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Form Approved OMB
No. 0938-0391

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	01/16/2025

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 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** 37861 Based on interview and record review, the facility failed to maintain a system-wide method for pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of nine sampled residents (Resident 1) by failing to account for the exact whereabouts of Resident 1 ' s controlled substance (narcotics) medication. This deficient practice increases the risks for mishandling of a controlled substance increases the risks of diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of medications, staff working in an impaired state, or accidental exposure of controlled substances to other residents possibly resulting in respiratory depression (the inability to breathe) leading to hospitalization or death. Findings: A review of Resident 1 ' s Admission Record indicated an admitted [DATE] with the diagnoses of aftercare following surgery for neoplasm (an abnormal growth of tissue in the body that can be cancerous or noncancerous), muscle weakness, and general anxiety disorder (condition of persistent worrying interfering with day-to-day life). A review of Resident 1 ' s Minimum Data Set ([MDS] resident assessment tool) dated 10/30/2024 indicated Resident 1 to be with no impairment in thought process and could understand and answer questions. A review of Physician ' s Orders for Resident 1 indicated a controlled substance medication order on 12/27/2024 at 5:02 p.m. for Lorazepam Oral Tablet 0.5 milligrams ([mg] unit of weight measurement), to be given one (1) tablet by mouth at bedtime for anxiety manifested by feelings of nervousness. On 1/16/2025 at 1 p.m., during an interview with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, At the start of every shift, we (Licensed Nurses) have to verify the narcotics count with the incoming Licensed Nurse with the outgoing nurse. We need both staff to sign that it was verified. It is important to count the narcotics because they are controlled medications, and we need to prevent the residents from taking them. Controlled medications can reduce the breathing rate and result in the patient being non-responsive, then the patient can die if they are not breathing. (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/2025 at 4:46 p.m., during an interview with the Director of Nursing (DON), DON stated that through the facility ' s internal investigation, Resident 1 ' s narcotic medication and the count sheet were missing and never found, and the exact number of tablets missing cannot be determined. DON stated the facility needs to account for controlled substances, indicating that whoever accesses it can have an overdose by respiratory depression described as a decrease in the breathing rate or have an adverse reaction with other medications causing the possibility of hospitalization or death. A review of the facility-provided undated policy and procedure titled Controlled Substances, indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. The policy also stated, The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; d. Destruction, waste and return to pharmacy records. Based on interview and record review, the facility failed to maintain a system-wide method for pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of nine sampled residents (Resident 1) by failing to account for the exact whereabouts of Resident 1's controlled substance (narcotics) medication. This deficient practice increases the risks for mishandling of a controlled substance increases the risks of diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of medications, staff working in an impaired state, or accidental exposure of controlled substances to other residents possibly resulting in respiratory depression (the inability to breathe) leading to hospitalization or death. Findings: A review of Resident 1's Admission Record indicated an admitted [DATE] with the diagnoses of aftercare following surgery for neoplasm (an abnormal growth of tissue in the body that can be cancerous or noncancerous), muscle weakness, and general anxiety disorder (condition of persistent worrying interfering with day-to-day life). A review of Resident 1's Minimum Data Set ([MDS] resident assessment tool) dated 10/30/2024 indicated Resident 1 to be with no impairment in thought process and could understand and answer questions. A review of Physician's Orders for Resident 1 indicated a controlled substance medication order on 12/27/2024 at 5:02 p.m. for Lorazepam Oral Tablet 0.5 milligrams ([mg] unit of weight measurement), to be given one (1) tablet by mouth at bedtime for anxiety manifested by feelings of nervousness. On 1/16/2025 at 1 p.m., during an interview with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, At the start of every shift, we (Licensed Nurses) have to verify the narcotics count with the incoming Licensed Nurse with the outgoing nurse. We need both staff to sign that it was verified. It is important to count the narcotics because they are controlled medications, and we need to prevent the residents from taking them. Controlled medications can reduce the breathing rate and result in the patient being non-responsive, then the patient can die if they are not breathing. (continued on next page)

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