STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555574	A. BUILDING _____ B. WING _____	**03/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STONEY POINT HEALTHCARE CENTER	**21820 CRAGGY VIEW ST. CHATSWORTH, CA 91311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident to resident abuse for two of two sampled residents (Resident 1 and Resident 2). This deficient practice had the potential to place the resident at risk for further abuse and may lead to serious outcomes. Findings: a. A review of Resident 1's Face Sheet (Admission Record) indicated the facility admitted Resident 1 on 3/19/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 9/16/19, indicated Resident 1 had moderately impaired cognition (ability to think, understand and reason). The MDS also indicated Resident 1 needed supervision with locomotion on and off the unit and eating. The MDS further indicated Resident 1 needed limited assistance from staff with bed mobility, transfer, and walking in room and in corridor. b. A review of Resident 2's Face Sheet (Admission Record) indicated the facility admitted Resident 2 on 10/30/19 with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE] indicated Resident 2 had intact cognition. The MDS also indicated Resident 2 needed supervision with bed mobility, transfer, walking in room and in corridor, locomotion on and off unit and eating. A review of Resident 1's Behavior and Mood Change of Condition dated 11/2/19 indicated Certified Nurse Assistant 1 (CNA 1) witnessed Resident 1 entering Resident 2's room. CNA 1 followed Resident 1 and found Resident 1 standing in front of Resident 2 and touching her inappropriately. The Behavior and Mood Change of Condition further indicated Resident 1's physician was made aware of Resident 1's inappropriate behavior towards Resident 2 and the physician ordered for Resident 1 to be transferred to the General Acute Care Hospital 1 (GACH 1) for further evaluation due to [MEDICAL CONDITION] (a disease in which the functioning of the brain is affected by some agent or condition) or [MEDICAL CONDITION] (mental disorder characterized by a disconnection from reality). On 2/6/20 at 4:08 p.m. during a concurrent interview and record review with the Director of Nursing (DON), she was unable to find documented evidence indicating a thorough investigation was done. The DON further stated the facility should have immediately conducted a thorough investigation of the alleged resident to resident abuse. A review of the facility's policy and procedure titled Abuse Investigation and Reporting with a revised date of 7/2017 indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the State Survey Agency (the Department) a possible resident to resident abuse for two of two sampled residents (Resident 1 and Resident 2). This deficient practice resulted in a delay of investigation to rule out abuse and had the potential to lead to further abuse. Findings: a. A review of Resident 1's Face Sheet (Admission Record) indicated the facility admitted Resident 1 on 3/19/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 9/16/19, indicated Resident 1 had moderately impaired cognition (ability to think, understand and reason). The MDS also indicated Resident 1 needed supervision with locomotion on and off the unit and eating. The MDS further indicated Resident 1 needed limited assistance from staff with bed mobility, transfer, and walking in room and in corridor. b. A review of Resident 2's Face Sheet (Admission Record) indicated the facility admitted Resident 2 on 10/30/19 with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE] indicated Resident 2 had intact cognition. The MDS also indicated Resident 2 needed supervision with bed mobility, transfer, walking in room and in corridor, locomotion on and off unit and eating. A review of Resident 1's Behavior and Mood Change of Condition dated 11/2/19 indicated Certified Nurse Assistant 1 (CNA 1) witnessed Resident 1 entering Resident 2's room. CNA 1 followed Resident 1 and found Resident 1 standing in front of Resident 2 and touching her inappropriately. The Behavior and Mood Change of Condition further indicated Resident 1's physician was made aware of Resident 1's inappropriate behavior towards Resident 2 and the physician ordered for Resident 1 to be transferred to the General Acute Care Hospital 1 (GACH 1) for further evaluation due to [MEDICAL CONDITION] (a disease in which the functioning of the brain is affected by some agent or condition) or [MEDICAL CONDITION] (mental disorder characterized by a disconnection from reality). On 2/6/20 at 4:08 p.m. during a concurrent interview and record review with the Director of Nursing (DON), she stated the incident was a possible resident to resident abuse and should have been reported to the Department within 2 hours. The DON was unable to explain why the incident was not reported to the Department. A review of the facility's policy and procedure titled Abuse Investigation and Reporting with a revised date of 7/2017 indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. All alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source) will be reported immediately, but no later than: a. two hours if the alleged violation involves abuse or has resulted in serious bodily injury or b. 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE