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	04/14/2026

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. Based on interview and record review, the facility failed to notify the physician promptly (acting immediately, without delay, or exactly at a scheduled time) for one of three sampled residents (Resident 3) when Resident 3 had reported that she (Resident 3) had constipation (when the bowel movements become less frequent and stools become difficult to pass).This failure had potential for delay in the delivery of necessary care and services and had the potential for increased risk of abdominal discomfort and pain to Resident 3.Findings:During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 2/10/2026, with diagnoses that included other acute kidney failure (often called Acute Kidney Injury [AKI], is a sudden, temporary loss of kidney function, often within hours or days), other pulmonary embolism (a medical emergency caused by a blood clot getting stuck in a lung artery [thick, muscular blood vessels that carry oxygen-rich blood away from the heart to the rest of the body] blocking blood flow) with acute cor pulmonale (the sudden, rapid failure of the right side of the heart caused by a severe lung issue, such as a large blood clot) and history of fall.During a review of Resident 3's Physician Order, dated 2/10/2026, the Physician Order indicated the following:1. Naloxegol oxalate (medication used to treat opioid-induced constipation [OIC] in adults with chronic, non-cancer pain) oral tablet 25 mg, give one tablet by mouth daily for constipation.2. Polyethylene Glycol (medication used to treat constipation and for bowel preparation) 3350 powder, give 17 grams by mouth daily for constipation. During a review of Resident 3'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 2/11/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 3 needed maximum assistance from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 3 was always incontinent (unable to control) of bowel functions.During a review of Resident 3's MAR, dated 4/2026, the MAR indicated nurses administered naloxegol and polyethylene glycol to Resident 3 daily.During an interview on 4/13/2026, at 9:17 a.m., with Resident 3, Resident 3 stated she (Resident 3) had constipation and had not had a bowel movement for 13 days. Resident 3 stated she (Resident 3) had notified the nurses, but no new medication was administered.During a review of Resident 3's Bowel Elimination Task dated 3/15/2026, to 4/13/2026, the Bowel Elimination Task indicated Resident 3 did not have bowel movement on the following dates: 3/15/2026, 3/19/2026, 4/2/2026, 4/6/2026, 4/9/2026, 4/12/2026, and 4/13/2026. During an interview on 4/13/2026, at 1:48 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 3 complained of constipation all the time. LVN 1 stated the last time Resident 3 verbalized constipation was last week (LVN 1 unable to remember exact date), and she (LVN 1) had notified her (Resident 3) that she (Resident 3) was already on naloxegol and polyethylene glycol daily for constipation. LVN 1 stated she (LVN 1) did not report to the Registered Nurse Supervisor (RNS) and did not call and notify the physician. LVN 1 stated she should have reported to (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the RNS and should have called the physician to obtain an additional medication to relieve constipation. LVN 1 stated Resident 3'c constipation can worsen and could affect her (Resident 3)'s mood.During an observation on 4/14/2026, at 5:15 a.m., inside Resident 3's room, Observed Registered Nurse 2 (RN 2) talked to Resident 3 and heard Resident 3 asked RN 2 for enema (a medical procedure used to treat constipation, fecal impaction, [a severe form of constipation where a large, hard mass of stool gets stuck in the rectum or lower colon] or prepare the bowels for medical examination by injecting (introducing) liquid directly into the rectum.During an interview on 4/14/2026, at 5:16 a.m., with Resident 3, Resident 3 stated she (Resident 3) had requested enema a week ago, but it was not administered.During an interview on 4/14/2026, at 5:29 a.m., with LVN 2, LVN 2 stated Resident 3's last bowel movement was on 4/11/2026, and Resident 3 gets her (Resident 3) routine naloxegol and polyethylene daily for constipation. LVN 2 stated Resident 3 did not have any other