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 _____	C 03/22/2025

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MACLAY HEALTHCARE CENTER	12831 MACLAY STREET SYLMAR, CA 91342

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident Number: CA00951926 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Deficiencies were issued for Facility Reported Incident number: CA00951926 (Refer to F583, F600, F610, F689, F644, F712, and F842). On 3/19/2025 at 4:12 p.m., the California Department of Public Health (CDPH) called an Immediate Jeopardy (IJ - a situation in which the facility ' s non-compliance with one or more requirements of participations had caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator and the Director of Nursing (DON) for the facility ' s failure to ensure that Resident 1 was kept free from physical abuse, as evidenced by Resident 2 injuring (to hurt or cause physical harm to another person) Resident 1 with a knife in the facility ' s smoking patio. On 3/22/2025 at 5:48 p.m., the Administrator provided an acceptable IJ removal plan (a plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to the IJ situation) for the facility ' s failure to keep Resident 1 free from physical abuse.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X6) DATE: 4/4/25

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.

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On 3/22/2025 at 8:15 p.m., while onsite and after verifying the facility ' s full implementation of the IJ Removal Plan through observation, interview, and record review and determined the IJ situation was no longer present. The IJ situation was removed while onsite, in the presence of the Administrator and the DON.

The acceptable IJ Removal Plan included the following summarized actions:

1. On 3/16/2025 at 8:31 a.m., Resident 1 approached Nursing Station 500 for assistance. Registered Nurse 1 (RN 1) noted that Resident 1 had a cut on his left thumb with bleeding. RN 1 immediately gave first aid (initial assistance and care given to a resident who has been injured) and called Licensed Vocational Nurse (LVN) 1 to attend to Resident 1. RN 1 asked Resident 1 how he (Resident 1) got the cut on his (Resident 1) left thumb and Resident 1 stated, "The guy (referring to Resident 2) is waving his (Resident 2) knife and I tried to seize (take hold of) it (knife)." RN 1 immediately went to the smoking patio to check and found Resident 2 about to go inside the facility with no visual (sight) of the knife.

2. On 3/16/2025 at 9 a.m., RN 1 initiated a change of condition (COC - when there is a sudden significant change in a resident ' s health status) on Resident 2. RN 1 did a body check on Resident 2 and noted an abrasion (a superficial injury where the outermost layer of skin is rubbed or torn off, often caused by contact with a rough surface) on Resident 2 ' s left hand and wrist. RN 1 gave first aid to Resident 2 who denied any pain. RN 1 called Resident 2 ' s primary medical doctor (MD) 1 on 3/16/2025 at approximately 9 a.m. who ordered to transfer Resident 2 to GACH

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2 for further evaluation. Resident 2 was assigned a 1:1 sitter (refers to a facility staff dedicated to providing continuous, one-on-one observation and care to a single resident, often to ensure their safety and prevent potential harm) to monitor his (Resident 2) aggressive behavior (any behavior intended to harm or cause distress to another person, either physically or emotionally). Resident 2 was transferred to GACH 2 for further psychiatric evaluation (a comprehensive assessment of an individual ' s mental health status, conducted by a qualified mental health professional) and treatment on 3/16/2025 at 6:10 p.m.

3. On 3/16/2025 at approximately 9:15 a.m., RN 1 initiated body assessment on Resident 1 and noted abrasions on both of his (Resident 1) knees. RN 1 initiated the COC on Resident 1. RN 1 called the paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) who arrived on 3/16/2025 at around 9:20 p.m. and transferred Resident 1 to GACH 1. RN 1 called the local police.

4. On 3/16/2025 at 9:05 p.m., Resident 1 came back from GACH 1 with eight stitches of sutures on Resident 1 ' s left thumb cut. Resident 1 was monitored for 72 hours for any fall complications and symptoms of emotional distress related to the altercation with Resident 2. Social Services staff continued to do a wellness visit to Resident 1 from 3/16/2025 to 3/19/2025 for emotional support and feeling of safety. The Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) visited Resident 1 on 3/17/2025 at 4 p.m. A Psychologist (a mental health professional who specializes in

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understanding and treating mental, emotional, and behavioral disorders) visited Resident 1 on 3/19/2025.

5. On 3/16/2025 at 2:30 p.m., the Director of Nursing (DON) via telephone had provided a 1:1 education (refers to individualized, one-on-one education provided to a single individual by a staff member or professional) to RN 1 regarding facility policies for abuse prevention that included all type of abuse and educating on the facility ' s policy and procedure on resident supervision specifically on following the residents ' smoking schedule to ensure that supervision is provided to residents in the smoking patio and on the other areas of the facility like the front entrance backyard and other patio location to ensure each resident ' s safety. On 3/21/2025 and 3/22/2025, the DON provided 1:1 education to RN 2, Certified Nursing Assistant (CNA) 1, and CNA 2 regarding resident safety, supervision, and abuse prevention and management. Licensed Vocational Nurse (LVN) 1, who is currently on vacation, will be educated prior to coming back on the floor.

6. On 3/17/2025 at 2 a.m., the facility readmitted Resident 2 from GACH 2. The facility provided 1:1 sitter to Resident 2 to monitor his aggressive behavior. Social Services staff continued doing wellness visit (an appointment to create or update a personalized prevention plan focusing on preventative care and health risk assessments) to Resident 2 starting on 3/17/2025 at 1:17 p.m. who verbalized he (Resident 2) is doing well in the facility. On 3/18/2025 at 2:30 p.m., The Psychiatrist had seen Resident 2. On 3/18/2025 at 12:44 p.m., four local police officers came to the facility and apprehended Resident 2.

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7. On 3/17/2025, the Administrator posted signs of "No Weapons Allowed" in the facility. The signs are posted in the front entrance door, facility entrance, and employee lounge. Additional posts will be done in other areas of the facility.

8. On 3/17/2025 until 3/22/2025, the Director for Staff Development (DSD), the Administrator, DON, and Assistant Administrator provided all facility staff with an in-service (a planned, workplace-based training program designed to enhance staff competency, improve job performance, and keep staff up to date with current best practices and new techniques) for all types of Abuse.

9. The facility made the following efforts to locate the knife used by Resident 2 to injure Resident 1:

a. On 3/16/2025, RN 1 and LVN 1 attempted to search Resident 2, however, Resident 2 refused.

b. On 3/16/2025, RN 1 and LVN 1 searched the Smoking Patio but could not locate the knife.

c. On 3/16/2025, the Administrator asked the police officer to conduct body search on Resident 2, the police officer stated that he cannot conduct it at this time.

d. On 3/16/2025, LVN 2 conducted a search in Resident 2 ' s room, in the trash cans, all drawers, closets, inside the shoes, under the mattresses, and the bathroom. Resident 2 ' s knife was not located.

e. On 3/16/2025, the housekeeper and laundry employees searched all trash carts, and laundry

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area, knife was not located.

f. On 3/19/2025, the Department heads conducted searches in all residents' rooms and belongings. Resident 2 ' s knife was not located.

g. On 3/19/2025, the Maintenance Supervisor searched the roof top, knife was not located.

h. On 3/22/2025, Administrator started reviewing the video footage to find the location of the knife. The Administrator is new, who started on 12/7/2024, was not given yet the capability to review the surveillance camera but is now able to review as of 3/22/2025. The Administrator is currently working with the Information Technology (IT) staff to assist if there will be any issues regarding the video surveillance footages.

i. The Administrator/designee will coordinate all efforts to exhaustively and continuously search for the missing knife used by Resident 2 until it (the knife) is found. Once knife is found the administrator will take a picture of where the knife was found, will place it in a bag, will handle with caution, and will turn it in to the police department. A notification will be sent to the SSA.

10. On 3/19/2025 to 3/22/2025, the DSD, Administrator, DON, and Assistant Administrator conducted in-services to staff regarding resident-to-resident verbal altercation and separating the residents to avoid escalation (an increase in the intensity or seriousness of something), recognizing potential threats, and handling situations where a weapon may be involved.

11. On 3/19/2025 and 3/20/2025, the MDS Nurse,

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DON, and Activity Staff smoking attendant conducted 1:1 smoking observation of residents smoking in the smoking patio. After the smoking observation of residents, the MDS Nurse conducted a Smoking Risks Evaluation to determine if a smoker requires supervision or is an independent smoker during smoking time. The MDS Nurse have identified eight residents who require supervision during smoking and ten residents who can independently smoke in the smoking patio. All the 18 residents have the potential to be affected by the deficient practice therefore the facility shall provide residents supervision both for supervised and independent smokers to ensure residents ' safety.

12. On 3/21/2025, a new policy and procedure for Firearms and Other Weapons was initiated and will be presented to the Medical Director on 3/24/2025 during an emergency meeting.

13. On 3/22/2025, RN Mentor in-serviced the Administrator and DON on the policy and procedure for abuse, how to detect and what is the definition of Abuse.

14. Department head managers during their routine rounds will conduct a safety room check on their assigned rooms to inspect the presence of sharp objects. Any kinds of sharp objects will be seized and reported to the Administrator for further follow-up.

