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	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacLay Healthcare Center	12831 MacLay Street Sylmar, CA 91342

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to completely investigate two resident-to-resident allegations of physical abuse for four of five sampled residents (Residents 1, 2, 3 and 4) by: 1. Failing to interview or obtain a written witness statement from Licensed Vocational Nurse 2 (LVN 2) and Certified Nursing Assistant 2 (CNA 2) who were assigned to Resident 1.2. Failing to interview or obtain a written witness statement from LVN 1 and CNA 5 who were assigned to Resident 2.3. Failing to interview or obtain a written witness statement from CNA 4 who was assigned to Resident 3.4. Failing to interview or obtain a written witness statement from LVN 4 and CNA 3 who were assigned to Resident 4.These failures resulted in incomplete investigation and had the potential to result in unidentified abuse in the facility and had the potential failure to protect residents from abuse.Findings:a. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 9/19/2016, with diagnoses that included other encephalopathy (a disturbance of brain function), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and generalized muscle weakness.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 1's Change of Condition Evaluation (CIC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 2/15/2026, the CIC indicated Resident 1 received physical contact from Resident 2. The CIC indicated Registered Nurse 1 (RN 1) witnessed and separated Resident 1 from Resident 2 and performed head-to-toe assessment with no pain and injuries.During an interview on 3/3/2026, at 12:41 p.m., with the Director of Staff Development (DSD), the DSD stated on 2/15/2026, RN 1, LVN 2 and CNA 2 were assigned to Resident 1.During a concurrent interview and record review on 3/3/2026, at 12:59 p.m., with the Director of Nursing (DON), of facility's submitted untitled document (Staff Interview), dated 2/15/2026, was reviewed. The DON stated the untitled document were the staff interviews. The DON stated when they investigate allegations of abuse, the facility interviews the staff and documents it or the staff write their own statements. The DON stated the Staff Interviews indicated statements from RN 1, two clinical students and one clinical instructor. The DON stated there were no staff statements from LVN 2 and CNA 2 who were assigned to Resident 1.b. During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 9/27/2025, with diagnoses that included end stage renal disease (ESRD- -irreversible kidney failure), unspecified chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and essential hypertension (HTN-high blood pressure).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were intact.During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/28/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's CIC, dated 2/15/2026, the CIC indicated RN 1 witnessed Resident 2 made (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physical contact with Resident 1 and separated Residents 1 and Resident 2 and assessed Resident 2 with no pain and injury.During a review of facility's Five-Day Investigation Summary, dated 2/19/2026, the Five-Day Investigation Summary indicated staff witnessed statements were reviewed.During an interview on 3/3/2026, at 12:41 p.m., with the DSD, the DSD stated on 2/15/2026, RN 1, LVN 1 and CNA 5 were assigned to Resident 2.During a concurrent interview, and record review on 3/3/2026, at 12:59 p.m., with the DON, the facility's submitted untitled document (Staff Interview), dated 2/15/2026, was reviewed. The DON stated the untitled document were the staff interviews. The DON stated the Staff Interviews indicated statements from RN 1, two clinical students and one clinical instructor. The DON stated there were no staff statements from LVN 1 and CNA 5 who were assigned to Resident 2.c. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 3/6/2020, with diagnoses that included other acute kidney failure (a sudden, often reversible, loss of kidney function occurring within hours or days), difficulty in walking and generalized weakness.