medication ordered for constipation. LVN 2 stated Resident 3 informed her (LVN 2) that she (Resident 3) had an order for enema but there was no order on Resident 3's medical record. LVN 2 stated she (LVN 2) had reported to RN 2 of Resident 3's request for enema. LVN 2 stated Resident 3's could have pain and get uncomfortable due to constipation.During an interview on 4/14/2026, at 5:49 a.m., with RN 2, RN 2 stated she (RN 2) was informed of Resident 3's not having a bowel movement for 13 days. RN 2 stated LVN 2 reported that Resident 3 needed something to relieve her (Resident 3) constipation but there was no as needed (PRN) medication. RN 2 stated if there was no PRN medication she (RN 2) should have notified the physician. RN 2 stated she (RN 2) had texted (the act or activity of sending text messages from one cell phone to another) the physician on 4/14/2026, at 1:30 a.m., using the RN phone and the physician had not replied. RN 2 stated today 4/14/2026, at 5:20 a.m., Resident 3 spoke to her (RN 2) and requested enema. RN 2 stated she (RN 2) had not yet documented that she (RN 2) had texted the physician. RN 2 stated Resident 3 can get moody, upset, frustrated and get abdominal pain and discomfort from constipation.During a concurrent interview and record review on 4/14/2026 at 6:19 a.m., with RN 2, RN cellphone text messages dated 4/14/2026, were reviewed. The text message indicated the following:1. on 4/14/2026, at 6:04 a.m. RN 2 send a text message to Physician's first number.2. On 4/14/2026, at 6:05 a.m., RN 2 send a text message to Physician's alternate second number.RN 2 stated the facility only has one RN cordless phone. RN 2 stated there was no documented evidence that she (RN 2) had notified the physician of Resident 3's concern on constipation on 4/14/2026, at 1:30 a.m. RN 2 stated that delay in physician notification can delay treatment. RN 2 stated there was no CIC documented for Resident 3's constipation. RN 2 stated she (RN 2) did not create a CIC for Resident 3's constipation.During an interview on 4/14/2026, at 7:01 a.m., with the DON, the DON stated when Resident 3 mentioned that she (Resident 3) had not had a bowel movement for 13 days, a CIC should have been created, physician should have been notified and obtain order for PRN medication for constipation, whether Resident 3's complaint was through or not. The DON stated RN 2 should have created the CIC for constipation. The DON stated not notifying the physician delayed the care needed by Resident 3. The DON stated delay in medication to relieve constipation could result in abdominal discomfort, nausea and affect Resident 3's sleep.During a review of facility's policy and procedure (P&P) titled, Change in Condition, undated and last reviewed on 4/24/2025, the P&P indicated, The facility will promptly recognize, assess, and respond to any change in a resident's physical, cognitive, or emotional condition to ensure timely medical intervention and maintain resident safety.1. Recognition a. All staff must observe and report any changes in resident status, including but not limited to: i. Vital signs ii. Mental status or behavior iii. Skin changes, wounds, or pressure injuries iv. Appetite, hydration, or intake changes v. Mobility or functional ability.2. Immediate Action a. Licensed nursing staff shall assess the resident promptly. b. Notify the physician or authorized practitioner according to seve1ity and facility protocol. c. Implement immediate interventions as needed to stabilize the residents.3. Documentation a. Document the change, assessment, interventions, and provider notifications in the electronic health record or medical record. b. Include date, time, and staff signature.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, 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 3) by failing to:1. Implement Resident 3's care plan on monitoring for anticoagulant therapy (often called blood thinners, medication used to reduce the risk of dangerous blood clots forming in blood vessels or the heart) side effects (an unintended, often unpleasant reaction to medication, treatment, or procedure that occurs alongside its intended purpose).2. Implement Resident 3's care plan for constipation (a condition in which stool becomes hard, dry, and difficult to pass, and bowel movements do not happen very often).3. Develop a care plan for