15. Upon admission and during quarterly Interdisciplinary Team (IDT - a collaborative group of individuals from different discipline who work together to achieve a common goal) meetings, the Social Services will educate residents and their representatives about the policy and

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F 000	Continued From page 7 procedure on abuse and the facility ' s protocol of not bringing any sharp objects or weapons to the facility. Any findings of such will be confiscated immediately and will be handed to the Administrator/DON. 16. Upon returning from out on pass (refers to a planned, temporary absence of a resident from the facility, authorized by a physician ' s order, for a specific purpose, with the expectation of the resident ' s return), if residents or representatives bring any items back to the facility, the charge nurse or RN supervisor will be asking for any items the resident would like to be added to the inventory list.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		

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F 583	Continued From page 8 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of four of four sampled residents (Resident 9, Resident 10, Resident 11, and Resident 12) were protected by failing to: 1. Ensure Resident 9 ' s narcotic (a drug or other substances that affects mood or behavior) sheet was not left unattended, facing the hallway, on Nurse Station 3 ' s Telephone Orders Only bin. 2. Ensure the clinical records of Resident 10, Resident 11, and Resident 12 were not left unattended on Nurse Station 3 computer. These deficient practices had the potential to violate Resident 9, Resident 10, Resident 11, and Resident 12's rights for privacy and confidentiality of personal and medical records. Findings: 1. During a record review of Resident 9 ' s Admission Record, the Admission Record	F 583		

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indicated the facility admitted the resident on 11/11/2021 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), essential hypertension (an abnormally high blood pressure that was not a result of a medical condition), and anxiety disorder (persistent and excessive worry that interferes with daily activities).

During a record review of Resident 9 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 9 ' s cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were intact.

During a record review of Resident 9 ' s Physician Order, dated 2/12/2024, the Physician Order indicated tramadol hydrochloride (a medication used to treat moderate to severe pain and was from a group of medicines called narcotics) 50 milligrams (mg - unit of measurement) one tablet every six hours as needed for pain.

During a concurrent observation and interview on 3/21/2025 at 9:04 a.m. with Registered Nurse (RN) 2, RN 2 stated Resident 9 ' s narcotic sheet was in the Telephone Orders Only bin at the nurse station 3. Observed Resident 9 ' s information on the narcotic sheet was facing the hallway. RN 2 stated that Resident 9 ' s information was visible to visitors, other residents, and to the facility staff that were not involved in Resident 9 ' s care. RN 2 stated visitors, other residents, and facility staff had the potential for unauthorized access to Resident 9 ' s clinical records. RN 2 stated the facility failed to ensure

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F 583	Continued From page 10 Resident 9 ' s right for privacy was protected. 2. During a record review of Resident 10 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 2/27/2025 with diagnoses including type 2 diabetes mellitus, essential hypertension, and muscle weakness. During a record review of Resident 10 ' s MDS, dated 3/5/2025, the MDS indicated Resident 10 ' s cognitive skills for daily decision making was moderately impaired. During a record review of Resident 11 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 2/21/2025 with diagnoses including type 2 diabetes mellitus, essential hypertension, and muscle weakness. During a record review of Resident 11 ' s MDS, dated 3/17/2025, the MDS indicated Resident 11 ' s cognitive skills for daily decision making was intact. During a record review of Resident 12 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 11/28/2023 with diagnoses including type 2 diabetes mellitus, essential hypertension, and muscle weakness. During a record review of Resident 12 ' s MDS, dated 3/5/2025, the MDS indicated Resident 12 ' s cognitive skills for daily decision making was moderately impaired. During a concurrent observation and interview on	F 583		

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F 583	Continued From page 11 3/21/2025 at 9:04 a.m. with RN 2, observed nurse station 3 ' s computer had Resident 10, Resident 11, and Resident 12 ' s clinical records on the screen. RN 2 stated the nurse station 3 computer screen indicated the access belonged to Licensed Vocational Nurse (LVN) 4, an 11 p.m. to 7 a.m. shift nursing staff. RN 2 stated Residents 10, 11, and 12 ' s clinical information was left unattended and had the potential for unauthorized access from other facility staff that were not involved on the residents ' care, visitors, and other outside agencies. RN 2 stated the facility failed to ensure Residents 10, 11, and 12 ' s right for privacy was protected. During a record review of the facility ' s Policy and Procedure (PnP) titled, "Electronic Medical Records," last reviewed on 4/2025, the PnP indicated only authorized persons who have been issued a password and user ID code will be permitted access to the electronic medical records system. The PnP indicated the medical records system safeguards the prevent unauthorized access of electronic protected health information (e-PHI). These safeguards included administrative, technical, and physical safeguards.	F 583		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		

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F 600	Continued From page 12 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect the resident ' s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 1) when on 3/16/2025 at 8:26 a.m., Resident 1 and Resident 2, who were both in the facility ' s smoking patio (an outdoor area designed for residents to enjoy fresh air and engage in activities), had a verbal altercation (a noisy argument or disagreement) that led to a physical altercation (a confrontation or fight involving physical contact or force) in which Resident 2 used a knife in his (Resident 2) possession to cause an injury to Resident 1. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. On 3/16/2025 at 8:29 a.m., Resident 1 sustained abrasions (when the surface layers of the skin have been broken) on bilateral (both) knees and left thumb laceration (a deep cut or tear in skin). Resident 1 was sent to General Acute Care Hospital 1 (GACH 1) on 3/16/2025 for further evaluation and wound treatment. Resident 1 ' s left thumb laceration, measuring three (3) centimeters (cm - unit of measurement) in length, 0.2 cm in width, with unknown depth, required eight stitches (fine, threadlike materials used to hold the edges of a	F 600		

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F 600	Continued From page 13 wound together). Based on the Reasonable Person Concept (what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer because of the noncompliance), due to Resident 1 ' impaired cognition (mental action or process of acquiring knowledge and understanding) and medical condition, an individual subjected to physical abuse may have physical pain, psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for yourself). On 3/19/2025 at 4:12 p.m., the California Department of Public Health (CDPH) called an Immediate Jeopardy (IJ - a situation in which the facility ' s non-compliance with one or more requirements of participations had caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator and the Director of Nursing (DON) for the facility ' s failure to ensure that Resident 1 was kept free from physical abuse, as evidenced by Resident 2 injuring (to hurt or cause physical harm to another person) Resident 1 with a knife in the facility ' s smoking patio. On 3/22/2025 at 5:48 p.m., the Administrator provided an acceptable IJ removal plan (a plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to the IJ situation) for the facility ' s failure to keep Resident 1 free from physical abuse. On 3/22/2025 at 8:15 p.m., while onsite and after	F 600		

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verifying the facility ' s full implementation of the IJ Removal Plan through observation, interview, and record review and determined the IJ situation was no longer present. The IJ situation was removed while onsite, in the presence of the Administrator and the DON.

The acceptable IJ Removal Plan included the following summarized actions:

1. On 3/16/2025 at 8:31 a.m., Resident 1 approached Nursing Station 500 for assistance. Registered Nurse 1 (RN 1) noted that Resident 1 had a cut on his left thumb with bleeding. RN 1 immediately gave first aid (initial assistance and care given to a resident who has been injured) and called Licensed Vocational Nurse (LVN) 1 to attend to Resident 1. RN 1 asked Resident 1 how he (Resident 1) got the cut on his (Resident 1) left thumb and Resident 1 stated, "The guy (referring to Resident 2) is waving his (Resident 2) knife and I tried to seize (take hold of) it (knife)." RN 1 immediately went to the smoking patio to check and found Resident 2 about to go inside the facility with no visual (sight) of the knife.

2. On 3/16/2025 at 9 a.m., RN 1 initiated a change of condition (COC - when there is a sudden significant change in a resident ' s health status) on Resident 2. RN 1 did a body check on Resident 2 and noted an abrasion (a superficial injury where the outermost layer of skin is rubbed or torn off, often caused by contact with a rough surface) on Resident 2 ' s left hand and wrist. RN 1 gave first aid to Resident 2 who denied any pain. RN 1 called Resident 2 ' s primary medical doctor (MD) 1 on 3/16/2025 at approximately 9 a.m. who ordered to transfer Resident 2 to GACH 2 for further evaluation. Resident 2 was assigned

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a 1:1 sitter (refers to a facility staff dedicated to providing continuous, one-on-one observation and care to a single resident, often to ensure their safety and prevent potential harm) to monitor his (Resident 2) aggressive behavior (any behavior intended to harm or cause distress to another person, either physically or emotionally). Resident 2 was transferred to GACH 2 for further psychiatric evaluation (a comprehensive assessment of an individual ' s mental health status, conducted by a qualified mental health professional) and treatment on 3/16/2025 at 6:10 p.m.

3. On 3/16/2025 at approximately 9:15 a.m., RN 1 initiated body assessment on Resident 1 and noted abrasions on both of his (Resident 1) knees. RN 1 initiated the COC on Resident 1. RN 1 called the paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) who arrived on 3/16/2025 at around 9:20 p.m. and transferred Resident 1 to GACH 1. RN 1 called the local police.

4. On 3/16/2025 at 9:05 p.m., Resident 1 came back from GACH 1 with eight stitches of sutures on Resident 1 ' s left thumb cut. Resident 1 was monitored for 72 hours for any fall complications and symptoms of emotional distress related to the altercation with Resident 2. Social Services staff continued to do a wellness visit to Resident 1 from 3/16/2025 to 3/19/2025 for emotional support and feeling of safety. The Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) visited Resident 1 on 3/17/2025 at 4 p.m. A Psychologist (a mental health professional who specializes in understanding and treating mental, emotional,

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and behavioral disorders) visited Resident 1 on 3/19/2025.

