to clean area, held a towel and wiped the countertop surfaces. Observed DA 1 proceeded to put away the clean pans and touched the lid of the trash without washing his hands. ii. During an observation on 7/13/2026 at 11:48 a.m., of the dishwashing area, observed DA 1 moved and pushed the grey trash can, drank Gatorade then proceeded to push the cart with resident's drinks and thickener and placed the thickener back in the storage area without washing his hands. During an observation on 7/13/2026 at 11:53 a.m., of DA 1 assisting in trayline, observed DA 1 supplied milk on the residents' trays and scooped ice from the ice machine. iii. During an observation on 7/13/2026 at 12:45 p.m., of DA 1 working in trayline, observed DA 1 held the trash can, threw the paper liner in the trash then proceeded to the handwashing station. Observed DA 1 washed his hands and rinse it for five (5) seconds then proceeded to trayline and held a meal tray. During an observation on 7/13/2026 at 12:48 p.m., of DA 1 working in trayline, observed DA 1 placed his hand in his mouth and then continued handling food trays without washing his hands. iv. During an observation on 7/13/2026 1:05 p.m. of DA 1 working in trayline, observed DA 1 held the trash can lid, threw away his gloves then proceeded to hold the milk and went to the walk-in refrigerator without washing his hands. Observed DA 1 touched his face then proceeded to label the beverage cups and placed it in the walk-in refrigerator without washing his hands. During an interview on 7/13/2026 at 2:07 p.m., with the RD, the RD stated DA 1 should wash his hands when putting his hand in his mouth due to because of saliva contamination. b. i. During an observation on 7/13/2026 at 12:14 a.m., of trayline lunch service, observed DA 2 wiped his hands on his pants and wore gloves and started dishing out corn coleslaw without washing his hands. During an observation on 7/13/2026 at 12:21 p.m., of DA 2 working in trayline, observed DA 2 held the lid of the trash then proceeded to dish out corn coleslaw without washing his hands. ii. During an observation on 7/14/2026 at 9:20 a.m., of the dishwashing process, observed DA 2 in the clean area dipped his hands in the red bucket containing sanitizer and water then put away clean dishes. During an observation on 7/14/2026 at 9:22 a.m., of the dishwashing process, observed DA 2 dipped his hands in the red bucket then put away clean dishes. During a concurrent observation and interview on 7/14/2026 at 9:41 a.m., of DA 2 dishwashing with the DS and DA 2, observed the DS dip his hands in the red bucket. The DS stated DA 2 placed his hands in the sanitizer bucket. DA 2 stated he dipped his hands in the sanitizer bucket because his co-worker told him to do so but he does not know the reason why. The DS stated DA 2 was not supposed to dip his hands in the sanitizer because it is used to clean surfaces and carts and not used to clean hands. The DS further stated cleaning of hands is done by going to the handwashing (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sink and handwash to prevent cross-contamination. c. i. During an observation on 7/13/2026 at 12:55 p.m., of food preparation, observed [NAME] 1 washed the green bell pepper, removed her gloves, touched the trash lid then threw the gloves in the trash. [NAME] 1 proceeded to cut and chopped the green bell peppers and tofu without washing her hands. ii. During an observation on 7/13/2026 at 1:03 p.m., of the food preparation, observed [NAME] 1 peeled an onion, removed her gloves then threw it in the trash can then wiped her hands with a paper towel then proceeded to cook without handwashing. During an interview on 7/13/2026 at 1:59 p.m., with the DS and the RD, the DS stated dietary staff should wash their hands when going outside and returning to the kitchen, after touching their face, hair and clothes. The RD stated dietary staff should wash their hands when touching the phone, in between tasks, when they pick up something on the floor, when something spills, handling dirty trays from outside, after cleaning, touching the trash and before starting to work. The RD further stated dietary staff should wash their hands for 20 seconds to make sure all the germs come out of their hands. During an interview on 7/13/2026 at 2:09 p.m., with the RD, the RD stated [NAME] 1 should have washed hands after washing the bell pepper, after throwing her gloves		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly when: 1. One (1) of two (2) dumpsters (a movable waste container designed to be brought and taken away by special collection vehicles, or to a bin that specially designed garbage truck lifts) was not closed when not actively being used. 2. Two of two trash cans in the kitchen were not properly covered and closed while not actively being used during lunch trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). 3. The dumpster body had dirt and food debris. 4. The surrounding area of the dumpster contained soiled gloves These failures had the potential to attract pests such as rats, cockroaches, flies, and ants, which may spread diseases to 126 of 126 residents living in the facility. Findings: 1. During an observation on 7/13/2026 at 8:10 a.m., observed one of two dumpsters were open and was not actively being used. During an interview on 7/14/2026 at 10:44 a.m., with the Maintenance Supervisor (MS), the MS stated the dumpster needed to be covered all the time to prevent birds from picking up the trash and spreading infections to the residents. 2. During an observation on 7/13/2026 at 12:02 p.m., of the grey trash can by the preparation area, observed the grey trash can was not completely closed. During an observation on 7/13/2026 at 12:52 p.m., of the grey trash can by the preparation area, observed one grey trash not completely closed and it was not being used. During an observation on 7/13/2026 at 1:01 p.m., of the grey trash cans by the preparation area and dishwashing area, observed two trash cans not completely closed and they were not being used. During a concurrent observation and interview 7/13/2026 at 2:14 p.m., of the trash cans in the kitchen with the Dietary Supervisor (DS) and the Registered Dietitian (RD), observed the trash cans by the preparation area and dishwashing area were not completely closed and they were not actively being used. The DS stated trash cans should be covered when not in use. The RD stated it was important to cover the trash, and it should be securely closed but it was not closed. The DS stated pests could cause cross contamination and spread germs to the residents. 3. During a concurrent observation and interview on 7/14/2026 at 10:37 a.m., with the DS, observed the dumpster surrounding and dumpster body. The DS stated they throw food in the outside dumpster. The DS stated there were food debris on the body of the dumpster and it was not okay and the trash needed to be clean because flies can go to it and spread germs to the residents as a potential outcome. 4. During a concurrent observation and interview on 7/14/2026 at 10:37 a.m., of the outside dumpster with the MS, observed soiled gloves on the floor of the dumpsters. The MS stated he was the one maintaining the dumpster area and the truck picks up trash five days a week, but they do not have a particular day of pickups. The MS stated the dumpster needs to be clean to make sure there are no birds to pick up the trash and spread infections to residents. The MS stated the janitor cleans the dumpster, but it was not clean due to visible debris. The MS stated there were only two (2) soiled dishes on the floor and the debris on the dumpster body was new. During a review of the facility's policy and procedure (P&P) titled, Miscellaneous Areas, dated 1/20/2026, the P&P indicated Garbage and trash can must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. The area must be swept and washed down by maintenance with a detergent on a regular basis. During a review of Food Code 2022, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside (continued on next page)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the food establishment. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide care in a manner that promoted dignity and respect by failing to: 1. Ensure residents were not served side dishes in paperware during lunch time. 2. Ensure Certified Nursing Assistant 3 (CNA 3) was not standing over one of one sampled resident (Resident 101) while assisting with eating. This deficient practice had the potential to affect 70 of 126, including Resident 39 and Resident 101, residents' self-esteem and self-worth. Findings: 1. During a review of Resident 39's admission Record, the admission Record indicated the facility initially admitted Resident 39 on 2/1/2023 and readmitted the resident on 1/8/2026 with diagnosis including, but not limited to essential hypertension (HTN, high blood pressure), type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) with acute exacerbation (a sudden, significant worsening). During a review of Resident 39's Minimum Data Sheet (MDS- a resident assessment tool) dated 4/10/2026, the MDS indicated Resident 39 understood others and was able to make self-understood. The MDS indicated Resident 39 is independent (resident completes the activity by themselves with no assistance from a helper) when eating. During a review of Resident 39's Order Summary Report, dated 4/10/2026, the Order Summary Report indicated Resident 139 had an order for consistent carbohydrate diet (CCHO, a diet used to manage blood sugar levels by providing the same amount of carbohydrates each meals), International Dysphagia Diet Standardization Initiative (IDDSI, globally standardized framework used to describe and classify texture of food and thickness of liquids for individual with swallowing difficulties) level six (6) texture (soft and bite size, consist of soft, moist, and tender foods require chewing before swallowing. Food must be cut into bite-sized pieces less than or equal to 1.5 centimeter x 1.5 centimeter) with thin consistency for liquids. During an observation on 7/13/2026 at 12:12 p.m., observed dietary staff serving corn coleslaw on paperware bowls. During an observation on 7/13/2026 at 12:14 p.m., observed Dietary Aide 2 (DA 2), serving corn coleslaw on paperware bowls in trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). During an observation on 7/13/2026 at 12:21 p.m., observed DA 2 serve corn coleslaw on paperware (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowls.^ During a concurrent^test tray (a process of tasting, temping, and evaluating the quality of food)^observation and^interview on^7/13/2026 at 1:16^p.m., of the regular diet with the Dietary Supervisor (DS), the DS stated paperwares are being used since he started his employment because of Coronavirus disease (COVID-19 a highly contagious respiratory illness) and^they had to buy every two weeks because the residents throw them away. The DS^stated^residents did not request their dishes to be placed on^paperware^and it was not okay and good practice due to residents' dignity.^ ^ During^an interview on^7/13/2026 at 1:21 p.m., with the Registered Dietitian (RD), the RD^stated^the^reason why^they use paperware is because the side dishes were thrown away and they tried educating nurses^not to throw them.^The RD^stated^the residents may not eat the food and lose weight as a potential outcome of food served on paperwares.^ During an interview on^7/14/2026 at 12:54^p.m., with^Resident^39, Resident^39 stated it would be better if cups, spoons and forks, and side dishes are not in disposable or plasticwares.^ During an interview on 7/15/2026 at 11:54 a.m., with Resident 39, Resident 39 stated^it was discussed in the resident council that the facility will start using plasticwares instead of silverware because residents could use it as weapon to cut themselves, however with the use of disposable beverage container, and side dishes, he did not agree with it.^Resident 39^stated^it did not bother^him;^however, it would be nice to serve in regular beverage^containers^and silverwares at it helped them eat the meat and vegetables because it is sturdy^(not easily broken) compared to plastic.^ During a review of the facility's policy and procedure^(P&P)^titled,^Dignity, dated^1/20/2026, the P&P 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.^ During a^review of the facility's meeting minutes titled, Quarterly Quality Assurance/Utilization Review Committee Meeting, dated 4/16/2026, the^minutes indicated, the facility will limit and eliminate standard silverwares and plastic cups during meals to best preserve the odds of preventing unwanted accidents or incidents. The minutes did not specify the use of disposable side dishes being disposable.^ 2. During a review of Resident 101's admission Record, the admission Record indicated the facility admitted the resident on 5/4/2026 with diagnoses that included dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 4 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 101 required partial/moderate assistance (helper does less than half the effort) with eating. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 101's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) initiated 5/6/2026, the care plan indicated a goal that Resident 101 will have needs anticipated and met by staff. The care plan indicated an intervention, initiated 7/15/2026, that Resident 101 requires extensive assistance with eating. During a concurrent observation and interview on 7/16/2026 at 8:18 a.m., with CNA 3, observed CNA 3 feeding Resident 101 in his wheelchair by his bed. CNA 3 was standing and not at eye level while feeding Resident 101. When asked how she feeds a resident, CNA 3 stated she should be sitting in a chair, left the room, returned with a chair, and started feeding Resident 101 while sitting in the chair. During an interview on 7/16/2026 at 8:30 a.m., with CNA 3, CNA 3 stated the practice is to feed a resident sitting in a chair at eye level with a resident. CNA 3 stated this was important because it is comfortable for the resident and for her, and to explain what she is feeding the resident. During an interview on 7/16/2026 at 8:58 a.m., with the Director of Nursing (DON), the DON stated residents that need assistance with eating are to be fed at eye level to provide dignity for the residents. During a review of the facility's policy and procedure titled, Assistance with Meals, last reviewed 1/20/2026, indicated residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.		

