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	06/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the attending physician (MD) for one of three sampled residents (Resident 1) when: 1. The Skilled Nursing Facility (SNF) 1, was unable to provide Speech Therapy (ST) on 5/15/2025 when MD ordered an ST and swallow evaluation (a test done by a Speech-Language Pathologist (SLP) to figure out why a person is having trouble swallowing). 2. Resident 1 continued to have difficulty swallowing and pocketing (the act of storing food inside the mouth without swallowing it) after the Change in Condition (COC) on 5/15/2025. These deficient practices resulted in Resident 1 not receiving the ST evaluation resulting in Resident 1 having a COC on 5/24/2025 where Resident 1 was noted with inability to eat, coughing and pocketing requiring transfer to General Acute Care Hospital (GACH) 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2024 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, often affecting one arm, leg, and sometimes the face) following cerebral infarction (a brain attack where part of the brain's blood supply is blocked or severely reduced) affecting the right dominant side, dysphagia (difficulty swallowing) oropharyngeal (anything related to the middle part of the throat), dementia (a progressive state of decline in mental abilities), and depression (a common mental health condition that causes persistent sadness, loss of interest in activities, and changes in how you think, feel, and act). During a review of Resident 1's care plan created on 3/5/2025, the care plan for nutritional problem or potential nutritional problems indicated intervention to monitor, document, and report as needed any sign and or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, and to provide and serve supplements as ordered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required substantial to maximum assistance (helper does more than half the effort) with toileting, showering, upper and lower body dressing and putting on and taking off footwear and required partial to moderate assistance (helper does less than half the effort) with oral hygiene, and personal hygiene. During a review of Resident 1's care plan created on 4/19/2025, the care plan for swallowing problem related to holding food in mouth and cheeks with intervention to check mouth after meal for pocketing food and debris and report to nurse, monitor, document, and report as needed any sign or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts to swallow and refusing to eat. During a review of Resident 1's Physician Order Summary Report, dated 4/20/2025, the Physician Order Summary Report indicated a physician's order for regular diet pureed texture, nectar thickened liquids consistency, large portion protein per meal. During a review of Resident 1's COC Evaluation, dated 5/15/2025 at 10:20 p.m., the COC Evaluation indicated Resident 1pocketing food when eating. Family Member (FM) 1 indicated Resident 1 having difficulty swallowing his food, Resident 1 pockets the food in his mouth. The MD was notified on 5/15/2025 at 7 p.m. with orders for speech and swallow evaluation, calorie count for seven days. During a review of Resident 1's Physician Order Summary Report, dated 5/15/2025, the Physician Order Summary Report indicated a physician's order for Speech and swallow evaluation in the morning. During a review of Resident 1's care plan created on 5/16/2025, the care plan for difficulty swallowing indicated interventions of speech and swallow eval, calorie count for seven days and to call MD for changes in Resident 1's conditions. During a review of Resident 1's Progress Notes dated 5/16/2025 at 2:17 p.m., the Progress Notes indicated continued monitoring for difficulty swallowing. Resident 1 is noted with some difficulty swallowing meals. During a review of Resident 1's Progress Notes dated 5/17/2025 at 1:26 p.m., the Progress Notes indicated Resident 1 is on monitoring for difficulty swallowing and pocketing the food in his mouth, still noted. During a review of Resident 1's Progress Notes dated 5/18/2025 at 1:23 p.m., the Progress Notes indicated Resident 1 is on monitoring for difficulty swallowing and pocketing the food in his mouth, still noted. During a review of Resident 1's COC Evaluation dated 5/24/2025 at 10:09 a.m., the COC Evaluation indicated Resident 1 noted slowly declining in mobility, unable to feed to sit in Resident 1's wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes dated 5/24/2025 at 1:13 p.m., the Progress Notes indicated Resident 1 was transferred to GACH 1 at 12:14 p.m. due to fever, decline in Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily), and unable to eat, coughing and pocketing food. During an interview on 6/3/2025 at 12p.m. with the Restorative Nursing Assistant (RNA) 1, RNA 1 stated on Saturday 5/24/2025 prior to Resident 1 being discharged