

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555583	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  MacLay Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  12831 MacLay Street Sylmar, CA 91342	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure four of 11 sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) were provided a safe and homelike environment. The facility failed to:</p> <ol style="list-style-type: none"> <li>1a. Ensure Resident 1, 2, and 3 had a restroom with functioning plumbing system.</li> <li>b. Ensure safe and private alternative restrooms were provided for Residents 1,2, and 3's toileting needs.</li> </ol> <p>2. Ensure Resident 4 was informed that other residents were directed to use Resident 4's restroom.</p> <p>These deficient practices resulted in Residents 1,2,3, and 4 not having a homelike comfortable and safe environment.</p> <p>Findings:</p> <p>During an interview on 10/23/2024 at 9:05 a.m. with the Director of Maintenance (DM), the DM stated station 4 had clogged drains since 1 p.m. on 10/22/2024. The DM stated resident rooms 1, 2, 3, and shower rooms B and C were affected by the clogged drains.</p> <p>During a concurrent observation and interview on 10/23/2024 at 9:27 a.m. with Maintenance Assistant 1 (MA 1), MA 1 stated the DM ran a 50-foot drain snake to unclog the drain and was unsuccessful. Observed the drain in the middle right side of station 4's patio had visible liquid up to the brim of the open pipe drain. MA 1 stated that the liquid on the pipe had been like that since yesterday, 10/22/2024. Observed station 4 shower rooms B and C with visible stagnant water pooling around the drain.</p> <p>1. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 11/9/2021 with diagnoses including dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2's Care Plan on self-care performance, initiated on 11/19/2021, the Care Plan indicated the resident had self-care performance deficit related to activity intolerance and impaired balance. The Care Plan interventions indicated Resident 2 prefers to use the toilet for toileting needs.</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/23/2024, the MDS indicated Resident 2's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 2 required the use of a walker or wheelchair for mobility (ability to move). The MDS indicated Resident 2 required supervision or assistance in walking 10 feet, toileting, and personal hygiene. The MDS indicated Resident 2 did not attempt and perform walking 50 feet with two turns before the current illness.</p> <p>2. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 1/30/2023 with diagnoses including hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (damage to the tissues in the brain due to a loss of oxygen to the area) affecting the right dominant side, repeated falls, and essential hypertension.</p> <p>During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 required the use of a wheelchair for mobility. The MDS indicated Resident 1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) in toileting, and personal hygiene.</p> <p>3. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 8/8/2024 with diagnoses including abnormalities with gait (the pattern that a person walks) and mobility, muscle weakness, and essential hypertension.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 required the use of a walker or a wheelchair for mobility. The MDS indicated Resident 3 required moderate assistance (helper lifts or holds trunk or limbs and provides less than half the effort) in toileting hygiene and walking 10 feet. The MDS indicated Resident 3 did not attempt to walk 50 feet with two turns and to walk 150 feet due to medical condition or safety concerns.</p> <p>4. During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 2/21/2024 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), essential hypertension, and depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was intact.</p> <p>During an interview on 10/23/2024 at 9:39 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Residents 2, 1, and 3's restroom was not working and was clogged. CNA 2 stated she was not informed where to assist the residents in the affected room on the residents' toileting needs.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/23/2024 at 9:45 a.m. with Licensed Vocational Nurse 1 (LVN 1) stated she was informed that residents in the room with a clogged drain were to use the occupied residents' room across nurse station 4. LVN 1 stated she was not informed if the residents in the room across nurse station 4 were aware that other residents were using their restroom. LVN 1 stated the residents' privacy and safety had the potential to be violated.</p> <p>During concurrent interviews on 10/23/2024 at 9:48 a.m. with Resident 1 and CNA 2, Resident 1 stated CNA 2 assisted him to the restroom in another residents' room to use the toilet. CNA 2 stated she assisted Resident 1 to use the restroom in the residents' room across the nurse station 4.</p> <p>During an interview on 10/23/2024 at 9:54 a.m. with Resident 2, Resident 2 stated the restroom had been clogged for three days. Resident 2 stated he was informed to use the restroom in another residents' room across nurse station 4 or the staff restroom at the end of station 4 hallway. Resident 2 stated the staff restroom required a code to enter. Resident 2 stated the facility staff did not provide the code to the staff restroom. Resident 2 stated it was inconvenient and unsafe to walk to another residents' room or down the end of the hallway in the middle of the night to use the toilet.