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	12/18/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (intentional bodily injury) for one of eight sampled residents (Resident 1) when on 12/3/2024, Resident 7 witnessed Resident 2 hit Resident 1 left arm causing a scratch using Resident 2's left hand. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. Findings: During a review of Resident 1's Record of Admission, the Record of Admission indicated the facility admitted the resident on 4/27/2024, with a diagnosis of saddle embolus of pulmonary artery with acute cor pulmonale (a life-threatening condition that occurs when a large blood clot blocks the main pulmonary artery, preventing blood flow to both lungs). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/1/2024, the MDS indicated that resident had moderate cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment (damage). During a review of Resident 1' Care Plan, dated 12/3/2024, the Care Plan indicated Resident 1 was at risk for emotional and psychological distress related to resident to resident incident and sustained a scratch in the left forearm. The Care Plan indicated Resident 1 was at risk for left forearm infection, acute pain, and further decline in activity of daily living. During a review of Resident 1's Change in Condition (COC) Evaluation, dated 12/3/2024, the COC Evaluation indicated Resident 1 had a scratch to the left forearm related to a physical altercation with another resident (Resident 2). During a review of Resident 2's Record of Admission, the Record of Admission indicated the facility initially admitted the resident on 10/8/2012 and readmitted on [DATE], with a diagnosis of hemiplegia (weakness or paralysis on one side of the body) following cerebral infarction (a stroke is a brain attack that happens when blood flow to the brain is stopped) affecting right dominant side. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's History & Physical (H&P), dated 9/19/2023, the H&P indicated that resident had the capacity to understand and make decisions. The H&P indicated Resident 2 can make needs known but cannot make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated resident had severe cognitive impairment. During a review of Resident 2's COC Evaluation, dated 12/3/2024, the COC Evaluation indicated Resident 2 had a verbal/physical altercation with another resident (Resident 1). THE COC Evaluation indicated Resident 2 was sent out to the general acute care hospital (GACH) emergency room for behavioral management. During a review of Resident 7's Record of Admission, the Record of Admission indicated the facility admitted the resident on 11/11/2021, with a diagnosis of type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). During a review of Resident 7's H&P, dated 8/2/2023, the H&P indicated resident had the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 had intact cognition. During an interview on 12/17/2024 at 1:55 p.m., Resident 7 stated that Resident 1 was sitting in her wheelchair by the door around 1:30 p.m. to 2 p.m. Then Resident 1 wheeled herself close to Resident 2 in front of Resident 2's closet and Resident 1 keep saying amen, amen, amen. Resident 7 stated that Resident 2 told Resident 1 to shut up and Resident 1 did not stop. Resident 7 stated that Resident 1 reached out and hit Resident 2's right arm then Resident 2 hit back at Resident 1 in her right arm that left a scratch in Resident 1's left arm. During an interview on 12/18/2024 at 11:03 a.m., License Vocational Nurse 3 (LVN 3) stated that Resident 7 witnessed that Resident 1 and Resident 2 hit each other's arm. LVN 3 stated this was considered physical abuse. During an interview on 12/18/2024 at 1:41 p.m., the Administrator (Admin) stated that based on their facility policy and procedure this was considered as physical abuse. During a review of the facility policy and procedure titled, Abuse Prevention Program, with last reviewed date of 4/2024, the policy indicated our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusions, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure titled, Abuse and Neglect - Clinical Protocol, with last reviewed date of 4/2024, the policy indicated Abuse is defined at 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.