| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555583 | A. Building<br>B. Wing | 01/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MacLay Healthcare Center | 12831 MacLay Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>46445<br><br>Based on observation, interview, and record review, the facility failed to implement policy and procedure on safeguarding of all prescribed medications for one of three sampled residents (Resident 3) by failing to ensure Resident 3's prescribed medication was stored in the medication cart of the nursing station where Resident 3 was located.<br><br>This deficient practice had the potential for non-authorized access to Resident 3's medications.<br><br>Findings:<br><br>During a record review of Resident 3'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 (an abnormally high blood pressure that was not a result of a medical condition), and depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities).<br><br>During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/27/2024, the MDS indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills were intact.<br><br>During a concurrent observation and interview on 1/28/2025 at 9:20 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 opened the first top drawer at nurse station 400 and observed a medication container labeled Airshield (a medication brand name) dietary supplement with Resident 3's name and room number. LVN 1 stated Resident 3 was a current resident in the facility. LVN 1 stated medications should be placed inside the locked medication cart or inside the locked medication room.<br><br>During a follow up interview on 1/28/2025 at 10:35 a.m. and a concurrent record review of Resident 3's medical records, reviewed with LVN 1, LVN 1 stated Resident 3's Physician Order did not indicate an order for Airshield dietary supplement. LVN 1 stated medications that were discontinued should be disposed inside the locked medication room. LVN 1 stated residents' medications stored in an unlocked nurse station drawers had the potential for another resident to ingest the medication and result I adverse effects (unwanted and undesirable effects of a medication).<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/28/2025 at 2:40 p.m. with the Director of Nursing (DON), the DON stated Resident 3's discontinued medication should be inside the locked medication room. The DON stated other residents had the potential to have access to Resident 3's medication and cause the other resident adverse effects. The DON stated the facility failed to follow the policy and procedures on medication storage.<br><br>During a review of the facility's policy and procedure (PnP) titled, Storage of Medications, last reviewed on 4/2024, the PnP indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. The PnP indicated discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. The PnP indicated compartments containing drugs and biologicals are locked when not in use. The PnP indicated unlocked medication carts are not left unattended. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445<br><br>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication errors by failing to ensure the physician orders were followed. Resident 1's medication dose was not clarified with the attending physician.<br><br>This deficient practice placed Resident 1 at risk for medication administration error that had the potential to result in difficulty in breathing.<br><br>Findings:<br><br>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 9/23/2021 and readmitted on [DATE] with diagnoses including metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), and muscle weakness.<br><br>During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/20/2025, the MDS indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills were intact.<br><br>During an observation and concurrent interview on 1/28/2025 at 9:24 a.m. with Licensed Vocational Nurse 1 (LVN 1), observed Resident 1's medication box indicated Atrovent (a medication used to relax muscles in the airway and increases air flow to the lungs) 17 micrograms (mcg - unit of measurement) inhaler. LVN 1 stated Resident 1's medication label indicated one puff by mouth every 24 hours as needed for shortness of breath, wheezing, or COPD.<br><br>During an interview on 1/28/2025 at 9:26 a.m. and a concurrent record review of Resident 1's Physician Orders, reviewed with LVN 1 the Physician Orders, dated 1/25/2025, indicated Atrovent HFA aerosol solution (a substance released in very fine mist) 17 mcg four puffs inhale orally every 24 hours as needed for shortness of breath, wheezing, or COPD. LVN 1 stated Resident 1's Medication Administration Record (MAR) indicated the resident did not receive any dose of Atrovent since the resident was readmitted from General Acute Care Hospital 1 (GACH 1). LVN 1 stated Resident 1's Nursing Note, dated 1/25/2025 at 3:23 p.m., indicated Registered Nurse 2 (RN 2) received a pharmacy note that indicated the resident's Atrovent HFA four puffs exceed the maximum single dose of 2 puffs. LVN 1 stated there was no physician order for Resident 1's Atrovent HFA one puff by mouth every 24 hours. LVN 1 stated the Resident 1 had the potential to receive the wrong medication dose.<br><br>During an interview on 1/28/2025 at 2:40 p.m. with the Director of Nursing (DON), the DON stated RN 2 did not verify Resident 1's medication dosage and frequency with the attending physician. The DON stated Resident 1 had the potential to receive a wrong dose of the medication. The DON stated the facility failed to ensure medications were clarified with the attending physician.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of the facility's policy and procedure (PnP) titled, Medication Administration, last reviewed on 4/2024, the PnP indicated any dose or order that appears inappropriate considering the resident's age, condition, or diagnosis is verified with the attending physician before processing. The PnP indicated the facility pharmacy will not process a medication order if it is unclear or confusing, until the clarification was made. |