STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555583	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacLay Healthcare Center	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)
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. 42311 Based on interview and record review, the facility failed to report an allegation of employee to resident abuse within two hours to the State Survey Agency (SSA), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and law enforcement as per its policies on abuse for one of three sampled residents (Resident 1). This deficient practice had the potential to place Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 2/15/2023, with diagnoses that included displaced intertrochanteric fracture of right femur (a hip fracture that occurs when the bone breaks between the bumps at the top of the thigh bone, and the injured leg is noticeably shortened and externally rotated), dysphagia (swallowing difficulty) and essential hypertension (persistently raised blood pressure with no secondary cause identified). During a record review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 had capacity to understand and make decisions. During a record review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/21/2024, the MDS indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for activities of daily living (ADL-oral and personal hygiene).The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. During a record review of Resident 1 ' s Change in Condition Evaluation (CIC), dated 10/23/2024, the CIC indicated at 10 p.m., Certified nursing Assistant 1 (CNA 1) was rough on Resident 1. The CIC indicated the physician was notified on 10/24/2024 at 12 midnight. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1 ' s Progress Notes, dated 10/23/2024, timed at 11:21 p.m., the Progress Notes indicated on 10/23/2024, at 9:30 p.m., Resident 1 was yelling and screaming. The Progress Notes indicated Licensed Vocational Nurse 1 (LVN 1) called Family Member 1 (FM 1) due to a language barrier and FM 1 translated that CNA 1 was rough on Resident 1. The Progress Note indicated LVN 1 notified Registered Nurse 1 (RN 1). During a record review of LVN 1 ' s written statement, the written statement indicated on 10/23/2024, at 9:30 p.m., Resident 1 kept yelling in foreign language and appeared upset. The written statement indicated LVN 1 called FM 1 and FM 1 translated that CNA 1 did not attend to Resident 1, CNA 1 turned the call light off, CNA 1 was rough to Resident 1 and CNA 1 hit Resident 1 in the head with a dirty incontinent brief. The written statement indicated LVN 1 reported to RN 1 immediately. During an interview on 10/31/2024, at 9:22 a.m., with Resident 1 and translated by LVN 2, Resident 1 stated CNA 1 changed her (Resident 1) incontinent brief and applied the powder on her private area as per her (Resident 1) request. Resident 1 stated she (Resident 1) lowered CNA 1 ' s hand down to prevent the powder from going to her (Resident 1) eyes. Resident 1 stated CNA 1 hit her (Resident 1) right wrist, CNA 1 turned around and took the used incontinent brief on the floor and threw it and hit her (Resident 1) head. Resident 1 stated she (Resident 1) informed FM 1. During an interview on 10/31/2024, at 9:39 a.m., with RN 1, RN 1 stated LVN 1 borrowed the RN Supervisors phone and called FM 1 to translate what Resident 1 was saying. RN 1 stated LVN 1 reported that CNA 1 threw the incontinent brief at Resident 1. RN 1 stated Resident 1 claimed CNA 1 was rough. RN 1 stated LVN 1 wrote a written statement, but she (RN 1) did not read it and just placed it in the Director of Staff Development (DSD ' s) office. RN 1 stated she did not report the allegation to the Director of Nursing (DON) and did not report to the Administrator (ADM) that night of 10/23/2024, but did report the following day 10/24/2024, to the DSD and Assistant Director of Nursing (ADON). RN 1 stated she did not call the law enforcement and stated if no injury from allegation of abuse the report can be done in 24 hours. RN 1 stated she did not notify the SSA and Ombudsman that night of 10/23/2024. During an interview on 10/31/2024, at 9:58 a.m., with the ADON, the ADON stated there was a delay in reporting allegation of abuse. ADON stated RN 1 should have reported to SSA, Ombudsman and law enforcement on 10/23/2024. The ADON stated the facility ' s policy for abuse was to report any allegation of abuse within two hours. The ADON stated the importance of reporting within two hours was to initiate the abuse investigation and for residents ' safety to prevent emotional distress. During an interview on 10/31/2024, at 10:19 a.m., with LVN 1, LVN 1 stated on 10/23/2024, at 9:30 p.m., she (LVN 1) heard yelling and found Resident 1 upset. LVN 1 stated she (LVN 1) called FM 1 and FM 1 informed her (LVN 1) that CNA 1 was rough on Resident 1 and that CNA 1 grabbed the wet incontinent