5. On 3/16/2025 at 2:30 p.m., the Director of Nursing (DON) via telephone had provided a 1:1 education (refers to individualized, one-on-one education provided to a single individual by a staff member or professional) to RN 1 regarding facility policies for abuse prevention that included all type of abuse. On 3/21/2025 and 3/22/2025, the DON provided 1:1 education to RN 2, Certified Nursing Assistant (CNA) 1, and CNA 2 regarding resident safety, supervision, and abuse prevention and management. Licensed Vocational Nurse (LVN) 1, who is currently on vacation, will be educated prior to coming back on the floor.

6. On 3/17/2025 at 2 a.m., the facility readmitted Resident 2 from GACH 2. The facility provided 1:1 sitter to Resident 2 to monitor his aggressive behavior. Social Services staff continued doing wellness visit (an appointment to create or update a personalized prevention plan focusing on preventative care and health risk assessments) to Resident 2 starting on 3/17/2025 at 1:17 p.m. who verbalized he (Resident 2) is doing well in the facility. On 3/18/2025 at 2:30 p.m., The Psychiatrist had seen Resident 2. On 3/18/2025 at 12:44 p.m., four local police officers came to the facility and apprehended Resident 2.

7. On 3/17/2025, the Administrator posted signs of "No Weapons Allowed" in the facility. The signs are posted in the front entrance door, facility entrance, and employee lounge. Additional posts will be done in other areas of the facility.

8. On 3/17/2025 until 3/22/2025, the Director for

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Staff Development (DSD), the Administrator, DON, and Assistant Administrator provided all facility staff with an in-service (a planned, workplace-based training program designed to enhance staff competency, improve job performance, and keep staff up to date with current best practices and new techniques) for all types of Abuse.

9. The facility made the following efforts to locate the knife used by Resident 2 to injure Resident 1:

a. On 3/16/2025, RN 1 and LVN 1 attempted to search Resident 2, however, Resident 2 refused.

b. On 3/16/2025, RN 1 and LVN 1 searched the Smoking Patio but could not locate the knife.

c. On 3/16/2025, the Administrator asked the police officer to conduct body search on Resident 2, the police officer stated that he cannot conduct it at this time.

d. On 3/16/2025, LVN 2 conducted a search in Resident 2 ' s room, in the trash cans, all drawers, closets, inside the shoes, under the mattresses, and the bathroom. Resident 2 ' s knife was not located.

e. On 3/16/2025, the housekeeper and laundry employees searched all trash carts, and laundry area, knife was not located.

f. On 3/19/2025, the Department heads conducted searches in all residents' rooms and belongings. Resident 2 ' s knife was not located.

g. On 3/19/2025, the Maintenance Supervisor searched the roof top, knife was not located.

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F 600	Continued From page 18 h. On 3/22/2025, Administrator started reviewing the video footage to find the location of the knife. The Administrator is new, who started on 12/7/2024, was not given yet the capability to review the surveillance camera but is now able to review as of 3/22/2025. The Administrator is currently working with the Information Technology (IT) staff to assist if there will be any issues regarding the video surveillance footages. i. The Administrator/designee will coordinate all efforts to exhaustively and continuously search for the missing knife used by Resident 2 until it (the knife) is found. Once knife is found the administrator will take a picture of where the knife was found, will place it in a bag, will handle with caution, and will turn it in to the police department. A notification will be sent to the SSA. 10. On 3/19/2025 to 3/22/2025, the DSD, Administrator, DON, and Assistant Administrator conducted in-services to staff regarding resident-to-resident verbal altercation and separating the residents to avoid escalation (an increase in the intensity or seriousness of something), recognizing potential threats, and handling situations where a weapon may be involved. 11. On 3/21/2025, a new policy and procedure for Firearms and Other Weapons was initiated and will be presented to the Medical Director on 3/24/2025 during an emergency meeting. 12. On 3/22/2025, RN Mentor in-serviced the Administrator and DON on the policy and procedure for abuse, how to detect and what is the definition of Abuse.	F 600		

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13. Department head managers during their routine rounds will conduct a safety room check on their assigned rooms to inspect the presence of sharp objects. Any kinds of sharp objects will be seized and reported to the Administrator for further follow-up.

14. Upon admission and during quarterly Interdisciplinary Team (IDT - a collaborative group of individuals from different discipline who work together to achieve a common goal) meetings, the Social Services will educate residents and their representatives about the policy and procedure on abuse and the facility ' s protocol of not bringing any sharp objects or weapons to the facility. Anyfindings of such will be confiscated immediately and will be handed to the Administrator/DON.

15. Upon returning from out on pass (refers to a planned, temporary absence of a resident from the facility, authorized by a physician ' s order, for a specific purpose, with the expectation of the resident ' s return), if residents or representatives bring any items back to the facility, the charge nurse or RN supervisor will be asking for any items the resident would like to be added to the inventory list.

(Cross Reference to F689)

Findings:

1. During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility originally admitted Resident 1 on 9/15/2020 and readmitted on 5/28/2024 with diagnoses including dementia (a progressive

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state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thoughts), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2024, the MDS indicated Resident 1 ' s cognition was moderately impaired. The MDS indicated Resident 1 ' s mobility (movement) device includes the use of a manual wheelchair (a wheeled mobility chair propelled by human power, either by the user themselves or by a caregiver pushing the wheelchair). The MDS indicated Resident 1 needing partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for shower or bathing self. The MDS indicated Resident 1 needing setup or clean-up assistance (helper sets up or cleans up; resident completes activity with helper assisting only prior to or following the activity) with eating.

During a review of Resident 1 ' s COC, dated 3/16/2025 at 9 a.m., the COC indicated Resident 1 came to the nursing station on 3/16/2025 at approximately around 8:40 a.m. with bleeding on left thumb. The COC indicated RN 1 conducted a body assessment on Resident 1 with noted laceration on left thumb and abrasion to bilateral knees. The COC indicated the paramedics transferred Resident 1 to GACH 1 for further evaluation.

2. During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated Resident 2 was admitted on 7/19/2024

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with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), schizophrenia, and hemiplegia (paralysis [inability to move] of one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain) affecting right dominant side.

During a review of Resident 2 ' s Inventory of Personal Effects (an itemized list of belongings of a resident), dated 7/19/2024, the Inventory of Personal effects did not indicate that Resident 2 was in possession of a knife. The form was completed and documented by CNA 4 and counter signed (a signature attesting the authenticity of a document already signed by another) by Resident 2.

During a review of Resident 2 ' s H&P, dated 7/22/2024, the H&P indicated Resident 2 had the mental capacity to understand and make decisions.

During a review of Resident 2 ' s MDS, dated 1/24/2025, the MDS indicated Resident 2 ' s cognition was intact. The MDS indicated Resident 2 ' s mobility devices included the use of a walker (a mobility aid designed to assist individuals with difficulty walking) and manual wheelchair. The MDS indicated Resident 2 needed partial/moderate assistance with toilet transfer.

During a review of Resident 2's COC Evaluation, dated 3/17/2025, the COC indicated that on the morning of 3/16/2025 Resident 2 had an altercation with another resident (Resident 1).

During a concurrent observation and interview on

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3/18/2025 at 10:10 a.m., with Resident 1 in Resident 1 ' s room, Resident 1 ' s left thumb was observed covered in a foam dressing. Resident 1 stated Resident 2 was disrespectful and used inappropriate words. Resident 1 stated, "He (referring to Resident 2) has no respect for anybody, he (Resident 2) can ' t talk like that."

During an interview on 3/18/2025 at 10:34 a.m. with RN 1, RN 1 stated on 3/16/2025 at approximately 8:40 a.m. Resident 1 came to the nursing station and informed RN 1 that Resident 2 cut his (Resident 1) hand while Resident 1 was trying to take a knife from Resident 2 in the smoking patio. RN 1 also stated that Resident 1 was bleeding from the laceration on his left thumb. RN 1 stated while in the smoking patio, he (RN 1) questioned Resident 2 regarding possession of a knife but Resident 2 denied. RN 1 stated he (RN 1) did not inspect Resident 2 for the possession of a knife since Resident 2 denied having a knife. RN 1 stated it was him (RN 1) who opened the door to the smoking patio for a resident (name not specified) and left it open allowing Resident 1 and Resident 2 to enter the smoking patio without staff supervision. RN 1 stated that he (RN 1) was in the nursing station when Resident 1 and Resident 2 had a physical altercation.

During an interview on 3/18/2025 at 11:56 a.m. with CNA 1, CNA 1 stated she was the CNA assigned to Resident 1 on 3/16/2025. CNA 1 stated she was with another resident (name not specified) when the physical altercation between Resident 1 and Resident 2 happened in the smoking patio. CNA 1 stated the next time she (CNA 1) saw Resident 1 was in the hallway near the nursing station with RN 1 applying pressure

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on Resident 1 ' s bleeding hand. CNA 1 stated she (CNA 1) heard Resident 1 saying he (Resident 1) was trying to get a knife from another resident (Resident 2).

During an interview on 3/19/2025 at 9:15 a.m., with RN 1, RN 1 stated on 3/16/2025 between 8 a.m. and 8:30 a.m., Resident 1 and Resident 2 were smoking in the smoking patio without staff supervision. RN 1 stated Residents 1 and 2 should have been supervised while smoking in the patio. RN 1 stated the physical abuse incident could have been prevented if a staff member was supervising the two residents (Resident 1 and Resident 2).