Resident 3 that indicates use of bilateral landing mat (a thick, cushioned, foldable gym mat designed to safely absorb the impact of landing) as ordered by the physician.These failures had the potential for delays in the delivery of necessary care and services and could place Resident 3 at risk for bleeding, constipation and injury.Findings:During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 2/10/2026, with diagnoses that included other acute kidney failure (often called Acute Kidney Injury [AKI], is a sudden, temporary loss of kidney function, often within hours or days), other pulmonary embolism (a medical emergency caused by a blood clot getting stuck in a lung artery [thick, muscular blood vessels that carry oxygen-rich blood away from the heart to the rest of the body] blocking blood flow) with acute cor pulmonale (the sudden, rapid failure of the right side of the heart caused by a severe lung issue, such as a large blood clot) and history of fall.During a review of Resident 3'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 2/11/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 3 needed maximum assistance from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 3 was always incontinent (unable to control) of bowel functions.a. During a review of Resident 3's Physician Order, dated 2/10/2026, the Physician Order indicated apixaban (blood thinner/anticoagulant medication used to prevent and treat dangerous blood clots) oral tablet five milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for pulmonary embolism/deep vein thrombosis (DVT- a blood clot that forms in a deep vein, usually in the leg or arm).During a review of Resident 3's Care Plan dated 2/16/2026, on anticoagulant therapy, the Care Plan indicated the following interventions:1. Monitor for side effects and effectiveness.2. Monitor/document/report adverse reactions (an unexpected, harmful, or unpleasant response to a medication or treatment, occurring even at normal doses) of anticoagulant therapy: blood tinged (a small amount of blood mixed in) or red blood in urine, black tarry stools (indicate bleeding in the upper digestive tract, such as the stomach or esophagus) dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (a state of having very little energy, feeling sluggish, tired, or unmotivated), bruising.During a review of Resident 3's Medication Administration Record (MAR-flowsheet that indicates medications given to a resident), dated 4/2026, the MAR indicated Resident 3 received apixaban two times a day at 9 a.m., and 5 p.m. from 4/1/2026, to 4/13/2026.During a concurrent interview and record review on 4/14/2026, at 7:01 a.m., with the Director of Nursing (DON), Resident 3's Physician Order, dated 2/10/2026, and MAR, dated 4/2026, were reviewed. The DON stated apixaban is an anticoagulant that had a side effect of bleeding and bruising. The DON stated Resident 3 who was on apixaban should be monitored for bleeding every shift and monitoring (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be documented in Resident 3's MAR. The DON stated there was no documented monitoring for the side effect of apixaban.During a concurrent interview and record review on 4/14/2026, at 7:10 a.m., with the DON, Resident 3's Care Plan, dated 2/16/2026, was reviewed. The DON stated Resident 3's Care Plan indicated an intervention to monitor side effects of apixaban. The DON stated the Care Plan for anticoagulant therapy monitoring was not followed.b. During a review of Resident 3's Physician Order, dated 2/10/2026, the Physician Order indicated the following:1. Naloxegol oxalate (medication used to treat opioid-induced constipation [OIC] in adults with chronic, non-cancer pain) oral tablet 25 mg, give one tablet by mouth daily for constipation.2. Polyethylene Glycol (medication used to treat constipation and for bowel preparation) 3350 powder, give 17 grams by mouth daily for constipation. During a review of Resident 3's Care Plan, dated 2/16/2026, for risk of constipation, the Care Plan indicated the following interventions:1. Medications as ordered.2. Monitor for effectiveness and report concerns to the physician for evaluation and review.During a review of Resident 3's MAR, dated 4/2026, the MAR indicated nurses administered naloxegol and polyethylene glycol to Resident 3 daily.During an interview on 4/13/2026, at 9:17 a.m., with Resident 3, Resident 3 stated she (Resident 3) had not had a bowel movement for 13 days. Resident 3 stated she (Resident 3) had notified the nurses, but no new medication was administered.During a review of Resident 3's Bowel Elimination Task dated 3/15/2026, to 4/13/2026, the Bowel Elimination Task indicated Resident 3 did not have bowel movement on the following dates: 3/15/2026, 3/19/2026, 4/2/2026, 4/6/2026, 4/9/2026, 4/12/2026, and 4/13/2026. During an interview on 4/13/2026, at 1:48 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 3 complaints of constipation all the time. LVN 1 stated the last time Resident 3 verbalized constipation was last week (LVN 1 unable to remember exact date), and she (LVN 1) had notified her (Resident 3) that she (Resident 3) was already on naloxegol and polyethylene glycol daily for constipation.During an observation on 4/14/2026, at 5:15 a.m., inside Resident 3's room, Observed Registered Nurse 2 (RN 2) talked to Resident 3 and heard Resident 3 asked RN 2 for enema (a medical procedure used to treat constipation, fecal impaction, [a severe form of constipation where a large, hard mass of stool gets stuck in the rectum or lower colon] or prepare the bowels for medical examination by injecting (introducing) liquid directly into the rectum.During an interview on 4/14/2026, at 5:16 a.m., with Resident 3, Resident 3 stated she (Resident 3) had requested enema a week ago, but it was not administered.During an interview on 4/14/2026, at 5:29 a.m., with LVN 2, LVN 2 stated Resident 3's last bowel movement was on 4/11/2026, and Resident 3 gets her (Resident 3) routine naloxegol and polyethylene daily for constipation. LVN 2 stated Resident 3 did not have any other medication ordered for constipation. LVN 2 stated Resident 3 informed her (LVN 2) that she (Resident 3) had an order for enema but there was no order on Resident 3's medical record. LVN 2 stated she (LVN 2) had reported to RN 2 of Resident 3's request for enema.During an interview on 4/14/2026, at 5:49 a.m., with RN 2, RN 2 stated LVN 2 reported that Resident 3 needed something to relieve her (Resident 3) constipation but there was no as needed (PRN) medication. RN 2 stated if there was no PRN medication she (RN 2) should have notified the physician. RN 2 stated there was no documented evidence that she (RN 2) had notified the physician of Resident 3's concern on constipation.During a concurrent interview and record review on 4/14/2026, at 7:10 a.m., with the DON, Resident 3's Care Plan, dated 2/16/2026, on at risk for constipation was reviewed. The DON stated Care Plan was not followed since the nurses did not notify the physician of Resident 3's constipation.c. During a review of Resident 3's Change in Condition (CIC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status) Evaluation, dated 2/26/2026, timed at 4:30 a.m., the CIC indicated Resident 3 slid of the bed in an attempt to go to the bathroom and found sitting on the floor. The CIC indicated the physician was notified at 4:45 a.m., and ordered bilateral landing pads, bed and wheelchair alarm (designed to prevent falls and wandering [to walk around slowly in a relaxed way or without any clear purpose or direction] by alerting caregivers when a high-risk patient attempts to leave their bed or chair).During a review of Resident 3's Care Plan, dated 2/26/2026, on at risk for fall (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and history of fall, the Care Plan indicated no bilateral landing pads.During a concurrent interview and record review on 4/14/2026, at 6:19 a.m. with RN 2, Resident 3's CIC, dated 2/26/2026, and Care Plans for fall were reviewed. RN 2 stated Resident 3 had a fall incident on 2/26/2026, and the physician ordered bilateral landing pads. RN 2 stated there were no bilateral landing pads in Resident 3's care plans. RN 2 stated since the physician ordered the bilateral landing pads, it should be in Resident 3's care plan to prevent fall. RN 2 stated care plans are list of care provided to resident to address problems like fall.During an interview on 4/14/2026, at 7:10 a.m. with the DON, the DON stated Resident 3's care plan for fall was not complete since the bilateral landing pads were not in the intervention to prevent fall. The DON stated care plans are the summary of care to be provided to the residents and care plans should be complete with interventions and care plans should be followed. During a review of facility's policy and procedure (P&P) titled, Comprehensive Care Plan, undated and last reviewed on 4/24/2025, the P&P indicated, The facility developed a Comprehensive Care Plan (CCP) for each resident to ensure individualized, resident-centered care that addresses medical, psychosocial, functional, and safety needs. To provide a structured framework for delivery, coordination, and evaluation of resident care, ensuring compliance. The CCP must include, but is not limited to:a. Resident identifiers, preferences, and goals,b. Medical diagnoses and treatment orders,c. Medication management.Implementation: All staff must follow the care plan to deliver resident-specific care.Review and revision: CCP must be reviewed at least quarterly and updated:a. After significant change in resident condition,b. Following hospitalization or major incident,c. When new interventions or goals are identified.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure the resident received care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 1) by failing to:1. Call the Wound Provider (WP) to obtain a physician wound care order and provide wound care treatment on 3/9/2026, to Resident 1's stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) from sacrococcyx (tailbone) extending to bilateral buttocks.2. Follow the WP order for wound treatment to right and left heel unstageable pressure ulcer (a severe wound where the true depth cannot be determined because it is completely covered by dead tissue) from 3/26/2026, to 3/31/2026.These failures had the potential for the development and worsening of Resident 1's pressure ulcers.Findings:a. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 2/2/2026, with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection), generalized muscle weakness and essential HTN (high blood pressure).During a review of Resident 1'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 2/4/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Physician Order, dated 2/6/2026, the Physician Order indicated clean sacrococcyx extending to bilateral buttocks with normal saline (prepared mixture of salt and sterile water), pat dry and apply Santyl (a prescription medication that removes dead tissue from chronic skin ulcers and severe burns to promote healing), calcium alginate (highly absorbent wound dressing), barrier cream (a protective shield for your skin) to periwound (skin area immediately surrounding a wound), cover with dry dressing daily and as needed for 30 days and reevaluate on 3/9/2026.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 1's Wound Assessment, dated 3/4/2026, the Wound Assessment indicated Resident 1 had stage 4 pressure ulcer on sacrococcyx extending to bilateral buttocks measuring 13.5 centimeter (cm-a metric unit of length) long, 11 cm wide and 3 cm deep. The Wound Assessment indicated the Wound Provider (WP) performed a debridement (surgical procedure to remove non-viable tissue) and ordered Santyl with calcium alginate daily and as needed.During a review of Resident 1's Physician Order, dated 3/10/2026, the Physician Order indicated clean sacrococcyx extending to bilateral buttocks with normal saline, pat dry and apply Santyl, calcium alginate, cover with dry dressing daily and as needed for 30 days and reevaluate on 4/9/2026.During a review of Resident 1's Treatment Administration Record (TAR- flowsheet that indicates treatment given to a resident), dated 3/2026, the MAR indicated no wound treatment administered to Resident 1's sacrococcyx pressure ulcer.During a concurrent interview and record review on 4/13/2026, at 12:06 p.m., with the Director of Nursing (DON), Resident 1's Physician Order, dated 2/6/2026, 3/10/2026, TAR, dated 3/2026, were reviewed. The DON stated there was no documented treatment provided to Resident 1's sacrococcyx stage 4 pressure ulcer on 3/9/2026. The DON stated Resident 1's pressure ulcer could worsen because treatment was not provided.During an interview on 4/14/2026, at 11:28 a.m. with Treatment Nurse 1 (TN 1), TN 1 stated the TN assigned on 3/9/2026, should have called the WP to renew order for stage 4 sacrococcyx pressure ulcer. TN 1 stated on 3/10/2026, she (TN 1) the order was not renewed so she (TN 1) called the WP and obtained an order for sacrococcyx pressure