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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 two of five sampled residents' (Resident 5 and Resident 4) drug regimen were free from the use of unnecessary (any medication with excessive dose, excessive duration, without adequate monitoring) psychotropic (any medication capable of affecting the mind emotions, and behavior) medications in accordance with the facility policies and procedures (P&P) by failing to: 1. Implement the physician's order to obtain orthostatic blood pressures (taking blood pressure measurements when lying, sitting, and standing to detect for significant drop in blood pressure during each position change) for Resident 5, who was receiving risperidone (an antipsychotic [medication that works by changing the effects of chemicals in the brain] medication). 2. a. Ensure the target behavior (specific, observable, and measurable behavioral symptom) for Resident 4 receiving quetiapine (an antipsychotic medication used to treat certain mental/mood conditions) was specific to allow for effective monitoring and evaluation by the licensed nurses. b. Ensure Resident 4's alprazolam (an anti-anxiety medication) daily dosage parameters were followed. These failures had the potential to place Resident 4 and 5 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic medications, resulting in impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: a. During a review of Resident 5's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 5 on 5/15/2026 with diagnoses that included psychosis, dementia (a progressive state of decline in mental abilities) and hypertension (high blood pressure). During a review of Resident 5's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool) dated 5/24/2026, the MDS indicated Resident 5 usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated Resident 5's had severe cognitive (ability to learn, think, remember and make decisions) impairment. The MDS indicated Resident 5 was dependent (helper does all of the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 5's active diagnosis included psychotic disorder (a condition characterized by delusions and/or hallucinations, often resulting in a loss of contact with reality), depression, and dementia. The MDS indicated Resident 5 is taking antipsychotic. During review of Resident 5's History and Physical (H&P), dated 5/20/2026, the H&P indicated Resident 5 does not have the capacity to make decisions or make needs known. (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 5's physician orders, the physician orders indicated the following orders dated 5/19/2026: -Risperidone oral tablet 1 milligram (mg-unit of measurement used for medication dosage and/or amount) by mouth two times a day for psychosis manifested by agitation as evidence by (AEB) trying to hit staff during ADLs. -Risperidone oral tablet 1 mg by at bedtime for psychosis manifested by AEB trying to hit staff during ADLs. -Orthostatic blood pressure (B/P) every Saturday. Take B/P while lying in bed then repeat upon sitting (Lying) every day shift every Saturday for Risperdal (brand name of Risperdone) use. -Orthostatic B/P every Saturday. Take B/P while lying in bed then repeat upon sitting (Sitting) every day shift for Risperdal use. During a review of Resident 14's care plan titled, [Resident] uses psychotropic medication Risperdal last revised on 6/14/2026, date initiated 5/25/2026, the care plan indicated the goal as The resident will be/remain free of psychotropic drug related complications, including.hypotension. The care plan indicated an intervention to monitor the resident for side effects (unintended response to a medication or medical intervention). During a concurrent interview and record review on 7/16/2026 at 12:28 p.m. with the Assistant Director of Nursing (ADON), Resident 5's physician orders and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 06/2026 and 07/2026 were reviewed. The ADON stated that there was supposed to be two separate BP blood pressures taken for Resident 5 every Saturday; while lying in bed and while sitting in bed. The ADON stated that the MAR should have two distinct sections for documenting Resident 5's BP to reflect that the blood pressure was done per the physician orders. The ADON stated that the MAR should have one section for recording the BP value and another specifying Resident 5's position, if lying or sitting. The ADON stated that it is important that Resident 5's BP was measured as per the physician orders. The ADON stated that Resident 5 was receiving antipsychotics and that one of the side effects of antipsychotics was a drop in BP. The ADON stated that if Resident 5's BP is not measured properly, a drop in BP could be missed which may result in Resident 5 having a fall. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use Residents last reviewed 1/20/2026, the P&P indicated, Residents receiving psychotropic medication are monitored and the response to treatment is documented. Monitoring may include lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the drug regimen review from the consultant pharmacist. In addition, residents are monitored for adverse consequences associated with psychotropic medications, including cardiovascular effects - .increased blood pressure, orthostatic hypotension. During a review of the facility's policy and procedure (P&P) titled, Blood Pressure. Monitoring last (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed 1/20/2026, the P&P indicated that to measure orthostatic blood pressure, repeat the same steps taken with how to take blood pressure after helping the resident to a standing position. b. During a review of Resident 4's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included psychosis, anxiety (feelings of uneasiness) and history of fall. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort) with eating. The MDS indicated Resident 4 takes an antipsychotic and anti-anxiety medication. b.1. During a review of Resident 4's Physician's Orders, dated 6/12/2026, the order indicated: Seroquel 100 mg, give one tablet by mouth two times a day for psychosis manifested by sudden anger outburst of anger. During a review of Resident 4's Medication Regimen Review (MRR-a process when the facility's pharmacist consultant conducts a comprehensive review of the facility residents' medications) covering the dates 6/15/2026 to 6/16/2026, the MRR indicated the pharmacist recommended the following: Seroquel for sudden outburst of anger may be seen as too vague and subjective and thus make this medication be considered inappropriate by surveyors. Clarify behaviors and be specific. During a review of Resident 4's Care Plan for Psychotropic Medication, initiated 6/19/2026, the care plan indicated Resident 4 is on Seroquel. The care plan indicated a goal that the resident will not suffer from any adverse effects from the medication use. The care plan indicated an intervention to monitor resident behaviors and report ineffectiveness of medication to provider if needed. During a concurrent interview and record review with Licensed Vocational Nurse 4 (LVN 4) on 7/15/2026 at 4:16 p.m., LVN 4 reviewed Resident 4's Physician's Orders which included the medication, Seroquel. LVN 4 stated there should be specific behaviors in the order, so that licensed nurses can be specific in their assessment. LVN 4 stated the licensed nurses may not know if the medication is effective if the behaviors are not specific to the resident. During a concurrent interview and record review with the ADON on 7/16/2026 at 9:13 a.m., the ADON reviewed Resident 4's Physician's Orders which included the medication Seroquel. The ADON stated outburst of anger is too vague. The ADON stated the order should have been clarified. The ADON stated it is important to monitor for specific behavior to see if it is improving or worsening and notify Resident 4's psychiatrist. The ADON stated this is important, ensuring Resident 4 is free from unnecessary medication and free from side effects such as sedation, drowsiness and risk for fall. During an interview with LVN 3 on 7/16/2026 at 12:13 p.m., LVN 3 stated she observed Resident 4's behaviors of yelling and screaming for no reason. b.2. During a review of Resident 4's Physician's Orders, the orders indicated the following: Alprazolam tablet 0.5 mg, give one tablet by mouth every eight hours as needed for anxiety for 14 days, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manifested by increase restlessness. Not to exceed (NTE) 0.75 mg in 24 hours, dated 6/12/2026 and discontinued 6/28/2026. During a review of Resident 4's MAR covering the dates 6/12/2026 to 6/30/2026, the MAR indicated Resident 4 was given two doses of alprazolam on 6/25/2026. During a concurrent interview and record review with LVN 4 on 7/16/2026 at 9:20 a.m., Resident 4's Physician's Orders which included the medication, alprazolam were reviewed. LVN 4 stated that NTE 0.75 mg meant alprazolam administered to Resident was not to exceed 0.75 mg in 24 hours period. LVN 4 stated the dosing parameters should have been clarified with Resident 4's psychiatrist to see if they wanted the 0.75 mg daily limit. Two doses given in a day would be 1 mg given, which is over the 0.75 mg daily limit. During a concurrent interview and record review with the Director of Nursing (DON) on 7/16/2026 at 11:33 a.m., the DON reviewed Resident 4's Alprazolam physician order and 6/2026 MAR. The DON stated if the Alprazolam was ordered not to exceed 0.75 mg, then there should not be two doses given on 6/25/2026, which would be over the daily limit. The DON stated Resident 4's psychiatrist should be called to see if they want the daily limit to be 0.75 mg. The DON stated it is important to follow the physician's orders so that Resident 4 would not be at risk for impaired coordination and sedation. During a review of the facility's P&P titled, Psychoactive/ Psychotropic Medication Use, last reviewed 1/20/2026, the P&P indicated the following: -A psychotropic medication is any drug that affects brain activities associated with mental processes and behavior which includes antipsychotic medications. -Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: determining adequate indications for use, adequate monitoring for efficacy and adverse consequences, and preventing, identifying, and responding to adverse consequences. -Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on an assessment of the resident's condition and therapeutic goals. During a review of the facility's P&P titled, Administering Medications, last reviewed 1/20/2026, the P&P indicated the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when: 1. Dietary Aide 3 (DA 3) from Skilled Nursing Facility 2 (SNF 2, a sister facility [a building or location that shares the same parent organization or owner as another place]) did not have facility training and competency verification from the Dietary Supervisor (DS) from SNF 1 before performing the dishwashing job. 2. Dietary Aide 2 (DA 2) did not know the reason why he should not dip his hands in the sanitizer bucket when doing hand hygiene. 