</p> <p>During an interview on 10/23/2024 at 10:02 a.m. with CNA 3, CNA 3 stated he saw other facility staffs assist residents to the residents' room across the nurse station 4 for the residents' toileting needs.</p> <p>During an interview on 10/23/2024 at 12:06 p.m. with Resident 3, Resident 3 stated the restroom in the resident's room was clogged. Resident 3 stated the residents in the room affected with the clogged restroom drain were informed to use the restroom in the occupied residents' room across the nursing station 4 or the staff restroom at the end of station 4 hallway. Resident 3 stated the staff restroom required a code which the residents were not provided. Resident 3 stated the staff restroom was small and a walker or wheelchair would not fit inside. Resident 3 stated using another resident's restroom or walking to the end of the station 4 hallway to use the restroom was inconvenient and unsafe.</p> <p>During an interview on 10/23/2024 at 2:39 p.m. with Resident 4, Resident 4 stated nobody informed the resident that other residents were using the restroom. Resident 4 stated the facility staff should inform the residents if residents other than the roommates were to use the restroom.</p> <p>During an interview on 10/24/2024 at 11:04 a.m. with the Director of Nursing (DON), the DON stated she was not aware that the residents in the room with a clogged drain used another residents' restroom or the staff restroom for their toileting needs. The DON stated the residents in the room with a clogged drain should have been offered a temporary room change or a commode (a portable toilet not connected to plumbing that features a removable chamber). The DON stated the staff restroom was small and would not fit the walker or wheelchair of the residents. The DON stated the residents using a walker or a wheelchair was not safe to use the staff restroom. The DON stated the facility failed to provide a homelike environment for the residents. The DON stated the facility failed to ensure safety of the residents when using the staff restroom, and the facility failed to ensure privacy for the residents that occupied the room across the nurse station 4.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (PnP) titled, Homelike Environment, last reviewed on 4/2024, indicated residents were provided with a safe, clean, comfortable, and homelike environment The PnP indicated staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445</b></p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of 11 sampled residents (Resident 9). On 10/17/2024 at 7:30 p.m., Certified Nursing Assistant 4 (CNA 4) witnessed Resident 10's left arm was around Resident 9's neck from behind, while Resident 10 punched Resident 9 with his (Resident 10) right closed fist multiple times on the face while Resident 9 was sitting on the wheelchair watching television (TV) in their (Resident 9 and Resident 10's) room.</p> <p>This deficient practice resulted in Resident 9 being subjected to physical abuse by Resident 10 while under the care of the facility. Resident 9 sustained swelling on the lips with bleeding and pain. Based on the Reasonable Person Concept (the usual behavior of an average person under the same circumstances), due to Residents 9's severely impaired cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) and medical condition, an individual subjected to physical abuse may have physical pain, psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for own self).</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record, the Admission Record indicated the facility admitted Resident 9 on 9/16/2024 with diagnoses including aphasia (a disorder that makes it difficult to speak) following cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), abnormalities of gait (the manner of walking or moving on foot) and mobility (the ability to move freely and easily), and muscle weakness.</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/23/2024, the MDS indicated Resident 9's cognition was severely impaired. The MDS indicated Resident 9 had little interest or pleasure in doing things, feeling down, depressed (in a state of general unhappiness), or hopeless for 12 to 14 days or nearly every day. The MDS indicated Resident 9 felt bad about self, a failure or let self or family down for 12 to 14 days or nearly every day. The MDS indicated Resident 9 sometimes felt lonely or isolated from those around the resident.</p> <p>During a review of Resident 9's Change in Condition (COC - a significant change in resident's health status) Evaluation, dated 10/17/2024, the COC Evaluation indicated that on 10/17/2024 at 7:30 p.m., the resident (Resident 9) received physical abuse from another resident (Resident 10). The COC Evaluation indicated Resident 9 was found sitting in a wheelchair watching TV when Resident 10 hit Resident 9 on the face. Resident 9 sustained swelling on the lips and had a five out of 10 pain level on the pain scale (a common scale that uses numbers from zero to 10, with zero representing no pain and 10 representing the worst possible pain). The COC Evaluation indicated Resident 9 required ice pack to be placed on the swollen lip. The COC Evaluation indicated Resident 9's Attending Physician was notified at 8:41 p.m. on 10/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 9's Progress Notes, dated 10/17/2024, the Progress Notes (documented by Licensed Vocational Nurse 2 [LVN 2]) indicated that on 10/17/2024 at 7:30 p.m., he (LVN 2) was called inside Resident 9 and Resident 10's room (Resident 9 and Resident 10 were roommates). Resident 9's Progress Note indicated CNA 4 witnessed Resident 10 held Resident 9's neck from behind. The Progress Notes indicated Resident 10 punched Resident 9 multiple times with a closed fist (the Progress Note did not indicate which fist). The Progress Notes indicated Resident 9 was noted with swollen lips.