ulcer wound treatment. TN 1 stated if there was no documented treatment done on 3/9/2026, it means treatment not provided to Resident 1. TN 1 stated not providing wound treatment can delay Resident 1's wound healing.b. During a review of Resident 1's Physician Order, dated 3/4/2026, the Physician order indicated the following: 1. left heel unstageable pressure ulcer-cleans with normal saline, pat dry, apply iodosorb (topical (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[applied directly to a specific surface of the body] antiseptic [a germ-killing substance that you apply to your skin to prevent infection] gel/powder used to treat chronic [persisting for a long time], exuding [a fluid released through pores or a wound], and infected wounds), cover with dry dressing daily for 30 days. 2. right heel unstageable pressure ulcer-cleans with normal saline, pat dry, apply iodosorb, cover with dry dressing daily for 30 days.During a review of Resident 1's Wound Assessment, dated 3/25/2026, the Wound Assessment indicated the WP ordered betadine (used on the skin to treat or prevent skin infection) and dry dressing daily to bilateral heels. During a review of Resident 1's Physician Order, dated 3/25/2026, the Physician order indicated the following: 1. left heel unstageable pressure ulcer-cleans with normal saline, pat dry, apply betadine, cover with dry dressing daily for 30 days. 2. right heel unstageable pressure ulcer-cleans with normal saline, pat dry, apply betadine, cover with dry dressing daily for 30 days.During a review of Resident 1's Care Plan, dated 2/3/2026, on left and right heel unstageable pressure ulcer, the Care Plan indicated a new intervention dated 3/25/2026, to clean left heel unstageable pressure ulcer with normal saline, apply betadine, cover with dry dressing daily for 30 days.During a review of Resident 1's Treatment Administration Record (TAR-), dated 3/2026, the TAR indicated from 3/26/2026, to 3/31/2026, nurses administered betadine and iodosorb daily to Resident 1's heels with unstageable pressure ulcer.During a concurrent interview and record review on 4/13/2026, at 12:06 p.m., with the DON, Resident 1's Physician Order, dated 3/25/2026 and TAR, dated 32026, were reviewed. The DON stated TNs should have called the WP and clarified which order to continue since there was a prior order of iodosorb on 3/4/2026, and on 3/25/2026, a new order was added for betadine to bilateral heels. The DON stated there could be a possible drug interaction (a situation where a substance, another drug, food, beverage, or supplement alters the effectiveness or safety of a medication) between betadine and iodosorb and could be too overpowering (too strong) for Resident 1's skin.During an interview on 4/14/2026, at 11:28 a.m., with TN 1, TN 1 stated Resident 1 had betadine and iodosorb applied to bilateral heels from 3/26/2026, to 3/31/2026. TN 1 stated the order was clarified on 4/1/2026, and the WP only ordered the betadine and discontinued the iodosorb. TN 1 stated wound care order should have been clarified on 3/25/2026, when the WP was at the facility. TN 1 stated multiple wound treatment might not be effective and can delay wound healing.During a review of facility's policy and procedure (P&P) titled, Pressure Ulcer Management, Treatment and Prevention, undated and last reviewed on 4/24/2025, the P&P indicated, The facility is committed to the prevention, early identification, and effective treatment of 1nessure ulcers (pressure injuries) in all residents.Treatment and Care: .1. Develop an individualized care plan for each resident with pressure ulcers.2. Clean wounds using appropriate solutions and techniques per facility and providerguidelines.3. Apply dressings as ordered, ensuring correct type and frequency of change.4. Monitor for signs of infection, necrosis, or delayed healing.5. Consult wound care specialists, physician, or dermatologist as needed.During a review of facility's policy and procedure (P&P) titled, Wound Documentation Policy, undated and last reviewed on 4/24/2025, the P&P indicated, Ongoing Wound Documentation:Licensed nurse to document: 1. At each treatment and dressing change. 3. Ensure documentation matches Treatment Administration Record (TAR).Care Plan: Interventions must reflect: 1. Pressure relief/offloading 2. Nutrition/hydration support 3. Wound treatment orders.

