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 _____	07/27/2020

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within the reach of three of eight sampled residents (Residents 6, 7, and 8). This deficient practice had the potential to delay the provision of services and not meeting the residents' needs. Findings: a. A review of Resident 6's Admission Record (Face Sheet) indicated the facility admitted the resident on 3/16/2020 with [DIAGNOSES REDACTED]. A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 6/18/2020, indicated Resident 6 was unable to communicate and make decisions, required extensive to total assistance with bed mobility, transfers, dressing, eating, and personal hygiene. On 6/4/2020, at 8:40 a.m., Resident 6 was observed in bed and the call light was observed hanging on top of the first drawer of the bedside table and not within Resident 6's reach. At 8:42 a.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated Resident 6's call light should always be within easy reach of the resident and proceeded to relocate the call light. b. A review of Resident 7's Admission Record indicated the facility admitted the resident on 5/13/2016, with [DIAGNOSES REDACTED]. A review of Resident 7's MDS dated [DATE], indicated Resident 7 was unable to make decisions and required extensive to total assistance with dressing, eating, bed mobility, transfers, and personal hygiene. On 6/4/2020, at 8:41 a.m., Resident 7 was observed in bed with the call light tucked under Resident 7's pillow on her left side. c. A review of Resident 8's Admission Record indicated the facility readmitted the resident on 3/3/2020 with [DIAGNOSES REDACTED]. A review of Resident 8's MDS dated [DATE], indicated Resident 8 was unable to make decisions and required extensive to total assistance with bed mobility, transfers, dressing, and personal hygiene. On 6/4/2020, at 8:42 a.m., Resident 8 was observed in bed with the call light clipped at the head of the bed, not within Resident 8's reach. At 8:50 a.m., during an interview, CNA 1 confirmed Resident 8's call light was not within Resident 8's reach and proceeded to place the call light within reach. During an interview with the Assistant Director of Nursing (ADON) on 6/4/2020, at 10:30 a.m., ADON stated that call lights should always be within reach of the residents. A review of the facility's policy on Answering the Call Light, dated 2001, indicated to respond to the residents' request and needs and when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 1) received timely respiratory treatment to improve Resident 1's breathing. This deficient practice resulted on delayed respiratory treatment. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted Resident 1 on 4/7/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 3/9/2020, indicated Resident 1 had severely impaired cognitive (knowledge and understanding through thought, experience and senses) skills for daily decision-making and required extensive assistance with bed mobility, transfer, dressing, eating, and personal hygiene. A review of Resident 1's SBAR (Situation-Background-Assessment-Recommendation (a technique that provides a framework for communication between members of the health care team about a resident's condition)) Communication form dated 3/2/2020, timed at 10:51 a.m., indicated both lung had wheezing sounds (high-pitched [MEDICATION NAME] sound while breathing as a result of narrowed or compressed airways). A review of Resident 1's physician's orders [REDACTED]. The physician also ordered to transfer Resident 1 to General Acute Care Hospital 1 (GACH 1) for Direct Admit (no emergency transfer). A review of the Medication Administration Record [REDACTED]. Further review of the Nursing Notes indicated there was no documentation the registered nursing (RN) further evaluated Resident 1's respiratory status after 12:32 p.m. On 7/14/2020, at 3:11 p.m., during an interview and concurrent record review, the Assistant Director of Nursing (ADON) confirmed the physician's orders [REDACTED]. ADON further stated that [MEDICATION NAME] was available in the medication emergency kit (e-kit) and the nurses should have administer the [MEDICATION NAME] inhalation within four hours of receiving the order. ADON stated nursing staff should have monitored and documented with more frequency (one to two hours), Resident 1's condition with emphasis on the respiratory function. Documentation should include the status of Resident 1's oxygen saturation (percentage of the oxygen carried by the red blood cells to the entire body), respiratory rate, respiratory sounds, type of respiration (shallow). ADON was unable to find documented evidence of such documentation for Resident 1. A review of facility's policy and procedure titled, Administering Medication, dated revised 4/2019, indicated medication are administered in a safe and timely manner, and as prescribed During an interview and concurrent review with ADON, on 7/14/2020, at 3:24 p.m., ADON confirmed a change in condition documentation on 3/2/2020 at 10:52 a.m., indicating Respiratory/ EENT Change of Condition- Respiratory Status. A review of facility's policy and procedure titled Change in a Resident's Condition or Status, dated revised May 2017, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. On 7/14/2020, at 3:11 p.m., during an interview and concurrent record review, the Assistant Director of Nursing (ADON) confirmed the physician's orders [REDACTED]. A review of facility's policy and procedure titled Administering Medication, dated revised 4/2019, indicated medication are administered in a safe and timely manner, and as prescribed
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 1) was administered a respiratory medications as ordered by the physician. This deficient practice resulted on delayed respiratory treatment. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted Resident 1 on 4/7/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 3/9/2020, indicated Resident 1 had severely impaired cognitive (knowledge and understanding through thought, experience and senses) skills for daily decision-making and required extensive assistance with bed mobility, transfer, dressing, eating, and personal hygiene. A review of Resident 1's SBAR (Situation-Background-Assessment-Recommendation (a technique that provides a framework for communication between members of the health care team about a resident's condition)) Communication form dated 3/2/2020, timed at 10:51 a.m., indicated both lung had wheezing sounds (high-pitched [MEDICATION NAME] sound while breathing as a result of narrowed or compressed airways). A review of Resident 1's physician's orders [REDACTED]. The physician also ordered to transfer Resident 1 to General Acute Care Hospital 1 (GACH 1) for Direct Admit (no emergency transfer). A review of the Medication Administration Record [REDACTED]. On 7/14/2020, at 3:11 p.m., during an interview and concurrent record review, the Assistant Director of Nursing (ADON) confirmed the physician's orders [REDACTED]. ADON further stated that [MEDICATION NAME] was available in the