</p> <p>During a review of Resident 10's Admission Record, the Admission Record indicated the facility admitted Resident 10 on 3/31/2021 with diagnoses including encephalopathy (damage or disease that affects the brain), rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber into the blood), and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10's cognition was severely impaired.</p> <p>During a review of Resident 10's Care Plan (untitled), last revised on 1/4/2023, indicated the resident (Resident 10) was noted with aggressive behavior and getting upset for no reason. The interventions included were to re-direct resident behavior and for the resident not to hurt others or damage property.</p> <p>During a review of Resident 10's History and Physical (HP), dated 4/29/2024, the HP indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 10's Care Plan (untitled), last revised on 9/30/2024, indicated the resident (Resident 10) had mood swings with poor impulse control. The Care Plan interventions included were to monitor, record, and report to the physician risk for harming others, increased anger, labile mood (rapid, often exaggerated changes in mood occur), or agitation (a state of anxiety or nervous excitement), feeling threatened by others or thoughts of harming someone.</p> <p>During a review of Resident 10's Physician Orders, dated 9/28/2024, the Physician Order indicated to monitor behavior episodes of sudden outburst of anger and tally with hashmark for each episode on the Medication Administration Record (MAR - a report detailing the medications administered to a resident) every shift.</p> <p>During a review of Resident 10's MAR, dated 10/1/2024 to 10/31/2024, the MAR indicated that on 10/14/2024 on the 11 p.m. to 7 a.m. shift, Resident 10 had two episodes of anger outburst.</p> <p>During a review of Resident 10's COC Evaluation, dated 10/17/2024, the COC Evaluation indicated on 10/17/2024 at 7:30 p.m., Resident 10 was witnessed behind Resident 9 while hitting the resident (Resident 9) on the face multiple times.</p> <p>During an interview on 10/24/2024 at 9:58 a.m. with Resident 9, Resident 9 stated another resident punched him on the face. Resident 9 was not able to provide other information about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/24/2024 at 10:12 a.m. with CNA 4, CNA 4 stated she (CNA 4) heard Resident 9 yelling inside the resident's room. CNA 4 stated she (CNA 4) then went inside Resident 9's room and found Resident 9 sitting on a wheelchair. CNA 4 stated Resident 10's left arm was around Resident 9's neck, while Resident 10 punched Resident 9's face with his (Resident 10) right closed fist multiple times. CNA 4 stated that Resident 10's punches were hits and misses on Resident 9's right cheek, right jaw, and right side of the mouth area. CNA 4 stated Resident 9 and Resident 10 were separated. CNA 4 stated Resident 9 had blood (amount not indicated) in the mouth and in the right lower lip that required an ice pack. CNA 4 stated Resident 10 punching Resident 9 is physical abuse.</p> <p>During a telephone interview on 10/24/2024 at 12:26 p.m. with LVN 2, LVN 2 stated he heard someone screaming at Station 1 LVN 2 stated that when he (LVN 2) entered inside Resident 9 and Resident 10's room, both residents were already separated. LVN 2 stated CNA 4 witnessed Resident 10 punching Resident 9 on the face. LVN 2 stated Resident 9's middle part of the lower lip was bleeding requiring an ice pack to be placed on the lips to prevent swelling and to stop the bleeding. LVN 2 stated Resident 10 had a history of aggressive behavior towards another resident. LVN 2 stated that Resident 10 punching Resident 9 is physical abuse.</p> <p>During an interview on 10/24/2024 at 12:38 p.m. with the Director of Nursing (DON), the DON stated residents should be free from abuse. The DON stated the physical act of intentionally punching a person is physical abuse. Resident 10 punching Resident 9 was considered as an abuse. The DON stated the facility failed to prevent the physical act of abuse from happening between Resident 9 and Resident 10.</p> <p>During a review of the facility's policy and procedure (PnP) titled, Abuse, Neglect (fail to care properly), Exploitation (the act of using someone or something unfairly for your own advantage) and Misappropriation (to steal something that you have been trusted to take care of and using it for yourself) Prevention Program, last reviewed on 4/2024, the PnP indicated the resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The PnP indicated that it included freedom from . verbal, mental, sexual, or physical abuse The PnP indicated the facility objective to protect residents from abuse by anyone including .b. other residents.</p>		