3. [NAME] 2 is unable to verbalize when to perform handwashing and identify clean and dirty areas. These failures had potential to result in harmful bacterial growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food and drinks that are contaminated with germs or chemicals) and violate resident's rights for privacy and confidentiality and medical records in 125 of 126 residents. Findings: 1. During an observation on 7/14/2026 at 9:25 a.m., of the dishwashing process in the dishmachine area, observed DA 3 throwing the leftover foods, plastic and menu tickets into the grey trash can. During an observation on 7/14/2026 at 9:27 a.m., of DA 3 dishwashing, observed DA 3 threw the meal ticket in the trash can. During a concurrent observation and interview on 7/14/2026 at 9:28 a.m., of DA 3 dishwashing with the DS, observed DA 3 continue to throw meal tickets in the trash from the soiled trays. The DS stated their process of dishwashing starts by throwing all the trash in the garbage can including the meal tickets. The DS stated DA 3 came from SNF 2 and he did not provide training before starting to work and help in their facility. During an interview on 7/14/2026 at 9:34 a.m., with the DS, the DS stated after dishwashing is done, the staff take the trash to the outside dumpster (a movable waste container designed to be brought and taken away by special collection vehicles, or to a bin that specially designed garbage truck lifts). The DS further stated the first step of dishwashing is to dispose of the meal tickets in the trash during stripping of the trays (removing trays from the cart and clearing them from the solid waste and food leftovers). The DS stated the meal tickets contained residents' food likes and dislikes, food allergies, name of the residents, ID number (medical record), diet order and room number. The DS stated throwing meal tickets on the trash is not good practice because the meal tickets contained Protected Health Information (PHI), including name and picture of the resident. The DS further stated they needed to separate the menu tickets and shred them before disposing due to Health Insurance Portability and Accountability Act (HIPPA, a federal law designed to protect sensitive patient health information from being disclosed without the residents' consent). The DS stated throwing the meal tickets on the trash is not protecting residents' health information and other people could get the residents information and use them as a potential outcome. During an interview on 7/14/2026 at 11:53 a.m., with the DS, the DS stated he asked the Administrator (ADM) for help because he was short of people in the kitchen and they borrowed DA 3 for only today. The DS stated he did not provide any training for DA 3 and he was not sure what training DA 3 had with SNF 2. The DS stated their process of onboarding staff is to train them first and identify if they could do the job alone, however, when he asked DA 3, DA 3 told him that he dishwash and did trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving]) task in their sister company. The DS further stated he did not know what kind of training DA 3 received from their sister facility and he did not evaluate DA 3's training before having him dishwash. The DS stated DA 3 may not be competent by not washing the dishes right and he did not know if DA (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 knows how to do dishwashing tasks. The DS stated if the dishes were not washed properly residents could potentially get sick from food poisoning. During an interview on 7/14/2026 at 2:17 p.m., with the ADM, the ADM stated he was aware that the DS from SNF 2 was here to observe survey process but not to do regular job. The ADM stated DA 3 was here not to do anything day to day or regular tasks that they are responsible for. The ADM stated he had not spoken to them yet, so he was not aware of what DA 3 was assisting with. The ADM stated both facilities (SNF 1 and SNF 2) can share employees if they are part-time in the other facilities and want full-time hours. The ADM further stated SNF 2 and them have the same job description, and it was acceptable they work in their facility. The ADM stated DA 3 was not employed in their facility (SNF 1) and the expectation is for DA 3 to help for a day and not to do a regular job. The ADM stated he has to check what DA 3 was exactly doing in the kitchen. During an interview on 7/14/2026 at 3:48 p.m., with the Director of Nursing (DON), the DON stated the menu ticket contained name, room number, age, gender, allergies, diet preferences, diet order, diet order, ID number which is the residents medical record number and the picture of the residents. The DON stated they should have shredded the menu tickets before throwing it in the trash because it contained PHI and needed to be protected. The DON stated they violated HIPPA by throwing it in trash and the information was exposed to other people. During an interview on 7/14/2026 at 3:57 a.m., with the DON, the DON stated they have shared employees in the past with their sister company during the pandemic because their practice was streamlined, they are under one umbrella and their policies and procedures are the same so she would assume that it is safe that they could share employees. The DON further stated before they have an employee start working in their facility, they checked their recent competency, records, checked their credentials, and gave task that were not too complex. The DON stated it was important to check records of the employees to ensure that the staff are competent before starting the job. The DON stated in emergency cases they needed to borrow an employee from their sister company, she would do a huddle so that the expectation would be set forth and would tell the supervisor to watch the employee closely. The DON stated if competency of staff were not verified and no training was given to them before starting the job, the employee would not know what to expect, and the standards of care would not be up to par with what is expected in the building. The DON stated the process of having a new staff start is to do their own orientation and onboarding and set up expectations. During an interview on 7/15/2026 at 9:11 a.m., with the Director of Staff Development (DSD), the DSD stated she does the onboarding for new hires by checking their credentials, training, clearance and background checks and provide tour of the facility and introduction to the department heads. The DSD stated she also follows a training calendar for all the mandatory training like HIPPA, infection control, and hand hygiene but she has not done HIPPA in-service yet this year. The DSD stated she was not aware that their sister facility was bringing an employee into their facility. The DSD stated she did not provide handwashing or HIPPA training to DA 3. The DSD stated if the employees did not receive training prior to starting the job in their facility, the employee could commit mistakes because their layout is completely different and it is a safety issue and infection control issue for the residents. During an interview on 7/15/2026 at 9:27 a.m., with the DON, the DON stated there was no signed job description, competency, and training for DA 3 their facility completed before working in the kitchen. During a review of the facility's policies and procedures (P&P) titled, Protected Health Information (PHI) Management and Protection of, dated 1/20/2026, the P&P indicated, Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws. 1. It is the responsibility of all personnel who have access to resident and facility information to ensure such information is managed and protected to prevent unauthorized release or disclosure.10. Health (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information may be considered not to be individually identifiable in the following circumstances: a. A person with appropriate knowledge and experience with generally acceptable statistical and scientific principles and methods determines that the risk is very small that the information could be used, alone, or with other reasonably available information, to identify the resident who is the subject of the information; or b. The following identifiers of the resident (and relatives, employers or household members) are removed: Names Medical record numbers Full face photographic images Any other unique identifying number, or characteristic code. During a review of the facility's P&P titled, HIPPA Training Program, dated 1/20/2026, the P&P indicated, All facility personnel, including business associates, are required to attend our facility's HIPPA compliance training program. 1. To ensure the confidentiality of our resident's protected health information (PHI) and facility information, a HIPPA and data security training program will be provided for all employees and business associates who have access to protected health information. 2. During an observation on 7/14/2026 at 9:20 a.m., of the dishwashing process, observed DA 2 in the clean area dipping his hands in the red bucket containing sanitizer and water and then put away clean dishes. During an observation on 7/14/2026 at 9:22 a.m., of the dishwashing process, observed DA 2 dipping his hands in the red bucket and then put away clean dishes. During a concurrent observation and interview on 7/14/2026 at 9:41 a.m., of DA 2's dishwashing with the DS and DA 2, observed DA 2 dipping his hands in the red bucket. The DS stated DA 2 placed his hands in the sanitizer bucket. DA 2 stated he dipped his hands in the sanitizer bucket because his co-worker told him to do so but he does not know the reason why. The DS stated DA 2 was not supposed to dip his hands in the sanitizer because it is used to clean surfaces and carts and not used to clean hands. The DS further stated cleaning of hands is done by going to the handwashing sink and handwash to prevent cross-contamination. During a review of the facility's P&P titled, Handwashing Procedure, dated 1/20/2026, the P&P indicated, Handwashing is important to prevent the spread of infection. Procedure: - Use warm water (100 F - 108 F) and soap, preferably from a dispenser. Wet hands and forearms first. Add soap and rub hands together foaming a lather. Rub the palms, back of the hands, the fingers, between the fingers, and the fingernail area, and above the wrist area for 20 seconds. Rinse thoroughly and dry hands. If wrist blades or food pedals do not control faucet, protect clean hands by turning faucets off with paper towels. - When hands need to be washed: Before starting work in the kitchen After handling soiled dishes and utensils. Before and after doing housekeeping procedures Before and after handling foods with the hands (cutting, peeling, mixing, etc.) After going to the toilet, after sneezing, after using a handkerchief or tissue or after touching your hair or face. Before and after eating or smoking After leaving a resident's room. Touching trash can and lid. During a review of the facility's job description (JD) titled, Dietary Assistant, dated and signed by DA 2 on 7/8/2026, the JD indicated, To leave the kitchen in a clean and sanitary manner and be of assistance when called upon by the cook or dietary supervisor. Participate in the orientation and on-going training of dietary staff. During a review of the facility's checklist, titled Dietary Aide Competency Skills Checklist, dated and signed by DA 2 on 7/8/2026, the checklist indicated, DA 2 satisfactory performed following established infection control precautions policies and procedures when performing daily task. The checklist did not indicate specific to handwashing competencies. 3. During an observation on 7/15/2026 at 10:30 a.m., of the food preparation, observed [NAME] 2 wiping the countertops and surfaces using a blue towel. During a concurrent observation and interview on 7/15/2026 at 10:35 a.m., of [NAME] 2's food preparation with the DS, observed [NAME] 2 put away pots and pans after wiping the countertops without washing her hands. The DS stated pans are clean and it was not acceptable practice for [NAME] 2 to hold a soiled towel and start putting away clean pans. The DS further stated [NAME] 2 needed to (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wash hands to prevent cross-contamination. During an interview on 7/15/2026 at 10:40 a.m., with [NAME] 2 and the DS, [NAME] 2 stated she got an in-service about handwashing and learned to wash hands when touching dirty items. [NAME] 2 stated the towel she used to wipe the countertop was clean then she then rinsed the towel with sanitizer. [NAME] 2 stated the countertops were clean and she wiped them for no reason. [NAME] 2 stated it was okay not to wash her hands because the areas she touched were clean and she just put away clean pans. The DS stated when [NAME] 2 started cleaning, the blue towel was clean then [NAME] 2 rinsed the towel and placed it in the red bucket hence the towel was not dirty. During an interview on 7/15/2026 at 10:48 a.m., with the DS, the DS stated the blue towel got dirty after cleaning the surfaces hence [NAME] 2 needed to wash her hands to prevent cross-contamination. During an interview on 7/15/2026 at 9:49 a.m., with Infection Preventionist Nurse (IPN), the IPN stated the training she gave the facility staff including the dietary staff were as follows: - Perform hand hygiene before and after wearing gloves, exiting and entering resident's room for at least 20 seconds if their hands were not soiled but if their hands were soiled, they need to wash for 1 minute. Hand hygiene includes handwashing in the handwashing sink and the use of the sanitizer. - Wearing jewelry is not allowed and bracelet that could cause possible cross contamination. - Long nails were not allowed because it might contaminate the food during preparation and the long nails could puncture and break the gloves that could contaminate the food. - Wearing nail polish is not allowed because you would not know if nail polish was clean or not for possible cross-contamination. The IPN stated she went to the kitchen last month and every month to observe hand hygiene and have the dietary staff demonstrate handwashing to her. The IPN stated she would do her rounds at 2pm before the dietary staff end their shift. The IPN stated she would go and do her observation during busy times to assess issues with handwashing and the reason why she does it at 2pm was not to disrupt kitchen operation. During an interview on 7/15/2026 at 10:05 a.m., with the IPN, the IPN stated dietary staff should wash their hands when going from dirty area to clean, after touching dirty lids and before pushing a clean cart, before touching food, after placing their hands in their mouth, and after touching their clothes. The IPN stated dietary staff should wash their hands for 20 seconds and not five (5) seconds because it's not enough time to clean their hands and there would be a risk of contaminating food. During a review of the facility's P&P titled, Sanitation, dated 1/20/2026, the P&P indicated, All food and Nutrition Services staff shall know the proper handwashing technique. The FNS director is responsible for the proper training of this. If an employee does need to go from soiled end to clean end, a strict handwashing routine must be followed. During a review of the facility's job description (JD) titled, Dietary Aide, dated and signed by [NAME] 2 on 5/21/2019, the JD indicated, Practice infection control policies and procedures of the department and facility. Attend in-service education and staff meetings as required. During a review of the facility's checklist, titled Dietary [NAME] Competency Skills Checklist, dated and signed by [NAME] 2 on 5/21/2026, the checklist indicated, [NAME] 2 satisfactory performed following established infection control precautions policies and procedures when performing daily task. The checklist did not indicate specific handwashing competencies. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-301.14 When to Wash. Food employee shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs when dietary staff did not follow the portion size of three (3) ounces (oz, unit of measurement) and served two (2) oz and four (4) oz of roast beef for regular and therapeutic diets (a personalized meal plan prescribed by a doctor to treat medical condition or manage symptoms). This failure had the potential to result in decrease in food flavor, decrease and increase in food and nutrient intake to 70 of 126 residents on regular, therapeutic diets, resulting in unplanned weight loss or unplanned weight gain. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Summer Menus, dated 7/13/2026, the spreadsheet indicated residents on regular texture would include the following foods on the tray: French dip-roast beef 3 oz Soft sandwich roll one (1) piece Au Jus 2 oz Sweet potato fries 1/2 cup (c, a household measurement) Ketchup 1 Tablespoon (tbsp, a household measurement) Corn coleslaw 1/2 c Cappuccino mousse 1/3 c Milk 4 oz During an observation on 7/13/2026 at 12:02 p.m., observed a pan of roast beef containing different portion sizes, some looked big and some looked small in trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). During a concurrent observation and interview on 7/13/2026 at 12:21 p.m., of the roast beef portion sizes with the Dietary Supervisor (DS), observed the DS weighing a serving of the roast beef using a facility scale. The DS stated one serving is one piece of roast beef. The DS stated the following pieces of meat weighed: 1st roast beef (1 pc) 2 oz 2nd beef (2 pcs) 3.8 oz 3rd beef (1 pc) 2 oz 4th beef (2 pcs) 4 oz 5th beef (1 pc) 2 oz 6th beef (2 pcs) 3.2 oz 7th beef 3 oz 8th beef 3 oz The DS stated he would serve 2 pcs of roast beef moving forward. During an observation on 7/13/2026 at 12:33 p.m., observed the DS serving one piece of roast beef to the trays. During an interview on 7/13/2026 at 1:25 p.m., with the DS, the DS stated [NAME] 1 left this morning and she was the one who sliced the roast beef and [NAME] 2 cooked the roast beef yesterday. The DS stated the roast beef portion size is 3 oz and they need to serve the right portion to make sure the residents would get their whole protein. The DS stated residents could get hungry if their food is under portioned causing weight loss and weight gain if it's over portioned as a potential outcome of not getting the roast beef portion correct. During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 1/20/2026, the P&P indicated, The facility will use approved recipes, standardized to meet the resident census. Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. During a review of the facility's P&P titled, Menu Planning, dated 1/20/2026, the P&P indicated, This menu service which provides the seasonal menus with corresponding recipes.4. The menus are planned to meet nutritional needs of the residents in accordance with established national guidelines, physician's orders and, to extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutritional Board of the National Research Council National Academy of Sciences. Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. During a review of the facility's P&P titled, Portion Sizes, dated 1/20/2026, the P&P indicated, Various portion sizes of the food served will be available to better meet the needs of the residents. During a review of the facility's standardized recipe titled, Recipe: French Dip Sandwich, dated 1/20/2026, the recipe indicated that roast beef portion size is 3 oz.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician of a change in condition for one of one residents (Resident 14) investigated under edema (swelling), by failing to notify the physician of Resident 14's left and right hand edema. This deficient practice had the potential for delay of necessary care and services and worsening of Resident 14's condition. Findings: During a review of Resident 14's admission Sheet (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted Resident 14 on 7/27/2022, and re-admitted on [DATE] with diagnoses that included congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) , acute respiratory failure (the lungs rapidly stop functioning properly), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/1/2026, the MDS indicated Resident 14 usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated Resident 14 had moderate cognitive (ability to learn, think, remember and make decisions) impairment. The MDS indicated Resident 14 was dependent (helper does all of the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 14's active diagnosis included heart failure, respiratory failure, and COPD. The MDS indicated Resident 14 was taking a diuretic (water pill - a medication that helps remove extra fluid from the body) medication. During review of Resident 14's History and Physical (H&P), dated 7/22/2027, the H&P indicated Resident 14 cannot make own medical decisions and was conserved (a judge has legally appointed another person or agency to make financial, medical, or personal decisions on their behalf). During an observation on 7/13/2026 at 3:36 p.m., observed Resident 14 lying in bed on his back with left arm resting on a pillow and right arm placed under a blanket. Resident 14's left hand was observed to have edema. During a concurrent observation and interview on 7/15/2026 at 9:38 a.m. with Licensed Vocational Nurse 2 (LVN 2) at Resident 14's bedside, observed Resident 14 lying in bed with hands under the blanket. LVN 2 folded Resident 14's blanket to expose the resident's arms that were resting on his upper abdomen. LVN 2 stated that Resident 14 had edema on both hands. LVN 2 applied pressure to Resident 14's edema and stated that it was pitting edema (a type of swelling where pressure on the affected area leaves dents on the skin that takes time to refill) measured at 2+ (indication of moderate fluid swelling caused by excess fluid on the tissues). LVN 2 stated that Resident 14 is receiving Lasix (a medication that helps remove extra fluid from the body). LVN 2 stated that she observed Resident 14's edema off and on since the resident's return from hospitalization. LVN 2 stated she did not report any of her observations of Resident 14's edema to a Registered Nurse (RN) or the physician since the swelling decreases when the resident's arms are elevated on a pillow. During a concurrent interview and record review on 7/15/2026 at 9:55 a.m. with RN 2, the Admission/readmission Evaluation/Assessment dated 6/23/2026, Nursing Comprehensive Skin Evaluation Assessment dated 6/24/2026, 6/30/2026, 7/8/2026 and Nursing Weekly Summary dated 7/3/2026 and 7/10/2026 were reviewed. The Admission/readmission Evaluation/Assessment indicated no presence of edema. The remaining documents reviewed did not indicate Resident 14 had (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	edema. RN 2 stated that an assessment of Resident 14's edema should have been done when first observed and the physician should have been notified of Resident 14's change of condition. RN 2 stated she did not find documentation of a change of condition for Resident 14's edema. RN 2 stated that it was important to notify the physician of Resident 14's edema so the physician can place necessary orders, such as laboratory or diagnostic tests, to further assess Resident 14's condition and provide appropriate care and treatment. During an interview on 7/16/2026 at 1:56 p.m. with the Director of Nursing (DON), the DON stated that Resident 14's edema is a change in condition and should have been reported to the RN for assessment and evaluation, who (RN) would then have notified the physician. The DON stated that not notifying the physician of Resident 14's edema resulted in Resident 14 not having orders for addressing the change of condition. During a follow-up interview on 7/15/2026 with LVN 2 at 2:05 p.m., LVN 2 stated she was incorrect in her initial statement that she observed Resident 14's edema off and on since Resident 14's last return from hospitalization. LVN 2 stated she observed the edema yesterday (7/14/2026) in the morning during her rounds while doing medication pass. LVN 2 stated Resident 14's edema on the previous day was at + 1 on both hands. LVN 2 stated she did not document her findings of Resident 14's edema of the hands because she forgot. LVN 2 stated she did not report Resident 14's edema to the RN or physician since the edema decreased with repositioning. The DON stated that not notifying the physician caused a delay in the appropriate monitoring and treatment of Resident 14's edema. The DON stated that Resident 14's had co-morbidities (when a person has two or more medical conditions at the same time) that places him at even higher risk for hospitalization when a change of condition is not reported and addressed promptly. During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status last reviewed 1/20/2026, the P&P indicated, The nurse will notify the resident's attending physician, provider, or physician on call when there has been a significant change of condition. A significant change of condition is a major decline or improvement in the residents status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). During a review of the facility's policy and procedure (P&P) titled, Resident Examination and Assessment last reviewed 1/20/2026, the P&P indicated, purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. The following information should be recorded in the resident's medical record. Notify the physician of any abnormalities. Report other information in accordance with facility policy and professional standards of practice.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review the facility failed to ensure resident were free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one of one sampled residents (Resident 121) by failing to ensure that a wedge pillow (special triangle-shaped pillows that raise the top half of the body while sleeping) was not placed under the mattress on the right side at the foot of the bed. This failure had the potential to result in the restriction of Resident 121's freedom of movement, a decline in physical functioning, injuries related to entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from, or death. Findings: During a review of Resident 121's admission Record, the admission Record indicated that the facility originally admitted Resident 121 on 4/30/2026 with diagnoses including history of falling, right femur displaced comminuted fracture (shattered injury of the thigh bone), bilateral (both side) artificial hip joint (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident 121's Minimum Data Set (MDS-a resident assessment tool), dated 5/7/2026, the MDS indicated Resident 121 had the ability to understand others and makes self-understood. The MDS indicated that Resident 121 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 121 was dependent (helper does all the effort) for bed mobility. The MDS also indicated that there were no physical restraints or alarms used for Resident 121. During a review of Resident 121's History and Physical (H&P), dated 5/1/2026, the H&P indicated that Resident 121 did have the capacity to understand and make decisions. During an observation on 7/13/2026 at 9:56 a.m. with Resident 121, Resident 121 was observed with a wedge pillow placed under the mattress on the right side at the foot of the bed. During an interview on 7/13/2026 at 11:01 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated that Resident 121 required two-person assistance for bed mobility and the wedge pillow was used for repositioning to prevent the development of wounds. During an interview on 7/13/2026 at 11:11 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated that Resident 121 was at risk of falling and needs assistance from two people for bed mobility. LVN 3 stated that the wedge pillow should be placed underneath the resident but on top of the mattress, not beneath the mattress, as putting it under the mattress turns it into a physical restraint. LVN 3 explained that when a wedge pillow is tucked under the mattress, the wedge pillow becomes immovable and prevents the resident from getting out of bed. During an interview on 7/16/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated that a wedge pillow should be used to help prevent wounds in residents who have mobility issues and require assistance with repositioning to reduce pressure. The DON explained that the pillow should be placed beneath the sheet, along the mid-lateral part of the body, not under the mattress, as placing it there would be ineffective. The DON stated that if a resident cannot freely remove an adaptive device such a wedge pillow, it may act as a restraint and in such cases, nursing staff are required to perform an entrapment evaluation. During a review of facility's Policy and Procedure (P&P) titled Physical Restraint Application, reviewed 1/20/2026, the P&P indicated that physical restraints are defined as any manual method or physical or mechanical device, material, or equipment affixed to or near the resident's body that cannot be easily removed by (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the individual, thereby restricting freedom of movement or normal access to their body. The P&P further clarifies that residents must be physically and cognitively able to self-release devices such as Velcro lap trays or tables, seat belts with Velcro, or easy snap seat belts; if the resident is unable to do so, the device is classified as a restraint. Under preparation for using physical restraints, the P&P requires verification of the physician's order, a review of the resident's care plan to assess for any special needs, and assembly of necessary equipment and supplies. Additionally, the P&P directs staff to adhere to the manufacturer's instructions for the proper use of restraints.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who had a Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level 1 positive received Level II (a resident is assessed on a Level I first which is a determination if a resident is suspected of having a serious mental illness. If a resident is positive for Level 1, then they are referred to Level II; a Level II Contractor from California Department of Health Services [DHCS, a government agency that provides health care to low-income individuals, children, older adults, and people with disabilities] comes to evaluate further) evaluation by the state-designated authority for one (Resident 7) of six sampled resident reviewed under PASARR. This failure had the potential for Resident 7, who has a diagnosis of Post-Traumatic Stress Disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) to not receive specialized mental health services to manage the resident's behaviors. Findings: During a review of Resident 7's admission Record, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included PTSD. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 4/02/2026, the MDS indicated Resident 7 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 7 has a diagnosis of PTSD. During a review of Resident 7's Trauma-informed Care Care Plan, initiated 3/27/2026, the care plan indicated Resident 7 is at risk for decreased psychosocial well-being and adjustment issues, emotional distress related to combat or exposure to a warzone in the military. The care plan indicated a goal that Resident 7 will demonstrate effective coping strategies as evidenced by active participation in health care decisions and activities of choice. The care plan indicated an intervention to encourage the resident to verbalize feelings. During a review of Resident 7's PASARR, dated 3/26/2026, the document indicated Resident 7 was positive for Level 1. Resident 7's PASARR indicated positive for serious mental illness (SMI). During a review of Resident 7's DHCS letter, dated 4/12/2026, the DHCS letter indicated the following: -SUBJECT: NOTICE OF ATTEMPTED EVALUATION -Information: If a Level I Screening returns a positive result for possible ID (Intellectual Disability)/DD (Developmental Disability)/RC (Related Condition), the Department of Developmental Services (DDS) determines if a Level II Evaluation is necessary and a representative from a DDS Regional Center will contact the facility for further action. -The letter indicated: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 screening. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN) on 7/16/2026 at 1:02 p.m., the MDSN reviewed Resident 7's 3/26/2026 PASARR and the DDS letter dated 4/12/2026. The MDSN stated the process is that if a resident is positive for Level 1, then the DHCS will contact the facility about conducting a Level II assessment. When asked about facility being unresponsive to two or more separate attempts of communication, the MDSN stated the facility has not spoken to any DHCS staff, and no attempts were made to communicate with them. The MDSN stated he should have followed up with DHCS. The MDSN stated it was important to follow-up with the DHCS so that Resident 7 would get a proper Level II assessment and possibly require specialized services. THE MDSN stated he would submit another PASARR on the computer so that the DHCS could contact him again. During a review of the facility's policy and procedure titled, PASARR, last reviewed 1/20/2026, indicated if a level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referred to the state PASARR representative for the Level II (evaluation and determination) screening process.