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

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.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) medication emergency kit (e-kit) and the nurses should have administer the [MEDICATION NAME] inhalation within four hours of receiving the order. A review of facility's policy and procedure titled, Administering Medication, dated revised 4/2019, indicated medication are administered in a safe and timely manner, and as prescribed A review of facility's policy and procedure titled Change in a Resident's Condition or Status, dated revised May 2017, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. On 7/14/2020, at 3:11 p.m., during an interview and concurrent record review, the Assistant Director of Nursing (ADON) confirmed the physician's orders [REDACTED]. A review of facility's policy and procedure titled Administering Medication, dated revised 4/2019, indicated medication are administered in a safe and timely manner, and as prescribed
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were being followed to prevent the spread of COVID-19 (Coronavirus Diseases 2019, a [MEDICAL CONDITION] infection highly contagious that causes respiratory complications and may result in hospitalization and death) by: a. Failing to ensure staff personal protective equipment (PPE) was removed prior to leaving a room designated for PUI (Persons Under Investigation - persons who have been exposed to or suspected to have COVID-19). b. Failing to ensure residents were wearing a face mask when outside of their rooms as per policy. These deficient practices had the potential to expose residents and staff to COVID-19 and put Residents 2, 3, 4, and 5 at an increased risk of contracting and/or spreading COVID-19. Findings: a. On 6/3/2020 at 12:15 p.m., Housekeeper 1 (HK 1) was observed exiting room [ROOM NUMBER], a PUI room. HK 1 left the room with the disposable gown and gloves on. HK 1 walked down the hallway, got a Wet Floor sign and brought it back inside room [ROOM NUMBER]. HK 1 then, removed her gown and gloves, disposed of them, and exited room. On 6/3/2020 at 12:30 p.m., during an interview, HK 1 stated she had received training on removing the gowns and gloves before leaving PUI's rooms. On 6/3/2020 at 2:30 p.m., during an interview, the Infection Prevention Nurse (IP Nurse) stated all staff, including housekeepers, were in-serviced on proper donning (apply PPE) and doffing (removing PPE). The IP Nurse stated gown and gloves should be removed prior to exiting the room, followed by hand hygiene. b. On 6/3/2020, between 11 a.m. and 11:20 a.m., several residents were observed outside of their rooms and in the hallways without a face mask on. Resident 3 was observed sitting on the floor in the hallway, next to his wheelchair, not wearing a mask. Staff were observed approaching Resident 3 and asking if he needed help, but no one reminded the resident to wear a mask. Resident 4 was observed standing at the double doors that lead to the lobby entrance, not wearing a mask. Staff was observed walking past the resident with no reminders to put on a mask. Resident 5 was observed leaving his room and walking down the hallway and back to his room several times, without a face mask. Nursing staff walked by the resident without reminding Resident 5 to wear a face mask. Resident 2 was observed being wheeled out of his room, through the hallways, and to the smoking patio, without a face mask on. On 6/3/2020 at 2:30 p.m., during an interview, the IP Nurse stated all residents needed to wear a face mask when outside of their room due to the COVID-19 infection crisis to prevent getting and spreading the infection. The IP Nurse stated some residents refuse or forget wearing the face masks or remove their mask. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, revised 10/2018, indicated the facility will provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. A review of the facility's COVID-19 Mitigation Plan indicated the policy was to protect the residents, staff and others who may be in the facility from harm during the COVID-19 pandemic. According to the facility's COVID-19 Mitigation Plan, in order to detect and prevent the spread of COVID-19, staff will be trained on proper donning and doffing procedures and residents leaving their room will be asked to wear a facemask.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** Based on observation, interview, and record review, the facility failed to ensure the call light was in working condition for one of eight sampled residents (Resident 2). This deficient practice resulted in delayed nursing care. Findings: On 6/3/2020 at 11:20 a.m., Resident 2 was observed in his room, sitting in a wheelchair and waving his hand. Upon entering the room, Resident 2 pointed to the light on his wall and waved the call light in his hand. When asked if Resident 2 needed assistance, he nodded. The light on the wall was observed to be on, but the light above the entrance door was not on. At 11:22 a.m., the call light board at the Nursing Station did not show Resident 2's call light was on. On 6/3/2020 at 11:25 a.m., during an interview and concurrent observation of the call light in Resident 2's room with the Infection Prevention Nurse (IP Nurse), the IP Nurse stated the light above Resident 2's room should turn on when the call light by the bed is activated. The IP Nurse stated there should also be an audible sound and a light on the call light board at the Nursing Station. On 6/3/2020 at 3:30 p.m., during an interview, the Maintenance Supervisor (MS) stated the light bulb above Resident 2's door went out (busted) and it will not trigger the alarm and light at the Nursing Station call light board. The MS stated they conduct monthly call light system audits and keeps track of which call lights were replaced. A review of the facility's policy and procedure titled, Answering the Call Light, Version 3.0, indicated the facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. The policy and procedure further indicated the call light will be plugged in at all times and functioning.