to GACH 1, RNA 1 attempted to feed Resident 1 pureed eggs and oatmeal and Resident 1 began to choke on the food. RNA 1 stated she reported to the nurse not sure who the nurse was, but Resident 1 was discharged shortly after that. During an interview on 6/3/2025 at 12:31 p.m. with the Director of Rehab (DOR), the DOR stated have not had an ST in the facility since the beginning of May. The DOR stated if a resident requires ST, we will downgrade their diet and then send out the resident to the hospital if needed. The DOR stated last day of ST in the building was 5/5/2025. The DOR stated Resident 1 did not get the ST eval as ordered because the facility did not have an ST at that time. The DOR stated informed the Director of Nursing (DON), if Resident 1 was pocketing food or having signs of choking needed to be sent out to hospital this was during a clinical meeting with all department heads not sure of the date. During an interview on 6/3/2025 at 12:36 p.m. with the DOR, the DOR stated Resident 1 was ordered to have ST three times a week for four weeks but since the ST resigned Resident 1 was discharged from ST. The DOR stated Resident 1 did not meet his goals, Resident 1 was discharged from ST because we could not provide the ST services for Resident 1. The DOR stated is not sure if the MD was notified that Resident 1 was not able to get ST eval as ordered by MD the one to contact the MD would have been nursing. During a concurrent interview and record review on 6/3/2025 at 1:22 p.m. of Resident 1's progress notes with the DON, the DON stated there was no notification to MD regarding not having an ST in the building. The DON stated based on timesheet the ST's last day was on 5/5/2025 and Resident 1 was ordered an ST eval on 5/15/2025. The DON stated knowing that Resident 1 needed to transfer out if there was no ST within seven days. The DON stated Resident was discharged to GACH 1 on 5/24/2025, nine days after ST eval order, the DON stated does not think Resident 1 had a lot of pocketing of food. The DON reviewed progress notes dated 5/16/2025 through 5/24/2025 the DON stated the progress notes indicates that Resident 1 was still pocketing food and had difficulty swallowing. The DON stated there is a potential for weight loss and potential for aspiration if Resident 1 is pocketing food. The DON stated not sure if nurses notified MD that Resident 1 was continuing to pocket food. The DON stated it is not documented and cannot say the MD was notified. The DON stated nurses should have notified MD and/or DON that Resident 1 was continuing to pocket food. The DON stated can be a risk for resident not to be transferred in a timely manner. The DON stated there was delay of care. The DON stated as a SNF we should be able to provide ST, can be potential we cannot provide the right services and treatment and delay in treatment. During a review of the facility's Policy and Procedure (P&P) titled, Specialized Rehabilitative Services, last revised on 4/2025, the P&P indicated our facility will provide Rehabilitative Services to residents as indicated by the MDS. 2. Specialized Rehabilitative Services include the following: b. Speech Pathology/Audiology; (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Therapeutic Services are provided only upon the written order of the resident's Attending Physician. During a review of the facility's P&P titled, Changes in Resident Condition, last revised on 4/2025, the P&P indicated the resident, attending physician and legal representative or interested family member are notified when changes in condition or certain events occur. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice when the facility failed to follow the Registered Dietitian's (RD- a food and nutrition expert who helps people improve their health through food choices and dietary changes) recommendations. This deficient practice had the potential for Resident 1 to have unplanned weight loss. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2024 and readmitted the resident on 3/19/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, often affecting one arm, leg, and sometimes the face) following cerebral infarction (a brain attack where part of the brain's blood supply is blocked or severely reduced) affecting the right dominant side, dysphagia (difficulty swallowing) oropharyngeal (anything related to the middle part of the throat), dementia (a progressive state of decline in mental abilities), and depression (a common mental health condition that causes persistent sadness, loss of interest in activities, and changes in how you think, feel, and act). During a review of Resident 1's care plan created on 3/5/2025, the care plan for nutritional problem or potential nutritional problems indicated intervention to monitor, document, and report as needed any sign and or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, and to provide and serve supplements as ordered. During a review of Resident 1's Weight Summary, the Weight Summary indicated the following Resident 1's weights: - 4/4/2025 154 pounds (lbs.