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) to maintain grooming and personal hygiene was free off yellow/white discharge on her bilateral eyes and cheeks for one of one sampled resident (Resident 54) investigated under the ADL care area. This deficient practice had the potential to negatively affect Resident 113's dignity and placed Resident 113 at risk for eye infections. Findings: During a review of Resident 54's admission Record, the admission Record indicated the facility admitted Resident 54 on 5/6/2024 with diagnoses that included dysphagia (swallowing difficulties), unspecified dementia (a progressive state of decline in mental abilities) and limitation in activities due to disability. During a review of Resident 54's Minimum Data Set (MDS, a resident assessment tool), dated 6/16/2026, the MDS indicated Resident 54 was never/rarely understood, and required substantial assistance (when helper does more than half the effort) from facility staff for showering/bathing. During a review of Resident 54's Activities of Daily Living Care Plan (CP), the CP indicated an intervention to provide Resident 54 assistance with ADLs as indicated. During a concurrent observation and interview on 7/13/2026 at 8:47 a.m., with Certified Nursing Assistant 2 (CNA 2) in the hallway right outside of Resident 54's room, CNA 2 looked at Resident 54's face and stated the resident had yellow/white discharge coming down both of her cheeks from her eyes. CNA 2 stated Resident 54 is unable to wash her own face, and she provided morning care about 15 minutes prior. CNA 2 stated she thought she washed Resident 54's face but was not certain. CNA 2 stated that she should have paid more attention because the discharge can feel uncomfortable or affect the residents' dignity. During an interview 7/16/2026 at 1:02 p.m., with the Director of Nursing (DON), the DON stated residents have the right to have a clean face. The DON stated Resident 54's face should be cleaned daily and as needed for good hygiene and dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Rights last reviewed on 1/20/2026, the P&P indicated residents have a right to a dignified existence. During a review of the facility's P&P titled, Activities of Daily Living (ADLS), Supporting last reviewed on 1/20/2026, the P&P indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, dressing, and personal and oral hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform and document an assessment of edema (swelling) of the hands for one of one residents (Resident 14), who has a diagnosis of congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and was receiving Lasix (a medication that helps remove extra fluid from the body). This failure had the potential for delay of necessary care and services that places Resident 14's at increased risk of complications, such as shortness of breath that results in hospitalization. Findings: During a review of Resident 14's admission Sheet (the front page of the chart that contains a summary of basic information about the resident), the admission sheet indicated the facility originally admitted Resident 14 on 7/27/2022 and re-admitted on [DATE] with diagnoses that included CHF, acute respiratory failure (the lungs rapidly stop functioning properly), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 7/1/2026, the MDS indicated Resident 14 usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated Resident 14 had moderate cognitive (ability to learn, think, remember and make decisions) impairment. The MDS indicated Resident 14 was dependent (helper does all of the effort) for activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 14's active diagnosis included heart failure, respiratory failure, and COPD. The MDS indicated Resident 14 was taking diuretic (water pill - a medication that helps remove extra fluid from the body). During review of Resident 14's History and Physical (H&P), dated 7/22/2027, the H&P indicated Resident 14 cannot make own medical decisions and was conserved (a judge has legally appointed another person or agency to make financial, medical, or personal decisions on their behalf). During an observation on 7/13/2026 at 3:36 p.m., observed Resident 14 lying in bed on his back with left arm resting on a pillow and right arm placed under a blanket. Resident 14's left hand was observed to have edema. During a concurrent observation and interview on 7/15/2026 at 9:38 a.m. with Licensed Vocational Nurse (LVN) 2 at Resident 14's bedside, observed Resident 14 lying in bed with hands under the blanket. LVN 2 folded Resident 14's blanket to expose resident's arms that were resting on his upper abdomen. LVN 2 stated that Resident 14 had edema on both hands. LVN 2 applied pressure to Resident 14's edema and stated that it was pitting edema (a type of swelling where pressure on the affected area leaves dents on the skin that takes time to refill) measured at 2+ (indication of moderate fluid swelling caused by excess fluid on the tissues). LVN 2 stated that Resident 14 is on Lasix. LVN 2 stated that she observed Resident 14's edema off and on since residents return from hospitalization. LVN 2 stated she did not report any of her observations of Resident 14's edema to a Registered Nurse (RN) or the physician since the swelling decreases when the arms are elevated on a pillow. During a concurrent interview and record review on 7/15/2026 at 9:55 a.m. with RN 2, the Admission/readmission Evaluation/Assessment dated 6/23/2026, Nursing Comprehensive Skin Evaluation/Assessment dated 6/24/2026 and Nursing Weekly Summary dated 7/3/2026 and 7/10/2026 were reviewed. The Admission/readmission Evaluation/Assessment indicated Resident 14 had no edema. The remaining documents reviewed did not indicate Resident 14 had edema. RN 2 stated Resident 14's edema should have been documented. RN 2 stated LVN 2 should have documented Resident 14's edema when first (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed and reported it to the RN to conduct further assessment. During a subsequent interview on 7/15/2026 with LVN 2 at 2:05 p.m., LVN 2 stated she was incorrect in her initial statement that she observed Resident 14's edema off and on since Resident 14's last return from hospitalization. LVN 2 stated she observed the edema yesterday (7/14/2026) in the morning during her rounds while doing medication pass. LVN 2 stated Resident 14's edema on the previous day was at + 1 on both hands. LVN 2 stated she did not document her findings of Resident 14's edema of the hands because she forgot. LVN 2 stated she did not report Resident 14's edema to the RN or physician since the edema decreased with repositioning. During an interview on 7/16/2026 at 1:56 p.m., with the Director of Nursing (DON), the DON stated that Resident 14's edema was a change of condition which required an assessment. The DON stated that Resident 14's edema should have been documented by LVN 2, escalated to the RN for assessment and evaluation. The DON emphasized that it is especially important in Resident 14's case, as Resident 14's co-morbidities (when a person has two or more medical conditions at the same time) places Resident 14 at higher risk for complications that could potentially lead to hospitalization. During a review of the facility's policy and procedure (P&P) titled, Resident Examination and Assessment last reviewed 1/20/2026, the P&P indicated, purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Physical exam: 1. Vital Signs. 2. Cardiovascular. 3. Respiratory. 4. Neurological. 5. Musculoskeletal. 6. Gastrointestinal. 7. Genitourinary. 8. Skin. 9. Activity Level. 10. Eyes, Ears, Nose, Throat. 11. Head and Neck. 12. Teeth and Gums. 13. Psychiatric/Behavioral 14. Pain The following information should be recorded in the resident's medical record. During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status last reviewed 1/20/2026, the P&P indicated, Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services to prevent pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) from developing for one of one sampled resident (Resident 121) by failing to offload (to reduce or remove pressure on the affected area to promote healing and prevent further damage) Resident 121's heels when in bed, in accordance with the Resident 121's care plan titled, At Risk for Skin Breakdown, initiated on 4/30/2026. This failure placed the Resident 121 at increased risk for the development or worsening of pressure ulcers/injuries. Findings: During a review of Resident 121's admission Record, the admission Record indicated that the facility originally admitted Resident 121 on 4/30/2026 with diagnoses including history of falling, right femur displaced comminuted fracture (shattered injury of the thigh bone), bilateral (both side) artificial hip joint (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident 121's Minimum Data Set (MDS-a resident assessment tool), dated 5/7/2026, the MDS indicated Resident 121 had the ability to understand others and makes self-understood. The MDS indicated that Resident 121 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 121 was dependent (helper does all the effort) for bed mobility. The MDS also indicated that there were no physical restraints or alarms used for Resident 121. During a review of Resident 121's History and Physical (H&P), dated 5/1/2026, the H&P indicated that Resident 121 did have the capacity to understand and make decisions. During a review of Resident 121's record titled, Braden Scale Observation/Assessment (a tool used to check a resident's risk of developing pressure ulcers.), dated 6/1/2026, the Braden scale assessment indicated that Resident 121 was at high risk to develop pressure injuries. During a review of Resident 121's care plan report titled At risk for skin breakdown related to Braden Risk Score (12.0 High Risk), initiated on 4/30/2026, the care plan report indicated interventions that included providing assistance with turning and repositioning as indicated, inspecting the skin during daily routines, offloading heels while the resident is in bed, and using lift pads (fabric sheets placed under a resident used to slide/turn/lift a resident) to reduce friction and shear. During an observation on 7/13/2026 at 9:56 a.m. inside Resident 121's room, Resident 121 was observed with a wedge pillow (special triangle-shaped pillows that raise the top half of the body while sleeping) placed under the mattress, positioned on the right side at the foot of the bed. Both Resident 121's heels were observed in contact with the mattress surface rather than being offloaded. During an interview on 7/13/2026 at 11:01 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated that Resident 121 required two-person assistance for bed mobility and the wedge pillow was used for repositioning to prevent wound development. During a concurrent interview and record review on 7/14/2026 at 3:59 p.m. with TN 1, Resident 121's care plan, titled At risk for skin breakdown, initiated on 4/30/2026 was reviewed. TN 1 stated that Resident 121 was assessed to be at increased risk based on the Braden scale assessment, and the care plan interventions included floating the heels while in bed, turning and repositioning as indicated, and using lift pads to prevent skin breakdown. TN 1 stated that placing the wedge pillow under the mattress results in the heels remaining in contact with the bed surface, consequently increasing the risk of redness and open wounds for Resident 121. TN 1 added that the wedge pillow should be positioned at the hip or lateral side and not at the heel (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area, emphasizing that it is inappropriate to use the wedge pillow to float the heels. TN 1 further noted that improper elevation of the heels compromises resident comfort and increases the likelihood of new skin breakdown for those already at high risk. During an interview on 7/16/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated that a wedge pillow should be utilized to aid in the prevention of wounds for residents experiencing mobility challenges and requiring assistance with repositioning. The DON added that the wedge pillow is most effective when placed beneath the sheet, along the mid-lateral portion of the body, rather than under the mattress, as placement under the mattress does not reduce pressure appropriately. Furthermore, the DON stated that improper placement may fail to relieve skin pressure, thereby increasing the risk of pressure injuries in residents. During a review of facility's Policy and Procedure (P&P) titled Prevention of Pressure Injuries, reviewed 1/20/2026, the P&P the guidelines recommend elevating the heels of residents at risk for pressure injuries to ensure the heels are not in contact with the support surface (floating the heels). The P&P also indicated the use of a heel off-loading device tailored to the individual's mobility and activity level is recommended and if such devices are not available or inappropriate, the use of standard pillows or cushions with adequate height should be used to maintain proper elevation and prevent heel contact with the support surface.		

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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 observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two of four sampled residents (Resident 10 and Resident 68) investigated under accidents by failing to ensure: 1. Resident 10 did not have a wheelchair on top of the landing pad (a cushioned floor pad designed to help prevent injury should a person fall) on the right side of the bed. 2. Resident 68 wore a soft helmet with a chin strap as ordered by the physician. These deficient practices had the potential to place Resident 10 and Resident 68 at risk for injuries. Findings: 1. During a review of Resident 10's admission Record, the admission Record indicated that the facility originally admitted Resident 10 on 5/27/2026 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a condition in which a person's peripheral nerves are damaged) and foot ulcer, difficulty in walking, chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure) and vascular dementia (a progressive state of decline in mental abilities). During a review of Resident 10's Minimum Data Set (MDS-a resident assessment tool), dated 7/8/2026, the MDS indicated Resident 10 had the ability to understand others and makes self-understood. The MDS indicated that Resident 10 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) to substantial/maximal assistance (helper does more than half the effort) for activities of daily living (ADLs & eating, toileting, hygiene, shower/bathing). The MDS indicated Resident 10 used a manual wheelchair and a walker for mobility devices.^^ During a review of Resident 10's record titled Fall Risk Observation/Assessment (a tool used that scores residents according to factors such as their history of falls, vision, balance, age, continence, mobility, cognitive status, systolic blood pressure, risk factors, and medications) dated 5/27/2026, the fall risk observation/assessment indicated that Resident 10 was high risk (likely) for fall. During an interview on 7/16/2026 at 9:24 a.m. with Registered Nurse 2 (RN 2), RN 2 stated that landing pads are used to prevent injuries by providing a soft surface landing, but they must always remain clear of objects to avoid causing harm; residents could injure themselves by hitting any part of their body or head, potentially resulting in lacerations, skin tears, bruises, bumps, or fractures (a break, crack or crush injury). RN 2 added that the CNAs and licensed nurses are responsible for ensuring the landing pad is unobstructed and the environment is safe to prevent injuries. RN 2 further stated it was unacceptable for a wheelchair to be left on top of the landing pad. During an interview on 7/16/2026 at 3:00 p.m. with the Director of Nursing (DON), the DON stated that landing pads should be documented as interventions in the nursing care plan. The DON stated that landing pads are used to reduce complications associated with falls and must remain clear of any (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objects or items, as obstacles could compromise their effectiveness and potentially lead to resident injury. During a review of facility's Policy and Procedure (P&P) titled Falls and Fall Risk, Managing, reviewed on 1/20/2026, the P&P indicated that staff should use both previous evaluations and current data to identify interventions tailored to each resident's specific risks and causes, aiming to prevent falls and reduce complications if a fall occurs. The P&P also highlights environmental factors, such as obstacles in footpaths, that may contribute to falling. Additionally, the P&P promotes resident-centered strategies for managing falls, including collaborating with the attending physician to implement appropriate measures like landing mats or hip padding, to help lessen the severity of fall-related injuries. 2. During a review of Resident 68's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis (a mental state where a person loses touch with reality, meaning they have trouble telling what is real and what is not) and repeated falls. During a review of Resident 68's History and Physical (H&P) dated 8/9/2025, the H&P indicated Resident 68 had the capacity to understand and make decisions. During a review of Resident 68's physician orders, it indicated an order dated 12/31/2025 for Resident 68 to wear soft protective helmet when out of bed for safety every shift. During an observation on 7/13/2026 at 8:56 a.m. in Resident 68's room, observed Resident 68 in his wheelchair with his soft helmet on; there was a right chin strap, and the left chin strap was not present, and the helmet was not secured to Resident 68's head. During a concurrent observation and interview on 7/13/2026 at 9:04 a.m. in Resident 68's room with Certified Nursing Assistant (CNA 2), CNA 2 observed Resident 68 in his wheelchair wearing his soft helmet with left chin strap missing. CNA 2 stated without a way to strap on the helmet, the helmet could slide off, and the resident could get hurt. During a concurrent observation and interview on 7/13/2026 at 9:032 a.m. in the hallway outside of Resident 68's room with Certified Occupational Therapy Assistant (COTA), COTA observed Resident 68's soft helmet and stated it was not safe because there was not a way to secure it. The COTA stated he will provide a new helmet because the resident could sustain an injury if he fell and hit his head. During an interview on 7/16/2026 at 11:46 a.m. with the Director of Nursing (DON), the DON stated Resident 68 had a history of a behavior of hitting his head and must wear a soft helmet for safety. The DON stated to ensure the safety of the resident, the soft helmet must be secured with a chin strap. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures (P&P) titled Safety and Supervision of Residents, review date 1/20/2026, the P&P indicated the facility strives to make the environment as free from hazards as possible. The P&P further indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities.		

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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. Based on interview and record review, the facility failed to ensure that a resident who was receiving hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment received services consistent with professional standards of practice by failing to ensure the hemodialysis communication assessment was completed on dates from 3/27/2026, 4/20/2026, and 6/19/2026 for one of one sampled residents (Resident 3). This deficient practice placed Resident 3 at risk for developing complications related to renal disease like swelling, high blood pressure, and shortness of breath. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 11/29/2022 with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells), end stage renal disease (ESRD-irreversible kidney failure), and dependence on renal (kidney) dialysis. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/8/2026, the MDS indicated that Resident 3 cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 3 required set up or clean-up assistance(helper sets up or cleans up; resident completes activity) to moderate assistance (helper does less than half) from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3's Order Summary Report, dated 7/15/2026, the Order Summary Report indicated the following physician orders: - Check hemodialysis tunneled catheter (soft, flexible tube tunneled beneath the skin from an entry point on the body to a central vein): Left chest for color, warmth and edema (swelling) every shift, initiated 8/6/2025. - Hemodialysis tunneled catheter left chest, ensure dressing remains intact every shift, dialysis center provides hemodialysis tunneled catheter access/maintenance and dressing changes, every shift, initiated on 8/6/2025. -Hemodialysis schedule: Mondays, Wednesdays, Fridays, initiated on 8/6/2025. During a review of Resident 3's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Resident 3 with altered renal tissue perfusion, initiated on 7/18/2025, the care plan indicated interventions including intake and output monitoring, tracking weight and reporting changes to the doctor, notifying the doctor if edema, chest pain, high blood pressure, or shortness of breath occur, checking the hemodialysis catheter site for complications, and monitoring vital signs (measure the basic functions of the body which includes body temperature, blood pressure, pulse and respiratory [breathing] rate) as indicated. During a concurrent interview and record review on 7/14/2026 at 3:16 p.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 3's record titled Nursing: Hemodialysis communication assessment. LVN 2 stated that the hemodialysis communication assessment for 3/27/2026, 4/20/2026, and 6/19/2026 were not complete. The hemodialysis communication assessment indicated the following: - 3/27/2026 - post-dialysis weight was left blank. - 4/20/2026 - vital signs and pre-dialysis and post-dialysis weight were left blank. - 6/19/2026 - post-dialysis weight was left blank. During a subsequent interview on 7/14/2026 at 3:16 p.m., with LVN 2, LVN 2 explained that the hemodialysis communication assessment record serves to document and relay the resident's condition before, during, and after hemodialysis treatment. According to LVN 2, licensed nurses are responsible for completing and clarifying the hemodialysis communication assessment upon the resident's return to the facility. LVN 2 stated that residents undergoing hemodialysis are susceptible to fluid imbalances and may experience either hypotension (low blood pressure) or hypertension. Furthermore, LVN 2 emphasized the importance of ensuring the assessment is thoroughly completed to promptly identify (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any complications, such as abnormal vital signs, new medical orders, or medications received by the resident. In cases where the dialysis facility does not provide a completed hemodialysis communication form, LVN 2 stated that it was the responsibility of the receiving nurse to contact the dialysis facility and obtain the required information. During an interview on 7/16/2026 at 3:00 p.m., with the Director of Nursing (DON), the DON stated that the hemodialysis communication assessment form was intended to document whether the resident tolerated the hemodialysis treatment, any medications administered, the condition of the hemodialysis access, as well as the resident's vital signs and weights. The DON stated the importance of recording this information, particularly the weight post-hemodialysis, since the resident is at risk for fluid overload, cardiac complications, and hospitalization. The DON further stated that licensed nurses are responsible for completing the form upon the resident's return to the facility and should contact the dialysis facility to obtain the necessary information if it is not available, ensuring complete documentation. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis Catheters-Access and Care of, reviewed 1/20/2026, the policy indicated that nurses are required to document in the resident's medical record during each shift: the location of the catheter, the condition of the dressing, whether dialysis occurred during the shift, any information provided by the dialysis nurse following dialysis, and relevant observations after dialysis.		