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	04/14/2026

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. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Residents 1) by failing to follow physician's order to administer hydralazine (medication used to treat high blood pressure [HTN]) for systolic blood pressure (sbp-measures the pressure the blood is pushing against the artery walls when the heart beats) above 110 millimeter mercury (mmHg- the standard unit of measurement used to record blood pressure, indicating how much force the blood exerts against artery walls).This failure had the potential to result in medication errors and could cause to Resident 1's uncontrolled hypotension (low blood pressure).Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 2/2/2026, with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection), generalized muscle weakness and essential HTN.During a review of Resident 1's Physician Order, dated 2/2/2026, the Physician Order indicated hydralazine hydrochloride oral tablet 25 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give 50 mg by mouth three times a day for HTN, hold for sbp less than 110 mmHg.During a review of Resident 1'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 2/4/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 4/2026, the MAR indicated the following on 4/10/2026:1. Licensed Vocational Nurse 3 (LVN 3) administered hydralazine to Resident 1 with a blood pressure of 107/68 mmHg at 1 p.m.2. LVN 4 administered hydralazine to Resident 1 with a blood pressure of 105/67 mmHg at 5 p.m.During a concurrent interview and record review on 4/13/2026, at 12:06 p.m., with the Director of Nursing (DON), Resident 1's Physician Order, dated 2/2/2026, and MAR dated 4/2026, were reviewed. The DON stated the Physician Order for hydralazine was to hold (temporarily stop) the medication if Resident 1's sbp was below 110 mmHg. The DON stated on 4/10/2026, at 1 p.m. Resident 1's bp was 107/68 mmHg and at 5 p.m., Resident 1's bp was 105/67 mmHg. The DON stated hydralazine should have been held on 4/10/2026, at 1 p.m. and at 5 p.m. following the physician order. The DON stated Resident 1's could develop uncontrolled hypotension (low blood pressure) because hydralazine was administered.During a review of facility's policy and procedure (P&P) titled, Medication Administration Procedure, undated and last reviewed on 4/24/2025, the P&P indicated, All medications shall be administered in accordance with the prescribers' orders.

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	04/14/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3), who was receiving apixaban (an anticoagulant medication that helps prevent the formation of blood clots) was monitored for its side effects of bleeding.This deficient practice had the potential to place Resident 3 at increased risk for side effects including bleeding.Findings:During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 2/10/2026, with diagnoses that included other acute kidney failure (often called Acute Kidney Injury [AKI]- is a sudden, temporary loss of kidney function, often within hours or days), other pulmonary embolism (a medical emergency caused by a blood clot getting stuck in a lung artery [thick, muscular blood vessels that carry oxygen-rich blood away from the heart to the rest of the body] blocking blood flow) with acute cor pulmonale (the sudden, rapid failure of the right side of the heart caused by a severe lung issue, such as a large blood clot) and history of fall.During a review of Resident 3's Physician Order, dated 2/10/2026, the Physician Order indicated apixaban oral tablet five milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for pulmonary embolism/deep vein thrombosis (DVT- a blood clot that forms in a deep vein, usually in the leg or arm).During a review of Resident 3'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 2/11/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Care Plan dated 2/16/2026, on anticoagulant therapy, the Care Plan indicated the following interventions:1. Monitor for side effects and effectiveness.2. Monitor/document/report adverse reactions (an unexpected, harmful, or unpleasant response to a medication or treatment, occurring even at normal doses) of anticoagulant therapy: blood tinged (a small amount of blood mixed in) or red blood in urine, black tarry stools (indicate bleeding in the upper digestive tract, such as the stomach or esophagus) dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (a state of having very little energy, feeling sluggish, tired, or unmotivated), bruising.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 3 needed maximum assistance from staff for toileting, showering, dressing and personal hygiene.During a review of Resident 3's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 4/2026, the MAR indicated Resident 3 received apixaban two times a day at 9 a.m., and 5 p.m. from 4/1/2026, to 4/13/2026.During a concurrent interview and record review on 4/14/2026, at 7:01 a.m., with the Director of Nursing (DON), Resident 3's Physician Order, dated 2/10/2026, and MAR, dated 4/2026, were reviewed. The DON stated apixaban is an anticoagulant that had a side effect of bleeding and bruising. The DON stated Resident 3 who was on apixaban should be monitored for bleeding every shift and monitoring should be documented in Resident 3's MAR. The DON stated there was no documented monitoring for the side effect of apixaban. The DON stated since Resident 3 was not monitored for the side effects of apixaban, it could possibly cause further bleeding.During a review of facility's policy and procedure (P&P) titled, Anticoagulation-Clinical Protocol, undated and last reviewed on 4/24/2025, the P&P indicated, a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications.Monitoring and Follow-up: .5. The staff and physicians will monitor for possible complications in individuals who are being anticoagulated and will manage related problems.a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.