- unit of weight) - 5/5/2025 151 lbs. - 5/18/2025 148 lbs. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required substantial to maximum assistance (helper does more than half the effort) with toileting, showering, upper and lower body dressing and putting on and taking off footwear and required partial to moderate assistance (helper does less than half the effort) with oral hygiene, and personal hygiene. During a review of Resident 1's Physician Order Summary Report, dated 4/20/2025, the Physician Order Summary Report indicated a physician's order for regular diet pureed texture, nectar thickened liquids consistency, large portion protein per meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Food and Nutrition Progress Notes dated 5/15/2025 at 5:13p.m. indicated weight loss related to variable oral intake, multiple medical conditions including dysphagia, dementia, and depression. The plan indicated to provide magic cup (a nutritional supplement designed to provide extra calories and protein for individuals who are experiencing involuntary weight loss or have difficulty consuming enough nutrients through regular meals) daily at lunch for one month. During an interview on 6/3/2025 at 3:56 p.m. with the Director of Nursing (DON), the DON stated for RD recommendations the RD comes two times a week, reviews the weights then gives recommendations, the facility then has three days to follow up on the recommendations including weekends. During a concurrent interview and record review on 6/3/2025 at 4:25 p.m. of Resident 1's Food and Nutrition Progress Notes with the DON, the DON stated could not find any recommendations for Resident 1. The DON stated the RD needs to put their recommendations into the Dietary Report. The DON stated Resident 1 was seen by RD on 5/15/2025. The DON reviewed Resident 1's Food and Nutrition Progress Notes and the DON stated RD recommended magic cup which was not provided to Resident 1. The DON stated there is a potential for the interventions not to be done and can lead to a further weight loss. During a review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention, last revised on 4/2025, the P&P indicated undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes: b. the resident's calorie, protein, and other nutrient needs compared with the resident current intake. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss for example: f. increased need for calories and or protein.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide Speech Therapy (ST) on 5/15/2025 when the Medical Doctor (MD) ordered an ST and swallow evaluation (a test done by a Speech-Language Pathologist (SLP) to figure out why a person is having trouble swallowing) for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 not receiving the ST eval resulting in Resident 1 having a COC on 5/24/2025 where Resident 1 was noted with inability to eat, coughing and pocketing requiring transfer to General Acute Care Hospital (GACH) 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2024 and readmitted the resident on 3/19/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, often affecting one arm, leg, and sometimes the face) following cerebral infarction (a brain attack where part of the brain's blood supply is blocked or severely reduced) affecting the right dominant side, dysphagia (difficulty swallowing) oropharyngeal (anything related to the middle part of the throat), dementia (a progressive state of decline in mental abilities), and depression (a common mental health condition that causes persistent sadness, loss of interest in activities, and changes in how you think, feel, and act). During a review of Resident 1's care plan created on 3/5/2025, the care plan for nutritional problem or potential nutritional problems indicated interventions including to monitor, document, and report as needed any sign and or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, and to provide and serve supplements as ordered. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required substantial to maximum assistance (helper does more than half the effort) with toileting, showering, upper and lower body dressing and putting on and taking off footwear and required partial to moderate assistance (helper does less than half the effort) with oral hygiene, and personal hygiene. During a review of Resident 1's care plan created on 4/19/2025, the care plan for swallowing problem related to holding food in mouth and cheeks with intervention to check mouth after meal for pocketing food and debris and report to nurse, monitor, document, and report as needed any sign or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts to swallow and refusing to eat. During a review of Resident 1's Physician Order Summary Report, dated 4/20/2025, the Physician Order Summary Report indicated a physician's order for regular diet pureed texture, nectar thickened liquids consistency, large portion protein per meal. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's COC Evaluation, dated 5/15/2025 at 10:20 p.m., the COC Evaluation indicated Resident 1pocketing food when eating. Family Member (FM) 1 indicated Resident 1 having difficulty swallowing his food. Resident 1 pockets the food in his mouth. The MD was notified on 5/15/2025 at 7 p.m. with orders for speech and swallow evaluation, calorie count for 7 days. During a review of Resident 1's Physician Order Summary Report, dated 5/15/2025, the Physician Order Summary Report indicated a physician's order for Speech and swallow evaluation in the morning. During a review of Resident 1's care plan created on 5/16/2025, the care plan for difficulty swallowing indicated interventions of speech and swallow evaluation, calorie count for 7 days and to call MD for changes in Resident 1's conditions. During a review of Resident 1's Progress Notes dated 5/16/2025 at 2:17 p.m., the Progress Notes indicated continued monitoring for difficulty swallowing. Resident 1 is noted with some difficulty swallowing meals. During a review of Resident 1's Progress Notes dated 5/17/2025 at 1:26 p.m., the Progress Notes indicated Resident 1 is on monitoring for difficulty swallowing and pocketing the food in his mouth, still noted. During a review of Resident 1's Progress Notes dated 5/18/2025 at 1:23 p.m., the Progress Notes indicated Resident 1 is on monitoring for difficulty swallowing and pocketing the food in his mouth, still noted. During a review of Resident 1's COC Evaluation dated 5/24/2025 at 10:09 a.m., the COC Evaluation indicated Resident 1 noted slowly declining in mobility, unable to feed to sit in Resident 1's wheelchair. During a review of Resident 1's Progress Notes dated 5/24/2025 at 1:13 p.m., the Progress Notes indicated Resident 1 was transferred to GACH 1 at 12:14 p.m. due to fever, decline in Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily), and unable to eat, coughing and pocketing food. During an interview on 6/3/2025 at 12p.m. with the Restorative Nursing Assistant (RNA) 1, RNA 1 stated on Saturday 5/24/2025 prior to Resident 1 being discharged to GACH 1, RNA 1 attempted to feed Resident 1 pureed eggs and oatmeal and Resident 1 began to choke on the food. RNA 1 stated she reported to the nurse not sure who the nurse was, but Resident 1 was discharged shortly after that. During an interview on 6/3/2025 at 12:31 p.m. with the Director of Rehab (DOR), the DOR stated have not had an ST in the facility since the beginning of May. The DOR stated if a resident requires ST, we will downgrade their diet and then send out the resident to the hospital if needed. The DOR stated last day of ST in the building was 5/5/2025. The DOR stated Resident 1 did not get the ST evaluation as ordered because the facility did not have an ST at that time. The DOR stated informed the Director of Nursing (DON), if Resident 1 was pocketing food or having signs of choking needed to be sent out to hospital this was during a clinical meeting with all department heads not sure of the date. (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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2025 at 12:36 p.m. with the DOR, the DOR stated Resident 1 was ordered to have ST three times a week for four weeks but since the ST resigned Resident 1 was discharged from ST. The DOR stated Resident 1 did not meet his goals, Resident 1 was discharged from ST because we could not provide the ST services for Resident 1. The DOR stated is not sure if the MD was notified that Resident 1 was not able to get ST eval as ordered by MD. The DOR stated the one to contact the MD would have been nursing. During a concurrent interview and record review on 6/3/2025 at 1:22 p.m. of Resident 1's progress notes with the DON, the DON stated there was no notification to MD regarding not having an ST in the building. The DON stated based on timesheet the ST last day was on 5/5/2025 and Resident 1 was ordered an ST eval on 5/15/2025. The DON stated knew that Resident 1 needed to transfer out if there was no ST within 7 days. The DON stated Resident was discharged to GACH 1 on 5/24/2025, 9 days after ST eval order. The DON stated does not think Resident 1 had a lot of pocketing of food. The DON reviewed progress notes dated 5/16/2025 through 5/24/2025 the DON stated the progress notes indicates that Resident 1 was still pocketing food and had difficulty swallowing. The DON stated there is a potential for weight loss and potential for aspiration if Resident 1 is pocketing food. The DON stated as a SNF we should be able to provide ST and with no ST there is a potential we cannot provide the right services and treatment and there can be a delay in treatment. During a review of the facility's Policy and Procedure (P&P) titled, Specialized Rehabilitative Services, last revised on 4/2025, the P&P indicated our facility will provide Rehabilitative Services to residents as indicated by the MDS. 2. Specialized Rehabilitative Services include the following: b. Speech Pathology/Audiology; 3. Therapeutic Services are provided only upon the written order of the resident's Attending Physician. During a review of the facility's P&P titled, Changes in Resident Condition, last revised on 4/2025, the P&P indicated the resident, attending physician and legal representative or interested family member are notified when changes in condition or certain events occur. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

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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. Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices for one of three sampled residents (Resident 1) when: 1. The facility failed to accurately document on Resident 1's medication administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for calorie count for seven days. 2. The facility failed to accurately document Resident 1's Calorie Count. These deficient practices resulted in inaccurate documentation of Resident 1's records. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2024 and readmitted the resident on 3/19/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, often affecting one arm, leg, and sometimes the face) following cerebral infarction (a brain attack where part of the brain's blood supply is blocked or severely reduced) affecting the right dominant side, dysphagia (difficulty swallowing) oropharyngeal (anything related to the middle part of the throat), dementia (a progressive state of decline in mental abilities), and depression (a common mental health condition that causes persistent sadness, loss of interest in activities, and changes in how you think, feel, and act). During a review of Resident 1's care plan created on 3/5/2025, the care plan for nutritional problem or potential nutritional problems indicated intervention to monitor, document, and report as needed any sign and or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, and to provide and serve supplements as ordered. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required substantial to maximum assistance (helper does more than half the effort) with toileting, showering, upper and lower body dressing and putting on and taking off footwear and required partial to moderate assistance (helper does less than half the effort) with oral hygiene, and personal hygiene. During a review of Resident 1's Physician Order Summary Report, dated 5/15/2025, the Physician Order Summary Report indicated a physician's order for calorie count for seven (7) days. During a review of Resident 1's MAR for 5/2025 for calorie count for seven days, there was no indication of it being signed off by staff. During a review of Resident 1's Calorie Count, the Calorie Count indicated on: - 5/21/2025 for lunch ate 0 percent (%-a way of expressing a number as a fraction of 100). (continued on next page)

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	06/03/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/21/2025 for dinner ate 25% - 5/22/2025 for dinner ate 50% - 5/23/2025 for lunch at 50% - 5/23/2025 for dinner was left blank. During a review of Resident 1's Meal Intake for May 2025, the Meal Intake indicated on: - 5/21/2025 for lunch ate 26 to 50% - 5/21/2025 for dinner refused to eat. - 5/22/2025 for dinner refused to eat. - 5/23/2025 for lunch ate 76-100% - 5/23/2025 for dinner at 76-100% During a concurrent interview and record review of Resident 1's Meal Intake, Calorie Count and MAR with the Director of Nursing (DON), the DON reviewed the Meal Intake with the Calorie Count and the DON stated should match and is not accurate. The DON stated for 5/21 it indicates Resident 1 ate 26 to 50% but the Calorie Count is documented as 0% for lunch and for dinner on 5/21 it indicates Resident refused but the Calorie Count indicates 25%. The DON reviewed Resident 1's MAR for 5/2025, the DON stated the calorie count for the seven days was not documented. The DON stated the MAR should have been checked off and initialed by the license staff, it needs to be signed and checked off indicating staff have done the task. The DON stated cannot validate the task was done. The DON stated the Meal Intake and Calorie Count should match for accuracy of records. The DON stated there is a potential for not being able to provide the right interventions and inconsistency. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, last revised on 4/2025, the P&P indicated the following information is to be documented in the resident medical record: c. treatments or services performed. 3. Documentation in the medical record will be objective, complete, and accurate.