During a concurrent observation, interview, and record review on 3/19/2025 at 12:10 p.m., the facility ' s video surveillance footage of the smoking patio with the recording date and time of 3/16/2025 at 8:22:57 a.m. (adjusted to reflect actual time) was observed and reviewed with the Administrator. The Administrator verified Resident 1 and Resident 2 as the residents in the video surveillance. Both residents (Resident 1 and Resident 2) were on their wheelchairs and were in the East Smoking Patio. The Administrator stated the video surveillance time stamp was not updated to reflect spring daylight savings time (refers to the practice of advancing clocks forward one hour from standard time, typically on the second Sunday in March, to make better use of natural daylight during the warmer months) and was one hour behind the actual time. The Administrator also stated the entrance to the East Smoking Patio was not visible in the video surveillance due to the location of the camera. The Administrator stated there was only one camera in the East Smoking Patio. The

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Administrator stated the following with time stamps adjusted to reflect the actual times:

a. On 3/16/2025 at 8:22:59 a.m., Resident 1 entered the East Smoking Patio from the hallway between Nursing Station 500 and the kitchen.

b. On 3/16/2025 at 8:24:08 a.m., Resident 2 entered the East Smoking Patio from the same entrance.

c. On 3/16/2025 at 8:26:58 a.m., Resident 1 stood up from his wheelchair and walked towards Resident 2 and started exchanging words.

d. On 3/16/2025 at 8:27:08 a.m., Resident 2 attempted to slap Resident 1 ' s hand while Resident 1 was pointing his hand towards Resident 2.

e. On 3/16/2025 at 8:29:22 a.m., Resident 2 pointed a knife towards Resident 1 ' s face.

f. On 3/16/2025 at 8:29:56 a.m., Resident 1 fell on the ground after trying to take the knife from Resident 2 ' s hands.

g. On 3/16/2025 at 8:30:20 a.m., Resident 1 went back and sat in his wheelchair and entered the facility at 8:30:42 a.m. The Administrator stated there was no facility staff present in the smoking patio as observed in the video surveillance.

During an interview on 3/19/2025 at 1:36 p.m., with the DON, the DON stated the facility failed to provide supervision to Resident 1 and Resident 2 on 3/16/2025 in the smoking patio, which led to a physical altercation between the two residents (Resident 1 and Resident 2) and Resident 1

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sustaining an injury. The DON stated the facility has not found the knife used by Resident 2. The DON stated there is a possibility that the knife is still in the facility or in the possession of another resident.

During an interview on 3/19/2025 at 3:16 p.m. with the Administrator, the Administrator stated Resident 1 had informed the Administrator that Resident 2 was using inappropriate words towards Resident 1. The Administrator also stated the physical altercation between Resident 1 and Resident 2 could have been prevented if the two residents (Resident 1 and Resident 2) were supervised in the smoking patio and were immediately separated by staff once the verbal altercation started between Resident 1 and Resident 2. The Administrator stated there was physical abuse and that Resident 2 willfully acted on injuring Resident 1.

During an interview on 3/20/2025 at 2:45 p.m. with the Administrator, the Administrator stated the knife used by Resident 2 to injure Resident 1 was not found. The Administrator also stated body inspection was not done on Resident 2 since Resident 2 refused. The Administrator stated there was a possibility Resident 2 ' s knife is still in the facility.

During a review of the current facility-provided policy and procedure titled, "Abuse, Neglect (the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress), Exploitation (means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion) and Misappropriation (the deliberate misplacement, exploitation or wrongful, temporary

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or permanent use of a resident ' s belongings or money without the resident ' s consent) Prevention Program," revised on 4/2021 and reviewed on 4/2024, the policy and procedure indicated, "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .... The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: ... b. other residents .... 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents ...."

During a review of the current facility-provided policy and procedure titled, "Smoking Policy-Residents," reviewed on 4/2024, the policy and procedure indicated, "This facility has established and maintains safe resident smoking practices .... Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking."

During a review of the current facility-provided policy and procedure titled, "Abuse Policy," last reviewed on 4/2024, the policy and procedure indicated, "Communities does not condone (accept and allow) resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including ... other residents .... Residents have the right to be free from abuse .... 1. Providing a safe environment for the resident is one of the most basic and essential duties of our facility .... 4. Identification of abuse shall be the

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F 600	Continued From page 27 responsibility of every employee .... Resident abuse is defined as the willful infliction of injury, unreasonable ... resulting in physical harm or pain, mental anguish .... Verbal abuse is defined as the use of oral, written, or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, regardless of their ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm .... Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking ... and willful neglect of the resident ' s basic needs .... If abuse happens: 1. Separate the assailant from the victim. 2. Isolate the assailant to protect others."	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		

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by:
Based on interview and record review, the facility failed to ensure a resident to resident altercation was thoroughly investigated for two of four sampled residents (Resident 1 and Resident 2). On 3/16/2025 at 8:26 a.m., Resident 1 and Resident 2, who were both in the facility ' s smoking patio (an outdoor area designed for residents to enjoy fresh air and engage in activities), had a verbal altercation (a noisy argument or disagreement) that led to a physical altercation (a confrontation or fight involving physical contact or force) in which Resident 2 used a knife in his (Resident 2) possession to cause an injury to Resident 1.

This failure had the potential to place the residents at risk for further abuse.

Findings:
During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility originally admitted Resident 1 on 9/15/2020 and readmitted on 5/28/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thoughts), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2024, the MDS indicated Resident 1 ' s cognition was moderately impaired. The MDS indicated Resident 1 ' s mobility (movement) device includes the use of a manual wheelchair (a wheeled mobility chair propelled by human power, either by the user themselves or by a

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caregiver pushing the wheelchair). The MDS indicated Resident 1 needing partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for shower or bathing self. The MDS indicated Resident 1 needing setup or clean-up assistance (helper sets up or cleans up; resident completes activity with helper assisting only prior to or following the activity) with eating.

During a review of Resident 1 ' s care plan on chronic (recurring) disruptive behavior (actions that interfere with the functioning of an individual or a group and cause disturbances to those around them, often involving aggression, defiance, or violation of social norms), revised on 9/28/2024, the care plan indicated Resident 1 had a history of physical abuse with another resident (name not indicated).

During a review of Resident 1 ' s History and Physical (H&P), dated 3/12/2025, the H&P indicated Resident 1 had the mental capacity to understand and make decisions.

During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated Resident 2 was admitted on 7/19/2024 with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), schizophrenia, and hemiplegia (paralysis [inability to move] of one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (loss of blood flow to a part of the brain) affecting right dominant side.

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F 610	Continued From page 30 During a review of Resident 2 ' s H&P, dated 7/22/2024, the H&P indicated Resident 2 had the mental capacity to understand and make decisions. During a review of Resident 2 ' s care plan, dated 3/16/2025, the care plan indicated Resident 2 was involved in an alleged altercation with another resident (Resident 1). During an interview on 3/18/2025 at 12:28 p.m. with the Administrator, the Administrator stated Registered Nurse (RN) 1 notified the Administrator that on 3/16/2025 at approximately 8:40 a.m., Resident 2 allegedly injured Resident 1 with a knife. The Administrator stated that on 3/16/25 police officers arrived at the facility and had requested the video surveillance of Resident 1 and Resident 2 ' s physical altercation in the East Smoking Patio. The Administrator stated she was not able to provide immediately the video surveillance to the police officers on that day. The Administrator stated the police officers left the facility on 3/16/2025 at approximately 11:30 a.m. The Administrator stated the video surveillance requested was provided to the police on 3/17/2025. The Administrator stated the police officers came back to the facility on 3/18/2025 and informed the Administrator that after reviewing the video surveillance provided they were arresting Resident 2. During a concurrent observation, interview, and record review on 3/19/2025 at 12:10 p.m., the facility ' s video surveillance footage of the smoking patio with the recording date and time of 3/16/2025 at 8:22:57 a.m. (adjusted to reflect actual time) was observed and reviewed with the	F 610		

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Administrator. The Administrator verified Resident 1 and Resident 2 as the residents in the video surveillance. Both residents (Resident 1 and Resident 2) were on their wheelchairs, were in the East Smoking Patio. The Administrator stated the video surveillance time stamp was not updated to reflect spring daylight savings time (refers to the practice of advancing clocks forward one hour from standard time, typically on the second Sunday in March, to make better use of natural daylight during the warmer months) and was one hour behind the actual time. The Administrator also stated the entrance to the East Smoking Patio was not visible in the video surveillance due to the location of the camera. The Administrator stated there was only one camera in the East Smoking Patio. The Administrator stated the following with time stamps adjusted to reflect the actual times:

a. On 3/16/2025 at 8:22:59 a.m., Resident 1 entered the East Smoking Patio from the hallway between Nursing Station 500 and the kitchen.

b. On 3/16/2025 at 8:24:08 a.m., Resident 2 entered the East Smoking Patio from the same entrance.

c. On 3/16/2025 at 8:26:58 a.m., Resident 1 stood up from his wheelchair and walked towards Resident 2 and they were exchanging words.

d. On 3/16/2025 at 8:27:08 a.m., Resident 2 attempted to slap Resident 1 ' s hand while Resident 1 was pointing his hand towards Resident 2.

e. On 3/16/2025 at 8:29:22 a.m., Resident 2 pointed a knife towards Resident 1 ' s face.