brief and hit Resident 1 in the head. LVN 1 stated she (LVN1) reported to RN 1 because Resident 1 had allegation of abuse. During an interview on 10/31/2024, at 11:10 a.m., with the Administrator (ADM), the ADM stated there was a delay in communicating and allegation of abuse should have been reported immediately. The ADM stated allegation is allegation and RN 1 need to communicate for proper investigation. The ADM stated their policy for reporting abuse is to report within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s policy and procedure (PP) titled, Abuse Investigation and Reporting, dated 2001, and last reviewed on 4/24/2024, the PP indicated, Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility. b. The local/State Ombudsman. c. The Resident ' s Representative (Sponsor) of Record. d. Adult Protective Services (where state law provides jurisdiction in long-term care). e. Law enforcement officials. f. The resident ' s Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42311 Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards of practice for one of three sampled residents (Resident 1). This deficient practice had the potential to result in confusion in the care and services rendered to Resident 1 and resulted in inaccurate information entered into Resident 1's medical record. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 2/15/2023, with diagnoses that included displaced intertrochanteric fracture of right femur (a hip fracture that occurs when the bone breaks between the bumps at the top of the thigh bone, and the injured leg is noticeably shortened and externally rotated), dysphagia (swallowing difficulty) and essential hypertension (persistently raised blood pressure with no secondary cause identified). During a record review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a record review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/21/2024, the MDS indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for activities of daily living (ADL-oral and personal hygiene). The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. During a record review of Resident 1 ' s Progress Notes dated 10/23/2024, timed at 11:21 p.m., the Progress Notes indicated on 10/23/2024, at 9:30 p.m., Resident 1 was yelling and screaming. The Progress Notes indicated Licensed Vocational Nurse 1 (LVN 1) called Family Member 1 (FM 1) due to a language barrier and FM 1 translated that CNA 1 was rough on Resident 1. The Progress Note indicated LVN 1 notified Registered Nurse 1 (RN 1). During a record review of LVN 1 ' s written statement, the written statement indicated on 10/23/2024, at 9:30 p.m., Resident 1 kept yelling in foreign language and appeared upset. The written statement indicated LVN 1 called FM 1 and FM 1 translated that CNA 1 did not attend to Resident 1, CNA 1 turned the call light off, CNA 1 was rough to Resident 1 and CNA 1 hit Resident 1 in the head with a dirty incontinent brief. The written statement indicated LVN 1 reported to RN 1 immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024, at 9:22 a.m., with Resident 1 and translated by LVN 2, Resident 1 stated CNA 1 changed her (Resident 1) incontinent brief and applied the powder on her private area as per her (Resident 1) request. Resident 1 stated she (Resident 1) lowered CNA 1 ' s hand down to prevent the powder from going to her (Resident 1) eyes. Resident 1 stated CNA 1 hit her (Resident 1) right wrist, CNA 1 turned around and took the used incontinent brief on the floor and threw it and hit her (Resident 1) head. Resident 1 stated she (Resident 1) informed FM 1. During an interview on 10/31/2024, at 10:19 a.m., with LVN 1, LVN 1 stated on 10/23/2024, at 9:30 p.m., she (LVN 1) heard yelling and found Resident 1 upset. LVN 1 stated she (LVN 1) called FM 1 and FM 1 informed her (LVN 1) that CNA 1 was rough on Resident 1 and that CNA 1 grabbed the wet incontinent brief and hit Resident 1 in the head. LVN 1 stated she (LVN1) reported to RN 1 because Resident 1 had allegation of abuse. During a concurrent interview and record review on 10/31/2024 at 11:27 a.m., with the ADON, Resident 1 ' s Progress Note dated 10/23/2024, timed at 11:21 p.m., and LVN 1 ' s written statement was reviewed. The ADON stated LVN 1 did not document that in Resident 1 ' s medical record that FM 1 translated Resident 1 ' s report that CNA 1 had hit Resident 1 in the head with a dirty incontinent brief. The ADON stated medical records should be complete and accurate. During a record review of facility ' s policy and procedure (PP) titled, Charting and Documentation undated and last reviewed on 4/2024, the PP indicated, 2. The following information is to be documented in the resident medical record: a. Objective observations. b. Medications administered. c. Treatments or services performed. d. Changes in the resident's condition. e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.