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decisions were intact.During a review of Resident 3's H&P, dated 1/21/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's CIC, dated 2/16/2026, the CIC indicated on 2/16/2026, at 2:15 p.m., Resident 3 maneuvered his electric motorized wheelchair (battery-powered mobility devices steered via a joystick, designed for individuals with limited strength or endurance) in the activity room and Resident 3's wheelchair made contact with Resident 4's wheelchair. The CIC indicated Resident 4 turned, extended his (Resident 4) arm toward Resident 3 and made physical contact. The CIC indicated staff intervened and separated the two residents, body assessment was done with no visible injury and denied pain. During an interview on 3/3/2026, at 10:14 a.m., with CNA 4, CNA 4 stated on 2/16/2025, she (CNA 4) was assigned to Resident 3. CNA 4 stated the incident happened in the activity room and she (CNA 4) was with another resident when the incident happened between Resident 3 and Resident 4.During an interview on 3/3/2026, at 10:39 a.m., with LVN 3, LVN 3 stated on 2/16/2026, at 2:15 p.m., she (LVN 3) was at Station 200 when she (LVN 3) was informed that her (LVN 3) resident (Resident 3) hit Resident 4 in the right shoulder. During an interview on 3/3/2026, at 12:41 p.m., with the DSD, the DSD stated on 2/16/2026, RN 1, LVN 3 and CNA 4 were assigned to Resident 3. During a concurrent interview and record review on 3/3/2026, at 12:59 p.m., with the DON, of facility's submitted untitled document (Staff Interview), dated 2/15/2026, was reviewed. The DON stated the untitled document were the staff interviews. The DON stated the Staff Interviews indicated statement from LVN 3. The DON stated there were no staff statement from CNA 4 who were assigned to Resident 3.d. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 6/2/2025, with diagnoses that included acute embolism (a life-threatening, sudden blockage in a lung artery, usually caused by a blood clot) and thrombosis (the dangerous formation of a blood clot inside a vein or artery, obstructing blood flow) of unspecified deep vein of the left lower extremity and essential hypertension.During a review of Resident 4's H&P, dated 6/6/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's CIC, dated 2/16/2026, the CIC indicated on 2/16/2026, at 2:15 p.m., Resident 4 extended his (Resident 4) arm toward Resident 3 and made physical contact. The CIC indicated staff intervened and separated the two residents. The CIC indicated Resident 3 hit Resident 4's left knee on the table. The CIC indicated RN 1offered pain medication but Resident 4 refused. The CIC indicated RN 1 assessed Resident 4 and had no visible injuries present.During an interview on 3/3/2026, at 10:23 a.m. with LVN 4. LVN 4 stated he (LVN 4) was assigned to Resident 4 but was not in the activity room when it happened. LVN 4 stated RN 1 just informed him (LVN 4) of the incident. LVN 4 stated he (LVN 4) had checked Resident 4 and had no pain and injury.During an interview on 3/3/202,6 at 10:52 a.m. with the Activity Director (AD), the AD stated on 2/16/2026, Activity Staff 1 (AS 1) reported that Resident 4's wheelchair bumped into Resident 3's wheelchair while in the activity room. The AD stated that was all AS 1 had (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	witnessed.During an interview on 3/3/2026, at 12:41 p.m., with the DSD, the DSD stated on 2/16/2026, RN 1, LVN 4 and CNA 3 were assigned to Resident 4.During a concurrent interview, and record review on 3/3/2026, at 12:59 p.m., with the DON, of facility's submitted untitled document (Staff Interview), dated 2/15/2026, was reviewed. The DON stated the untitled document were the staff interviews. The DON stated the Staff Interviews indicated no staff statements were documented. The DON stated there were no staff statements from LVN 4 and CNA 3 who were assigned to Resident 4.During a concurrent interview and record review on 3/3/2026, at 1:10 p.m., with the DON, facility's policy and procedure titled, Abuse Investigation and Reporting, undated and last reviewed on 4/2025, the P&P indicated, The individual conducting the investigation as a minimum: .h. interviews staff members (on all shifts) who have had contact with the residents during the period of the alleged incident;i. interviews the resident's roommate, family members, and visitors; .k. reviews all events leading up to the alleged incident; [NAME]. documents the investigation completely and thoroughly.9. The following guidelines are used when conducting interviews: . d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. The DON stated based on the facility's policy, the investigation was not complete.During an interview on 3/3/2026, at 1:18 p.m., with the Administrator (ADM), the ADM stated the allegation of abuse on 2/15/2026, and 2/16/2026, the ADM had interviewed RN 1 and AS 1. The ADM stated she (ADM) did not interview the assigned staff for Residents 1, 2, 3, and 4. The ADM stated she (ADM) should have interviewed the assigned staff to make sure all information was obtained and to verify information was all correct and not to miss any details of the incident. The ADM stated Residents 1, 2, 3 and 4 had incomplete investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 2) by failing to develop a care plan on Resident 2's refusal for medication. This failure had the potential for delays in the delivery of necessary care and services to Resident 2.Findings:During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 9/27/2025, with diagnoses that included end stage renal disease (ESRD -irreversible kidney failure), unspecified chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and essential hypertension (HTN-high blood pressure).During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 2's Physician Order, dated 1/23/2026, the Physician Order indicated Lokelma (medication used to treat high potassium levels) oral packet 10 grams, give one packet by mouth daily every Wednesday, Friday and Sunday for hyperkalemia (a serious condition characterized by elevated potassium levels in the blood, it can cause muscle weakness, numbness, tingling, nausea, and life-threatening heart arrhythmias [irregular heart beat]).During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/28/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Medication Administration Record (MAR), dated 2/2026, the MAR indicated on 2/1/2026, Resident 2 refused the medication.During a concurrent interview, and record review on 3/3/2026, at 10:59 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order, dated 1/23/2026, MAR, dated 2/1/2026, and Care Plans, were reviewed. The ADON stated there was no care plan developed for Resident 2's refusal of Lokelma. The ADON stated Licensed Vocational Nurse 5 (LVN 5) should have notified the physician of resident 2's refusal and document Resident 2's refusal. The ADON stated Lokelma is to use for hyperkalemia. The ADON stated if there were no care plan for Resident 2's refusal of Lokelma, there would be no intervention to correct the hyperkalemia and could potentially cause further increase in Resident 2's potassium level.During an interview on 3/2/2026, at 11:54 a.m., with the DON, the DON stated care plan should have been developed for Resident 2's refusal of medication. The DON stated care plan should have been developed to create a new treatment plan to prevent further elevation of potassium. The DON stated without a care plan Resident 2's hyperkalemia might not be corrected.During a review of facility's policy and procedure (P&P), titled, Comprehensive Care Plan, undated and last reviewed on 4/2025, the P&P indicated, The facility develops a Comprehensive Care Plan (CCP) for each resident to ensure individualized, resident-centered care that addresses medical, psychosocial, functional, and safety needs. The CCP is developed by the Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together) and updated regularly based on resident conditions and preferences.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 accurate and complete medical record for one of five sampled residents (Resident 1) by failing to accurately document medication administrations. Licensed Vocational Nurse 6 (LVN 6) and LVN 7 documented administration of medication in Resident 1's Medication Administration Record (MAR), from 2/17/2026, to 2/19/2026, even when Resident 1 was in General Acute Care Hospital (GACH) from 2/15/2026, at 7:20 p.m., to 2/19/2026, at 3:02 p.m.These failures had the potential to result in medication errors, cause confusion in care and the medical records containing inaccurate documentation.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 9/19/2016, with diagnoses that included other encephalopathy (a disturbance of brain function), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and generalized muscle weakness.During a review of Resident 1's Physician Order, dated 6/6/2025, the Physician Order indicated the following:1. Atorvastatin calcium (medication used to lower bad cholesterol) oral tablet 40 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth at bedtime for hyperlipidemia (an excess of lipids or fats in the blood).2. Levothyroxine sodium (replacement therapy for underactive thyroid to normalize low hormone levels) oral tablet 25 micrograms (mcg- unit of measurement for weigh), give one tablet by mouth in the morning for hypothyroidism (the thyroid gland, located in the neck, is underactive and does not produce enough thyroid hormones).3. Docusate sodium capsule (stool softener used to relieve occasional constipation) 100 mg, give one capsule by mouth two times a day for bowel management, hold for loose (watery) stools.4. Ferrous Sulfate (supplement used to treat and prevent iron deficiency anemia by replenishing iron levels required for red blood cell production) oral tablet, 325 mg, give one tablet by mouth two times a day for supplement.5. Lubiprostone (medication used to treat chronic idiopathic constipation [a persistent, functional gastrointestinal disorder defined by, or more, difficult, or incomplete bowel movements for at least three months without an underlying organic cause]), oral capsule 24 mcg, give one capsule by mouth two times a day for constipation, hold for loose stools.6. Pantoprazole sodium (medication used to treat certain conditions in which there is too much acid in the stomach) oral tablet delayed released 40 mg, give one tablet by mouth two times a day for gastritis (inflammation of the stomach lining).During a review of Resident 1's Physician Order, dated 1/14/2026, the Physician Order indicated quetiapine fumarate (medication used to treat insomnia (common, persistent sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early, resulting in poor sleep quality) tablet 25 mg, give one tablet by mouth at bedtime for mood stabilizer manifested by verbalization feelings of highs and lows.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 1's Physician Order, dated 2/19/2026, the Physician Order indicated senna (medication used to relieve occasional constipation in adults and children) oral tablet 8.6 milligram, give two tablets by mouth at bedtime for bowel management, hold if loose stool.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 2/2026, the MAR indicated LVN 6 administered the following medications on the following dates and times:1. Atorvastatin on 2/17/2026, at 9 p.m.2. Quetiapine on 2/17/2026, at 9 p.m.3. Senna on 2/17/2026, at 9 p.m.4. Docusate on 2/17/2026, and 2/18/2026, at 5 p.m.5. Ferrous on 2/17/2026, and 2/18/2026, at 5 p.m.6. Pantoprazole on 2/17/2026, at 5 p.m.7. Lubiprostone on 2/18/2026, at 6 p.m.During a review of Resident 1's MAR, dated 2/2026, the MAR indicated LVN 7 administered the following medications on the following dates and times:1. Levothyroxine on 2/18/2026, and 2/19/2026, at 6:30 a.m.2. Pantoprazole on 2/18/2026, and 2/19/2026, at 6:30 a.m.During a review of Resident 1's Change of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Condition Evaluation (CIC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 2/15/2026, the CIC indicated Resident 1 received physical contact from Resident 2. The CIC indicated Registered Nurse 1 (RN 1) witnessed and separated Resident 1 from Resident 2 and performed head to toe assessment with no pain and injuries. The CIC indicated the physician ordered to transfer Resident 1 to GACH for further evaluation.During a review of Resident 1's Progress Notes, dated 2/15/2026, timed at 7:25 p.m., the Progress Notes indicated on 2/15/2026 at 7:20 p.m., the facility transferred Resident 1 to GACH.During a review of Resident 1's Progress Notes, dated 2/19/2026, timed at 3:02 p.m., the Progress Notes indicated the facility readmitted Resident 1 from GACH.During a concurrent interview, and record review on 3/3/2026, at 10:59 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Physician Orders, dated 6/6/2025, 1/14/2026, and 2/19/2026, MAR, dated 2/2026, Progress Notes, dated 2/15/2026 to 2/19/2026, were reviewed. The ADON stated Resident 1 was at GACH from 2/15/2026, to 2/19/2026. The ADON stated while Resident 1 was at GACH, LVN 6 documented administration of the following medications on the following dates and times:1. Atorvastatin on 2/17/2026, at 9 p.m.2. Quetiapine on 2/17/2026, at 9 p.m.3. Senna on 2/17/2026, at 9 p.m.4. Docusate on 2/17/2026, and 2/18/2026, at 5 p.m.5. Ferrous on 2/17/2026, and 2/18/2026, at 5 p.m.6. Pantoprazole on 2/17/2026, at 5 p.m.7. Lubiprostone on 2/18/2026, at 6 p.m.During a concurrent interview and record review on 3/3/2026, at 11:15 a.m., with the ADON, Resident 1's Physician Orders, dated 6/6/2025, MAR, dated 2/2026, Progress Notes, dated 2/15/2026 to 2/19/2026, were reviewed. The ADON stated Resident 1 was at GACH from 2/15/2026 to 2/19/2026. The ADON stated while Resident 1 was at GACH, LVN 7 documented administration of levothyroxine and pantoprazole on 2/18/2026, and 2/19/2026, at 6:30 a.m. The ADON stated LVN 6 and LVN 7 should check Resident 1's name identifier to make sure they are administering medication to the right resident. The ADON stated LVN 6 and LVN 7 should make sure Resident 1 was at the facility before medication administration. The ADON stated Resident 1's medical record was inaccurate.During an interview on 3/3/2026, at 11:54 a.m., with the Director of Nursing DON, the DON stated LVN 6 and LVN 7 should not document administration of medication when Resident 1 was at GACH. The DON stated nurses should be paying attention to prevent inaccurate documentation. The DON stated nurses should have documented medication not given since Resident 1 was not at the facility. The DON stated Resident 1's medical record was inaccurate and could cause confusion in care.During a review of facility's policy and procedure (P&P), titled, Charting and Documentation Policy, undated and last reviewed on 4/2025, the P&P indicated, All resident care, assessments, medications, treatments, and changes in condition must be documented in the medical record promptly, accurately, and according to facility and regulatory requirements. Document care at the time it is provided or immediately afterward.