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F 610	Continued From page 32 f. On 3/16/2025 at 8:29:56 a.m., Resident 1 fell on the ground after trying to take the knife from Resident 2 ' s hands. g. On 3/16/2025 at 8:30:20 a.m., Resident 1 went back and sat in his wheelchair and entered the facility at 8:30:42 a.m. The Administrator stated there was no facility staff present in the smoking patio as observed in the video surveillance. During an interview on 3/19/2025 at 3:16 p.m. with the Administrator, the Administrator stated she should have requested the surveillance videos on all cameras to see the residents ' (Resident 1 and Resident 2) location after the incident of Resident 1 ' s and Resident 2 ' s physical altercation. The Administrator stated her investigation was not thorough. During an interview on 3/21/2025 at 6:04 p.m. with the Administrator, the Administrator stated the location of the knife used by Resident 2 to injure Resident 1 was not known. During a review of facility ' s policy and procedure (P&P) titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," last reviewed on 4/2024, the P&P indicated, "All allegations are thoroughly investigated. The administrator initiates investigations ....The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation."	F 610		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		

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F 644	Continued From page 33 A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level I Screening (preliminary screening to identify individuals potentially needing specialized services due to mental illness or intellectual/developmental disabilities) was completed for one of four sampled residents (Resident 2). This deficient practice had the potential to result in a delay of necessary care and services to Resident 2. Findings:	F 644		

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F 644	Continued From page 34 During a review of resident 2 ' s PASSR Level I Screening, dated 7/12/2024, the PASSR Level I Screening indicated Resident 2 did not have serious mental diagnoses. The PASRR Level I Screening also indicated Resident 2 did not require PASRR Level II Screening (a comprehensive evaluation to confirm the diagnosis and determine appropriate placement and servies). During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated Resident 2 was admitted on 7/19/2024 with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), schizophrenia, and hemiplegia (paralysis [inability to move] of one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (loss of blood flow to a part of the brain) affecting right dominant side. During a review of Resident 2 ' s "Admission Diagnosis Worksheet," dated 7/23/2024, the "Admission Diagnosis Worksheet" indicated Resident 2 had diagnoses of stroke, asthma (a condition that causes swelling and narrowing of airways causing difficulty in breathing), hypertension (high blood pressure), and anxiety. During a review of Resident 2 ' s Admission Minimum Data Set (MDS - resident assessment tool), dated 7/25/2024, the Admission MDS indicated Resident 2 was diagnosed with anxiety disorder.	F 644		

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F 644	Continued From page 35 During a review of Resident 2 ' s MDS, dated 10/25/2024, the MDS indicated Resident 2 was diagnosed with depression (mental health illness causing a persistent feeling of sadness, loss of interest, and can interfere with daily life), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and anxiety disorder. During a review of Resident 2 ' s History and Physical (H&P), dated 7/22/2024, the H&P indicated Resident 2 had the mental capacity to understand and make decisions. During a review of Resident 2 ' s care plan, initiated on 3/17/2025, the care plan indicated Resident 2 had a mood challenge related to anxiety disorder, psychosis, and depression. During a concurrent interview and record review with MDS Specialist on 3/22/2024 at 2:42 p.m., Resident 2 ' s "Initial Psychiatric Evaluation," dated 9/25/2024 was reviewed. The "Initial Psychiatric Evaluation" indicated Resident 2 had diagnoses of Psychotic disorder and had episodes of delusions (having false or unrealistic beliefs) and hallucinations (a sensory experience that appears real but is not based on actual external stimuli). The MDS Specialist stated Level 1 PASRR Screening should have been completed for Resident 2. During an interview on 3/22/2025 at 6:45 p.m. with the Director of Nursing (DON), the DON stated PASRR Screening provide the recommended behavioral interventions and care residents need. The DON stated PASRR Level I Screening should have been completed for Resident 2. The DON also stated the facility ' s	F 644		

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F 644	Continued From page 36 failure could potentially cause delay in provision of necessary care to Resident 2. During a review of the current facility-provided policy and procedure (P&P) titled, "Subject: PASRR," dated 9/26/23, the P&P indicated status change Level I PASRR screening should be completed for a resident if there is a change in psychiatric diagnoses or if there is a discrepancy between PASRR diagnoses and diagnoses given by the attending physician or psychiatrist.	F 644		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision (refers to the ongoing monitoring and guidance provided by staff to ensure the safety and well-being of residents) for two of four residents (Resident 1 and Resident 2) when on 3/16/2025 at 8:26 a.m., Resident 1 and Resident 2, who were both in the facility ' s smoking patio (an outdoor area designed for residents to enjoy fresh air and engage in activities), had a verbal altercation (a noisy argument or disagreement) that led to a physical altercation (a confrontation or fight involving physical contact or force) in which Resident 2 used a knife in his (Resident 2)	F 689		

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F 689	Continued From page 37 possession to cause an injury to Resident 1. This deficient practice resulted in Resident 1 sustaining abrasions (when the surface layers of the skin have been broken) on bilateral (both) knees and left thumb laceration (a deep cut or tear in skin) on 3/16/2025 at 8:29 a.m. On 3/16/2025, Resident 1 was sent to General Acute Care Hospital 1 (GACH 1) for further evaluation and wound treatment. Resident 1 ' s left thumb laceration, measuring three (3) centimeters (cm - unit of measurement) in length, 0.2 cm in width, with unknown depth, required eight stitches (fine, threadlike materials used to hold the edges of a wound together, promoting healing). On 3/19/2025 at 4:12 p.m., the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s non-compliance with one or more requirements of participations has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator and the Director of Nursing (DON) for the facility ' s failure to provide staff supervision on 3/16/2025 at 8:26 a.m., when Resident 1 and Resident 2 were both in the facility ' s smoking patio. On 3/22/2025 at 7:41 p.m., the DON provided an acceptable IJ removal plan (a plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to the IJ situation) for the facility ' s failure to provide supervision on 3/16/2025 at 8:26 a.m., to Resident 1 and Resident 2. On 3/22/2025 at 8:15 p.m., while onsite and after verifying the facility ' s full implementation of the IJ Removal Plan through observation, interview,	F 689		

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and record review, the SSA removed the IJ situation in the presence of the Administrator and the DON.

The acceptable IJ Removal Plan included the following summarized actions:

1. On 3/16/2025 at 8:31 a.m., Resident 1 approached Nursing Station 500 for assistance. Registered Nurse (RN) 1 noted that Resident 1 had a cut on his left thumb with bleeding. RN 1 immediately gave first aid (initial assistance and care given to a resident who has been injured) and called Licensed Vocational Nurse (LVN) 1 to attend to Resident 1. RN 1 asked Resident 1 how he (Resident 1) got the cut on his (Resident 1) left thumb and Resident 1 stated, "The guy (referring to Resident 2) is waving his (Resident 2) knife and I tried to seize (take hold of) it (knife)." RN 1 immediately went to the smoking patio to check and found Resident 2 about to go inside the facility with no visual (sight) of the alleged knife.

2. On 3/16/2025 at 9 a.m., RN 1 initiated a change of condition (COC - when there is a sudden significant change in a resident ' s health status) on Resident 2. RN 1 did a body check on Resident 2 and noted an abrasion (a superficial injury where the outermost layer of skin is rubbed or torn off, often caused by contact with a rough surface) on Resident 2 ' s left hand and wrist. RN 1 gave first aid to Resident 2 who denied any pain. RN 1 called Resident 2 ' s primary medical doctor (MD) 1 on 3/16/2025 at approximately 9 a.m. who ordered to transfer Resident 2 to GACH 2 for further evaluation. Resident 2 was assigned a 1:1 sitter (refers to a facility staff dedicated to providing continuous, one-on-one observation and care to a single resident, often to ensure their

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safety and prevent potential harm) to monitor his (Resident 2) aggressive behavior (any behavior intended to harm or cause distress to another person, either physically or emotionally). Resident 2 was transferred to GACH 2 for further psychiatric evaluation (a comprehensive assessment of an individual ' s mental health status, conducted by a qualified mental health professional) and treatment on 3/16/2025 at 6:10 p.m.

3. On 3/16/2025 at approximately 9:15 a.m., RN 1 initiated body assessment on Resident 1 and noted abrasions on both of his (Resident 1) knees. RN 1 initiated the COC on Resident 1. RN 1 called the paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) who arrived on 3/16/2025 at around 9:20 p.m. and transferred Resident 1 to GACH 1. RN 1 called the local police.

4. On 3/16/2025 at 9:05 p.m., Resident 1 came back from GACH 1 with eight stitches of sutures on Resident 1 ' s left thumb cut. Resident 1 was monitored for 72 hours for any fall complications and symptoms of emotional distress related to the altercation with Resident 2. Social Services staff continued to do a wellness visit to Resident 1 from 3/16/2025 to 3/19/2025 for emotional support and feeling of safety. The Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) visited Resident 1 on 3/17/2025 at 4 p.m. A Psychologist (a mental health professional who specializes in understanding and treating mental, emotional, and behavioral disorders) visited Resident 1 on 3/19/2025.