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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 to place a duration of therapy for one of one sampled resident's (Resident 4) medication, Lovenox (an anticoagulant [or blood thinner] medication injected through the skin subcutaneously [through the fat of the skin] to prevent blood clots [gel-like clump of blood]). This failure had the potential for Resident 4 to be subjected to unwanted subcutaneous injections and unnecessary medication. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 6/12/2026 with diagnoses that included subdural hematoma (a collection of blood that pools between the brain and the dura mater [tough outer protective covering] caused by a broken blood vessel). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 6/19/2026, the MDS indicated Resident 4 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 4 takes an anticoagulant. During a review of Resident 4's physician orders dated 6/12/2026, the physician orders indicated an order for enoxaparin (generic name for Lovenox) 40 milligrams per 0.4 milliliter (mg/ml, a unit of measurement), inject 40 mg subcutaneously one time a day for deep vein thrombosis prophylaxis (to prevent DVT, a blood clot that starts in the leg and can travel to the lungs causing difficulty breathing and death). During a review of Resident 4's Medication Regimen Review (MRR, a process when the facility's pharmacist consultant conducts a comprehensive review of the facility residents' medications) covering the dates 6/15/2026 to 6/16/2026, the MRR indicated the pharmacist recommended a duration of therapy should be clarified for Resident 4's medication, Lovenox. During a review of Resident 4's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) for Anticoagulant, initiated 6/15/2026, the care plan indicated Resident 4 is at risk for potential bleeding and bruising due to anticoagulant therapy. The care plan indicated a goal that signs and symptoms of bruising or bleeding will be promptly identified with interventions to alleviate initiated timely. The care plan indicated the following interventions: - Administer medication as ordered. Rotate injection site to ensure consistent absorption and prevent skin complications. - Assess for signs signifying blood loss and notify physician if observed. - Labs as ordered. Report abnormal results to the physician. - Monitor for blood in urine or stool. Report abnormal findings to the physician. - Monitor for bruising or bleeding. Report abnormal findings to the physician. - Periodic drug regimen review by the physician to order reduction or discontinuation of. During an interview on 7/16/2026 at 9:20 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated the duration of therapy for the medication Lovenox should have been addressed upon admission. LVN 4 was not able to locate an admission pharmacy review for Resident 4. However, the Lovenox duration was mentioned in the monthly MRR, which covers the dates 6/13/2026 to 6/16/2026, and indicated there should be a duration to the Lovenox medication. During an interview on 7/16/2026 at 10:50 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the duration for Resident 4's Lovenox should have been addressed upon admission. The ADON was not able to provide any documentation the duration had been discussed with Resident 4's physician. During an interview on 7/16/2026 at 11:33 a.m., with the Director of Nursing (DON), the DON stated she spoke to Resident 4's physician who said the Lovenox could be discontinued when Resident 4 was able to walk 150 feet. The DON was unable to provide any progress note of this conversation or a doctor's order with this condition indicated. The DON was unable to provide any kind of care plan for monitoring of walking or any other notes regarding Lovenox. During a review of the facility's policy and procedure titled, Medication Regimen Reviews, last reviewed 1/20/2026, (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the following: Upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to label and store drugs and biologicals by not ensuring a resident's carboxymethylcellulose sodium drops 0.5% (over-the-counter artificial tear lubricant) had been labeled with the resident's name for one of five sampled residents (Resident 82). This deficient practice had the potential for residents to receive medication that was not intended for them. Findings: During a review of Resident 82's admission Record, the admission Record indicated the facility admitted the resident on 4/13/2023 and re-admitted the resident on 12/4/2024 with diagnoses that included hypertension (high blood pressure). During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool) dated 4/11/2026, the MDS indicated Resident 82 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. Resident 82's MDS indicated the resident was independent with personal hygiene. During a review of Resident 82's physician orders dated 7/14/2026, the physician order indicated carboxymethylcellulose sodium drops 0.5%, one drop in both eyes every 12 hours for dry eyes. During a concurrent medication cart observation and interview on 7/15/2026 at 10:03 a.m., with Licensed Vocational Nurse 3 (LVN 3), observed Medication Cart 3. Observed a bottle of carboxymethylcellulose sodium drops 0.5% eye drops labeled with a room number and bed letter. LVN 3 stated the eye drops belonged to Resident 82. LVN 3 stated there should be a resident's name on the box. LVN 3 stated medications should be labeled with the resident name and not room number and bed letter because residents move rooms and the licensed nurses might not re-label the box with the new room number and bed letter. LVN 3 stated this is important so that the medication could not be accidentally given to another resident. During a concurrent interview and record review on 7/15/2026 at 11:12 a.m., with the Director of Nursing (DON), reviewed the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 1/20/2206. The DON stated the policy indicated that all medication should, at a minimum, be labeled with the resident's name. The DON stated that meant a first and last name. The DON stated they should not be labeled with only a room and bed letter because residents change rooms and could get mixed up with another resident's medication. During a review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 1/20/2026, indicated that all medication should, at a minimum, be labeled with the resident's name.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures for two of four sampled residents (Resident 14 and Resident 34) by failing to: 1. Label Resident 14's nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) oxygen tubing. This deficient practice had the potential to place Resident 14 at increased risk for infection. 2. Ensure Licensed Vocational Nurse 6 (LVN 6) did not leave Resident 34's room who was on enhanced barrier precautions (EBP, a method of using personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments]) during medication administration while still wearing an isolation gown (provides protection against splashing and spraying of body fluids). This deficient practice had the potential to increase the risk of spreading infection to other residents. Findings:~ 1. During a review of Resident 14's admission Sheet, the admission Sheet indicated the facility originally admitted Resident 14 on 7/27/2022 and re-admitted the resident on 6/23/2026 with diagnoses that included acute respiratory failure (the lungs rapidly stop functioning properly), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 14's Minimum Data Set (MDS &ndash; a resident assessment tool) dated 7/1/2026, the MDS indicated Resident 14 had moderate cognitive (ability to learn, think, remember and make decisions) impairment. The MDS indicated Resident 14 was dependent (helper does all of the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 14 was on oxygen therapy while a resident in the facility. During review of Resident 14's History and Physical (H&P) dated 7/22/2027, the H&P indicated Resident 14 cannot make own medical decisions. During a review of Resident 14's Order Summary Report dated 7/16/2026, the Order Summary Report indicated the following orders: - Oxygen (O2) two (2) liters per minute (LPM &ndash; unit of measure that shows how much flow rate of prescribed oxygen) via NC continuous per concentrator tank every shift, order dated 6/23/2026. - Change O2 tubing every night shift every Sunday dated 6/23/2026. - Change O2 tubing Sunday as needed when soiled or broken dated 6/23/2026. During a review of Resident 14's care plan titled, Resident has an alteration in the respiratory system with acute symptoms and is dependent on O2., initiated 6/30/2026, the care plan indicated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions that included, oxygen therapy as ordered initiated 6/30/2026 and change O2 tubing Sunday night shift and PRN (as needed). During an observation on 7/13/2026 at 3:36 p.m., observed Resident 14 lying in bed with oxygen being delivered via nasal cannula. The oxygen tubing was unlabeled. During a concurrent observation and interview on 7/13/2026 at 4:00 p.m., with Licensed Vocational Nurse 1 (LVN 1), observed Resident 14's nasal cannula oxygen tubing. LVN 1 stated the oxygen tubing did not have a label. LVN 1 stated there should be a label with the date the tubing was last changed. LVN 1 stated that the oxygen tubing was changed weekly to prevent infection. LVN 1 stated without a label on Resident 14's oxygen tubing, it is unknown if the tubing has been changed timely as ordered. LVN 1 stated that with no label to indicate when the oxygen tubing was changed, this places Resident 14 at risk for infection from potential bacterial or microorganism that have accumulated on the oxygen tubing if it had not been changed as scheduled. During an interview on 7/16/2026 at 8:33 a.m., with the Director of Nursing (DON), the DON stated that all respiratory tubing should be labeled to know that it is fresh and new. The DON explained that it means the tubing is being used beyond the time it is supposed to be used. The DON stated that it is important that Resident 14's oxygen tubing was labeled to ensure that the tubing placed on Resident 14 belongs to Resident 14. The DON stated that the tubing should also have the date indicating when it was changed so that it is known when is due again to be changed. The DON stated that if Resident 14's oxygen tubing was not labeled, Resident 14 had the potential for respiratory infections from microbes in the oxygen tubing from not changing it as scheduled. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, last reviewed 1/20/2026, the P&P indicated, Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge. The following categories are used to distinguish the level of sterilization /disinfection necessary for items used in resident care: .Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms, although small number of bacterial spores are permissible. During a review of the facility's P&P titled, Infection Prevention and Control Program, last reviewed 1/20/2026, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Important facets of infection prevention include: instituting measures to avoid complications or dissemination. 2. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had severe cognitive impairment. The MDS indicated Resident 34 has a gastrostomy tube (G-Tube, a plastic tube inserted into the stomach to infuse medications for one who has problems swallowing) and receives nutrition through the G-Tube. During a medication administration observation on 7/14/2026 at 4:11 p.m., with LVN 6, observed LVN (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Stoney Point Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21820 Craggy View St. Chatsworth, CA 91311	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6 taking Resident 34's blood pressure wearing an isolation gown and gloves. LVN 6 then removed their gloves and walked towards the medication cart which was placed right outside Resident 34's room at the doorway while still wearing an isolation gown. LVN 6 was about to open the medication cart when the survey team stopped him and asked him why he was still wearing the isolation gown. LVN 6 removed the isolation gown but stated he was not aware he had to remove it since he was still inside the room while the medication cart was at the doorway. When asked if LVN 6's isolation gown could potentially come in contact with the medication cart, LVN 6 stated he (LVN 6) was not aware this could be an infection control issue. During an interview on 7/14/2026 at 4:53 p.m., with the Infection Preventionist Nurse (IPN) and the Director of Staff Development (DSD), the IPN and DSD stated that it is best practice for LVN 6 to remove the gown before coming in contact with anything outside Resident 34's room to prevent cross contamination (the physical, unintended transfer of harmful bacteria, from one surface or object to another). During a review of the facility's P&P titled, Enhanced Barrier Precautions, last reviewed 1/20/2026, the P&P indicated the following: EBP refer to infection prevention and control interventions designed to reduce the transmission of multidrug-resistant organisms during high contact resident care activities. EBP are to be used for residents with indwelling medical devices and does not have secretions or excretions that are unable to be covered or contained. During a review of the facility's P&P titled, Personal Protective Equipment & Using Gowns, last reviewed 1/20/2026, the P&P indicated after completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room.		