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F 689	Continued From page 40 5. On 3/16/2025 at 2:30 p.m., the Director of Nursing (DON) via telephone had provided a 1:1 education (refers to individualized, one-on-one education provided to a single individual by a staff member or professional) to RN 1 regarding facility policies for abuse prevention that included all type of abuse and educating on the facility ' s policy and procedure on resident supervision specifically on following the residents ' smoking schedule to ensure that supervision is provided to residents in the smoking patio and on the other areas of the facility like the front entrance backyard and other patio location to ensure each resident ' s safety. On 3/21/2025 and 3/22/2025, the DON provided 1:1 education to RN 2, Certified Nursing Assistant (CNA) 1, and CNA 2 regarding resident safety, supervision, and abuse prevention and management. Licensed Vocational Nurse (LVN) 1, who is currently on vacation, will be educated prior to coming back on the floor. 6. On 3/17/2025 at 2 a.m., the facility readmitted Resident 2 from GACH 2. The facility provided 1:1 sitter to Resident 2 to monitor his aggressive behavior. Social Services staff continued doing wellness visit (an appointment to create or update a personalized prevention plan focusing on preventative care and health risk assessments) to Resident 2 starting on 3/17/2025 at 1:17 p.m. who verbalized he (Resident 2) is doing well in the facility. On 3/18/2025 at 2:30 p.m., The Psychiatrist had seen Resident 2. On 3/18/2025 at 12:44 p.m., four local police officers came to the facility and apprehended Resident 2. 7. On 3/17/2025, the Administrator posted signs of "No Weapons Allowed" in the facility. The signs are posted in the front entrance door, facility	F 689		

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F 689	Continued From page 41 entrance, and employee lounge. Additional posts will be done in other areas of the facility. 8. On 3/17/2025 until 3/22/2025, the Director for Staff Development (DSD), the Administrator, DON, and Assistant Administrator provided all facility staff with an in-service (a planned, workplace-based training program designed to enhance staff competency, improve job performance, and keep staff up to date with current best practices and new techniques) for all types of Abuse. 9. The facility made the following efforts to locate the knife used by Resident 2 to injure Resident 1: a. On 3/16/2025, RN 1 and LVN 1 attempted to search Resident 2, however, Resident 2 refused. b. On 3/16/2025, RN 1 and LVN 1 searched the Smoking Patio but could not locate the knife. c. On 3/16/2025, the Administrator asked the police officer to conduct body search on Resident 2, the police officer stated that he cannot conduct it at this time. d. On 3/16/2025, LVN 2 conducted a search in Resident 2 ' s room, in the trash cans, all drawers, closets, inside the shoes, under the mattresses, and the bathroom. Resident 2 ' s knife was not located. e. On 3/16/2025, the housekeeper and laundry employees searched all trash carts, and laundry area, knife was not located. f. On 3/19/2025, the Department heads conducted searches in all residents' rooms and	F 689		

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F 689	Continued From page 42 belongings. Resident 2 ' s knife was not located. g. On 3/19/2025, the Maintenance Supervisor searched the roof top, knife was not located. h. On 3/22/2025, Administrator started reviewing the video footage to find the location of the knife. The Administrator is new, who started on 12/7/2024, was not given yet the capability to review the surveillance camera but is now able to review as of 3/22/2025. The Administrator is currently working with the Information Technology (IT) staff to assist if there will be any issues regarding the video surveillance footages. i. The Administrator/designee will coordinate all efforts to exhaustively and continuously search for the missing knife used by Resident 2 until it (the knife) is found. Once knife is found the administrator will take a picture of where the knife was found, will place it in a bag, will handle with caution, and will turn it in to the police department. A notification will be sent to the SSA. 10. On 3/19/2025 and 3/20/2025, the Department Heads conducted resident safety check on their assigned rooms using the resident inventory of personal belongings log to identify presence of any weapons or sharp objects after obtaining consents from self-responsible and alert residents and from residents ' responsible parties for residents who are not self-responsible. 11. On 3/19/2025 and 3/20/2025, the MDS Nurse, DON, and Activity Staff smoking attendant conducted 1:1 smoking observation of residents smoking in the smoking patio. After the smoking observation of residents, the MDS Nurse conducted a Smoking Risks Evaluation to determine if a smoker requires supervision or is	F 689		

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an independent smoker during smoking time. The MDS Nurse have identified eight residents who require supervision during smoking and ten residents who can independently smoke in the smoking patio. All the 18 residents have the potential to be affected by the deficient practice therefore the facility shall provide residents supervision both for supervised and independent smokers to ensure residents ' safety.

12. On 3/21/2025, a new policy and procedure for Firearms and Other Weapons was initiated and will be presented to the Medical Director on 3/24/2025 during an emergency meeting.

13. Department head managers during their routine rounds will conduct a safety room check on their assigned rooms to inspect the presence of sharp objects. Any kinds of sharp objects will be seized and reported to the Administrator for further follow-up.

Findings:

1. During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility originally admitted Resident 1 on 9/15/2020 and readmitted on 5/28/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thoughts), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2024, the MDS indicated Resident 1 ' s cognition was moderately impaired. The MDS

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indicated Resident 1 ' s mobility (movement) device includes the use of a manual wheelchair (a wheeled mobility chair propelled by human power, either by the user themselves or by a caregiver pushing the wheelchair). The MDS indicated Resident 1 needing partial/moderate assistance (helper does less than half the effort and helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for shower or bathing self. The MDS indicated Resident 1 needing setup or clean-up assistance (helper sets up or cleans up; resident completes activity with helper assisting only prior to or following the activity) with eating.

During a review of Resident 1 ' s "Non-Compliance for Smoking Policy" warning, dated 1/11/2024, the "Non-Compliance for Smoking Policy" warning indicated Resident 1 was given a verbal warning after Resident 1 was found on the smoking patio during a non-smoking time turning an ashtray dispenser (a device or container designed to hold and dispense ashtrays) upside down to remove any cigarettes that had already been discarded and Resident 1 chewed on the cigarette butts.

During a review of Resident 1 ' s care plan on chronic (recurring) disruptive behavior (actions that interfere with the functioning of an individual or a group and cause disturbances to those around them, often involving aggression, defiance, or violation of social norms), revised on 9/28/2024, the care plan indicated Resident 1 had a history of physical abuse with another resident (name not indicated).

During a review of Resident 1 ' s care plan with the focus on the resident as a smoker and chews

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tobacco, revised on 10/3/2024, the care plan indicated Resident 1 was non-compliant (disobedient) with the smoking policy and was on the patio during non-smoking time, turning the ash tray dispenser upside down to remove cigarette butts to chew. The care plan indicated Resident 1 will not smoke without supervision.

During a review of Resident 1 ' s COC, dated 3/16/2025 at 9 a.m., the COC indicated Resident 1 came to the nursing station on 3/16/2025 at approximately around 8:40 a.m. with bleeding on left thumb. The COC indicated RN 1 conducted a body assessment on Resident 1 with noted laceration on left thumb and abrasion to bilateral knees. The COC indicated the paramedics transferred Resident 1 to GACH 1 for further evaluation.

2. During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated Resident 2 was admitted on 7/19/2024 with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), schizophrenia, and hemiplegia (paralysis [inability to move] of one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (loss of blood flow to a part of the brain) affecting right dominant side.

During a review of Resident 2 ' s Inventory of Personal Effects (an itemized list of belongings of a resident), dated 7/19/2024, the Inventory of Personal effects did not indicate that Resident 2 was in possession of a knife. The form was completed and documented by CNA 4 and

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counter signed (a signature attesting the authenticity of a document already signed by another) by Resident 2.

During a review of Resident 2 ' s H&P, dated 7/22/2024, the H&P indicated Resident 2 had the mental capacity to understand and make decisions.

During a review of Resident 2 ' s care plan on resident as a supervised smoker (refers to an individual who, due to assessed needs or identified risks, requires direct supervision or assistance when smoking to ensure their safety and the safety of those around them), revised on 10/10/2024, the care plan indicated Resident 2 was non-compliant with the use of the smoking apron, schedule time, and was at risk for injury from unsafe smoking practices. The care plan indicated Resident 2 ' s risk to smoke without supervision will be minimized, and Resident 2 will be monitored for any unsafe smoking practices.

During a review of Resident 2 ' s MDS, dated 1/24/2025, the MDS indicated Resident 2 ' s cognition was intact. The MDS indicated Resident 2 ' s mobility devices included the use of a walker (a mobility aid designed to assist individuals with difficulty walking) and manual wheelchair. The MDS indicated Resident 2 needed partial/moderate assistance with toilet transfer.

During a review of Resident 2's COC Evaluation, dated 3/17/2025, the COC indicated that on the morning of 3/16/2025 Resident 2 had an altercation with another resident (Resident 1).

During a review of the facility ' s "Smoking Schedule," (undated), the "Smoking Schedule"

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indicated that on Saturdays and Sundays, residents are scheduled to smoke between 9 a.m. to 9:30 a.m., 11 a.m. to 11:30 a.m., 1 p.m. to 1:30 a.m., 3 p.m. to 3:30 p.m., and 7 p.m. to 7:30 p.m.

During a concurrent observation and interview on 3/18/2025 at 10:10 a.m. with Resident 1 in Resident 1 ' s room, Resident 1 ' s left thumb was observed covered in a foam dressing. Resident 1 stated Resident 2 was disrespectful and used inappropriate words. Resident 1 stated, "He (referring to Resident 2) has no respect for anybody, he (Resident 2) can ' t talk like that."

During an interview on 3/18/2025 at 10:34 a.m. with RN 1, RN 1 stated on 3/16/2025 at approximately 8:40 a.m. Resident 1 came to the nursing station and informed RN 1 that Resident 2 cut his (Resident 1) hand while Resident 1 was trying to take a knife from Resident 2 in the smoking patio. RN 1 also stated that Resident 1 was bleeding from the laceration on his left thumb. RN 1 stated while in the smoking patio, he (RN 1) questioned Resident 2 regarding possession of a knife but Resident 2 denied. RN 1 stated he (RN 1) did not inspect Resident 2 for the possession of a knife since Resident 2 denied having a knife. RN 1 stated it was him (RN 1) who opened the door to the smoking patio for a resident (name not specified) and left it open allowing Resident 1 and Resident 2 to enter the smoking patio with no staff present to supervise the two residents (Resident 1 and Resident 2). RN 1 stated that he (RN 1) was in the nursing station when Resident 1 and Resident 2 had a physical altercation.

During an interview on 3/18/2025 at 11:56 a.m.

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F 689	Continued From page 48 with CNA 1, CNA 1 stated she was the CNA assigned to Resident 1 on 3/16/2025. CNA 1 stated she was with another resident (name not specified) when the physical altercation between Resident 1 and Resident 2 happened in the smoking patio. CNA 1 stated the next time she (CNA 1) saw Resident 1 was in the hallway near the nursing station with RN 1 applying pressure on Resident 1 ' s bleeding hand. CNA 1 stated she (CNA 1) heard Resident 1 saying he (Resident 1) was trying to get a knife from another resident (Resident 2). During a concurrent observation and interview on 3/18/2025 at 3:18 p.m. with Activity Staff (AS) 1 in the hallway, AS 1 was sitting in the hallway, near the smoking patio with doors closed. Two residents (names not indicated) were observed smoking in the patio through the glass panel on the doors. AS 1 stated the residents smoking in the patio are independent smokers but require supervision since occasionally, they pick up cigarette butts from the floor and try to chew them. AS 1 also stated she should have supervised residents while staying outdoors in the smoking patio. AS 1 stated the entire smoking patio is not visible from behind the hallway doors and she is not able to see all the residents in the patio. AS 1 stated all residents smoking in the patio should be supervised to prevent resident injury. During an interview on 3/19/2025 at 9:15 a.m., with RN 1, RN 1 stated on 3/16/2025 between 8 a.m. and 8:30 a.m., Resident 1 and Resident 2 were smoking in the smoking patio without supervision. RN 1 stated Residents 1 and 2 should have been supervised while smoking in the patio.	F 689		

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F 689	Continued From page 49 During a concurrent interview and record review on 3/19/2025 at 11:22 a.m. with the MDS Specialist, Resident 2 ' s "Smoking Evaluation," dated 10/10/2024, was reviewed. The "Smoking Evaluation" indicated Resident 2 was noted with episode of non-compliance with the use of the smoking apron and required periodic supervision. The MDS Specialist stated Resident 2 was a supervised smoker. The MDS Specialist also stated residents should not be smoking outside of the scheduled smoking times and all residents should be supervised by the facility staff while smoking. During a concurrent observation, interview, and record review on 3/19/2025 at 12:10 p.m., the facility ' s video surveillance footage of the smoking patio with the recording date and time of 3/16/2025 at 8:22:57 a.m. (adjusted to reflect actual time) was observed and reviewed with the Administrator. The Administrator verified Resident 1 and Resident 2 as the residents in the video surveillance. Both residents (Resident 1 and Resident 2) were on their wheelchairs, were in the East Smoking Patio. The Administrator stated the video surveillance time stamp was not updated to reflect spring daylight savings time (refers to the practice of advancing clocks forward one hour from standard time, typically on the second Sunday in March, to make better use of natural daylight during the warmer months) and was one hour behind the actual time. The Administrator also stated the entrance to the East Smoking Patio was not visible in the video surveillance due to the location of the camera. The Administrator stated there was only one camera in the East Smoking Patio. The Administrator stated the following with time	F 689		

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F 689	Continued From page 50 stamps adjusted to reflect the actual times: a. On 3/16/2025 at 8:22:59 a.m., Resident 1 entered the East Smoking Patio from the hallway between Nursing Station 500 and the kitchen. b. On 3/16/2025 at 8:24:08 a.m., Resident 2 entered the East Smoking Patio from the same entrance. c. On 3/16/2025 at 8:26:58 a.m., Resident 1 stood up from his wheelchair and walked towards Resident 2 and they were exchanging words. d. On 3/16/2025 at 8:27:08 a.m., Resident 2 attempted to slap Resident 1 ' s hand while Resident 1 was pointing his hand towards Resident 2. e. On 3/16/2025 at 8:29:22 a.m., Resident 2 pointed a knife towards Resident 1 ' s face. f. On 3/16/2025 at 8:29:56 a.m., Resident 1 fell on the ground after trying to take the knife from Resident 2 ' s hands. g. On 3/16/2025 at 8:30:20 a.m., Resident 1 went back and sat in his wheelchair and entered the facility at 8:30:42 a.m. The Administrator stated there was no facility staff present in the smoking patio as observed in the video surveillance. During an interview on 3/19/2025 at 1:36 p.m. with the DON, the DON stated the facility failed to provide supervision to Resident 1 and Resident 2 on 3/16/2025 in the smoking patio, which led to a physical altercation between the two residents (Resident 1 and Resident 2) and Resident 1 sustaining an injury. The DON stated the facility	F 689		

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has not found the knife used by Resident 2. The DON stated there is a possibility that the knife is still in the facility or in the possession of another resident.

During an interview on 3/19/2025 at 3:16 p.m. with the Administrator, the Administrator stated Resident 1 had informed the Administrator that Resident 2 was using inappropriate words towards Resident 1. The administrator also stated the physical altercation between Resident 1 and Resident 2 could have been prevented if the two residents (Resident 1 and Resident 2) were supervised in the smoking patio.

During an interview on 3/20/2025 at 2:45 p.m. with the Administrator, the Administrator stated the knife used by Resident 2 to injure Resident 1 was not found. The Administrator also stated body inspection was not done on Resident 2 since Resident 2 refused. The Administrator stated there was a possibility Resident 2 ' s knife is still in the facility.

During a review of the current facility-provided policy and procedure titled, "Smoking Policy-Residents," last reviewed on 4/2024, the policy and procedure indicated, "This facility has established and maintains safe resident smoking practices .... Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking."

During a review of the current facility-provided policy and procedure titled, "Safety and Supervision of Residents," last reviewed on 4/2024, the policy and procedure indicated,

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F 689	Continued From page 52 "Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .... Individualized, Resident-Centered Approach to Safety: 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .... 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision .... Systems Approach to Safety: ... 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment of if there is a change in the resident ' s condition."	F 689		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		

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F 712	Continued From page 53 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a face-to-face visit (a required in-person meeting between a healthcare provider and a resident) was made by a physician or alternate visits by a Nurse Practitioner (NP) was conducted timely according to the facility ' s policy and procedure on "Physician Visits" for three of four sampled residents (Resident 5, Resident 6, and Resident 8). This deficient practice had the potential to result in an undetected decline in Residents 5, 6, and 8's medical, health or psychosocial conditions and can lead to a delay in the necessary provision of care, treatment, and services. Findings: During a record review of Resident 5 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/10/2024 with diagnoses including cellulitis (a bacterial infection of the skin and tissues, causing redness, swelling, and pain) of the left upper extremity (shoulder, arm and leg), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and muscle weakness. During a record review of Resident 5 ' s Attending Progress Note, dated 11/21/2024, the Attending	F 712		

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Progress Note indicated NP 1 visited and assessed the resident. The note did not indicate that the Attending Physician (MD) visited Resident 5.

During a record review of Resident 5 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/24/2024, the MDS indicated Resident 5 ' s cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact.

During a record review of Resident 5 ' s History and Physical (H&P), dated 12/11/2024, the H&P indicated MD 1 and NP 2 visited and assessed the resident. There was no documented H&P or Attending Progress Note in Resident 5 ' s electronic health record (EHR) and printed medical records after 12/11/2024.

During a record review of Resident 6 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/8/2024 with diagnoses including type 2 diabetes mellitus, cystitis (inflammation of the bladder [a hallow organ that stores urine in the body]), and depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities).

During a record review of Resident 6 ' s MDS, dated 1/15/2025, the MDS indicated Resident 6 ' s cognitive skills for daily decision making were intact.

During a record review of Resident 6 ' s H&P, dated 7/8/2024, the H&P indicated NP 3 visited and assessed the resident. The note did not

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indicate that MD 2 visited Resident 6. There was no documented H&P or Attending Progress Note in Resident 6 ' s EHR and printed medical records after 7/8/2024.

During a record review of Resident 8 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 6/8/2023 with diagnoses including type 2 diabetes mellitus, essential hypertension (an abnormally high blood pressure that was not a result of a medical condition), and anxiety disorder (persistent and excessive worry that interferes with daily activities).

During a record review of Resident 8 ' s MDS, dated 12/12/2024, the MDS indicated Resident 8 ' s cognitive skills for daily decision making were intact.

During a record review of Resident 8 ' s H&P, dated 12/20/2024 and 3/7/2025, the H&P indicated MD 1 and NP 2 visited and assessed the resident. There was no documented H&P or Attending Progress Note in Resident 8 ' s EHR and printed medical records for 1/2025 and 2/2025.

During an interview on 3/21/2025 at 9:04 a.m. and a concurrent record review of Resident 5, Resident 6, and Resident 8 ' s H&Ps and Attending Physician Notes, reviewed with Registered Nurse (RN) 2, RN 2 stated there were no documented evidence that Resident 8 ' s MD visited the resident on 1/2025 and 2/2025. RN 2 stated a physician ' s progress notes should be in the residents ' medical records. RN 2 stated no documented physician progress notes indicated the MD did not assess the resident. RN 2 stated

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the residents ' condition had the potential to worsen. RN 2 stated the facility failed to ensure the attending physicians visited the residents and documented the visit according to the facility ' s policy and procedure.

During an interview on 3/21/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated the physician progress notes were proof that the MD assessed the residents and verified the residents ' medications were accurate. The DON stated the staff involved in the residents ' care had the potential to make inconsistent or inaccurate medical decisions that had the potential to cause harm to the residents.

During a record review of the facility ' s Policy and Procedure (PnP) titled, "Physician Visits," last reviewed on 4/2024, the PnP indicated the attending physician must visit his/her patients at least once every 30 days for the first 90 days following the resident ' s admission and then at least every 60 days thereafter. The policy indicated that after the first 90 days, if the attending physician determines that a resident need not be seen by him every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A physician assistant or NP may make alternate visits after the initial 90 days following admission.

During a record review of the facility ' s PnP titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the Attending Physician will visit the residents in an timely .... The PnP indicated the MD will provide progress notes in a timely manner for placement in the medical record. The PnP indicated the note should either be written of entered at the time of

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F 712	Continued From page 57 the visit or should be returned to the facility for placement on the chart within one week.	F 712		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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F 842	Continued From page 58 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical records of three of four sampled resident ' s (Resident 5, Resident 6, and Resident 7) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to:	F 842		

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F 842	Continued From page 59 1. Ensure Resident 5 and Resident 7 ' s physician telephone orders were dated and signed. 2. Ensure Resident 5, Resident 6, and Resident 7 ' s Attending Physician (MD) reviewed and signed the residents ' Order Summary every month. 3. Ensure Resident 6 ' s medical records do not contain blank worksheet forms and blank consent forms with Nurse Practitioner's (NP) signatures. These deficient practices had the potential for inaccurate medical interventions and inaccurate information on Residents 5, 6, and 7 ' s medical records. Findings: a. During a record review of Resident 5 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/10/2024 with diagnoses including cellulitis (a bacterial infection of the skin and tissues, causing redness, swelling, and pain) of the left upper extremity (shoulder, arm and leg), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and muscle weakness. During a record review of Resident 5 ' s Physician Order for oxycodone-acetaminophen (a medication used to relieve severe pain) 10-325 milligrams (mg - unit of measurement) and tramadol hydrochloride (a medication used to relieve moderate to severe pain), dated 12/10/2024, the order did not indicate the physician ' s signature and the date the physician orders were signed. The transcribed physician ' s	F 842		

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order in the electronic health record (EHR) indicated the communication method (the method the order was received) for the physician orders were through telephone.

During a record review of Resident 5 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/24/2024, the MDS indicated Resident 5 ' s cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact.

During an interview on 3/20/2025 at 12:34 p.m. and concurrent record review of Resident 5 ' s Order Summary, dated 12/10/2025, reviewed with Licensed Vocational Nurse (LVN) 3, the Order Summary did not indicate a physician ' s signature and date Resident 5 ' s orders were signed. MD 1 signed Resident 5 ' s Order Summary on 9/4/2024. LVN 3 stated MD 1 ' s signature on the Order Summary indicated MD 1 approved the listed orders for Resident 5. LVN 3 stated the medical records staff were responsible to ensure the physicians signed Resident 5 ' s physician telephone orders and the resident ' s Order Summary. LVN 3 stated unsigned physician ' s orders had the potential for Resident 5 ' s unapproved and inaccurate orders.

During an interview on 3/21/2025 at 10:45 a.m. with the Health Information Director (HID), the HID stated she was responsible for ensuring the facility audits were done timely and the residents ' medical records were complete. The HID stated she was responsible to ensure the MDs sign the residents ' medical records. The HID stated the physicians should not sign blank consent forms. The HID stated there should be three months of

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F 842	Continued From page 61 printed and signed resident ' s Order Summary in the residents ' medical records. The HID stated incomplete resident medical records had the potential for residents to receive inaccurate and incomplete care. The HID stated the facility failed to ensure the residents ' medical records were complete and accurate. During an interview on 3/21/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated Resident 5 and Resident 7 ' s physician telephone orders and Order Summary were not signed. The DON stated the MDs should review and sign the Order Summary for Resident 5 and Resident 7 every month. The DON stated unsigned physician orders had the potential for resident harm due to inaccurate or incorrect orders. The DON stated the facility failed to follow the telephone order policy and failed to ensure the physician telephone orders and the residents ' Order Summary were signed and dated. During a record review of the facility ' s Policy and Procedure (PnP) titled, "Medication and Treatment Orders," reviewed on 4/2024, the PnP indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. The PnP indicated verbal orders must be signed by the prescriber at his or her next visit. During a record review of the facility ' s PnP titled, "Telephone Orders," last reviewed on 4/2024, the PnP indicated verbal telephone orders may be accepted from each resident ' s Attending Physician. The PnP indicated telephone orders must be countersigned by the physician during his or her next visit.	F 842		

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F 842	Continued From page 62 During a record review of the facility ' s PnP titled, "Charting and Documentation," last reviewed on 4/2024, the PnP indicated that documentation in the medical record will be objective, complete, and accurate. During a record review of the facility ' s PnP titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the physician will periodically review all medications prescribed for the resident .... The PnP indicated the physician will verify accuracy of verbal orders when they are given and will authenticate, co-sign, and date them in a timely manner no later than the next visit to the resident. b. During a record review of Resident 6 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/8/2024 with diagnoses including type 2 diabetes mellitus, cystitis (inflammation of the bladder [a hallow organ that stores urine in the body]), and depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities). During a record review of Resident 6 ' s MDS, dated 1/15/2025, the MDS indicated Resident 6 ' s cognitive skills for daily decision making was intact. During an interview on 3/20/2025 at 12:55 p.m. and concurrent record review of Resident 6 ' s medical records, reviewed with LVN 3, Resident 6 ' s medical records did not have a printed and signed Order Summary. Resident 6 ' s medical records indicated a physician ' s signature, signed by the NP, on the following blank forms:	F 842		

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 _____	C 03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACLAY HEALTHCARE CENTER	**12831 MACLAY STREET SYLMAR, CA 91342**

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F 842	Continued From page 63 1. One set of Admission Diagnosis Worksheet. 2. Two sets of Facility Verification of Informed Consents. 3. One set of Certification and Recertification for Medicare A Skilled Nursing Facility. 4. One set of MD Query on Malnutrition form. LVN 3 stated Resident 6 ' s Order Summary should be in the resident ' s medical records. LVN 3 stated MD 2 should sign Resident 6 ' s Order Summary every month to indicate that MD 2 approved the orders required for Resident 6 ' s care. LVN 3 stated the Facility Verification of Informed Consents were consents used for residents that required psychotropic medications (medications used to stabilize or improve mood, mental status, or behaviors) and restraints. LVN 3 stated Resident 6 ' s physicians should sign the resident ' s medical record forms after it was completed. LVN 3 stated signed blank forms and consents had the potential for Resident 6 to receive inappropriate or wrong care. During an interview on 3/21/2025 at 10:45 a.m. with the Health Information Director (HID), the HID stated she was responsible for ensuring the facility audits were done timely and the residents ' medical records were complete. The HID stated she was responsible to ensure the MDs sign the residents ' medical records. The HID stated the physicians should not sign blank consent forms. The HID stated there should be three months of printed and signed resident ' s Order Summary in the residents ' medical records. The HID stated incomplete resident medical records had the potential for residents to receive inaccurate and	F 842		

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 842	Continued From page 64 incomplete care. The HID stated the facility failed to ensure the residents ' medical records were complete and accurate. During an interview on 3/21/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated Resident 5 and Resident 7 ' s physician telephone orders and Order Summary were not signed. The DON stated the MDs should review and sign the Order Summary for Resident 5 and Resident 7 every month. The DON stated unsigned physician orders had the potential for resident harm due to inaccurate or incorrect orders. The DON stated the facility failed to follow the telephone order policy and failed to ensure the physician telephone orders and the residents ' Order Summary were signed and dated. During a record review of the facility ' s PnP titled, "Charting and Documentation," last reviewed on 4/2024, the PnP indicated that documentation in the medical record will be objective, complete, and accurate. During a record review of the facility ' s PnP titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the physician will periodically review all medications prescribed for the resident ...The PnP indicated the physician will verify accuracy of verbal orders when they are given and will authenticate, co-sign, and date them in a timely manner no later than the next visit to the resident. c. During a record review of Resident 7 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/11/2009 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung	F 842		

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F 842	Continued From page 65	F 842		

disease characterized by long term poor airflow), epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]), and depression.

During a record review of Resident 7 ' s MDS, dated 1/31/2025, the MDS indicated Resident 7 ' s cognitive skills for daily decision making was intact.

During a record review of Resident 7 ' s Physician Order for Lotensin (a medication used to treat high blood pressure), dated 1/23/2025, did not indicate the physician ' s signature and the date the physician orders were signed. The transcribed physician ' s order in the EHR indicated the communication method for the physician orders were by telephone.

During an interview on 3/21/2025 at 9:04 a.m. and concurrent record review of Resident 7 ' s Order Summary, dated 9/4/2024, reviewed with Registered Nurse (RN) 2, RN 2 stated the printed Order Summary in Resident 7 ' s medical record was the MD 1 signed and dated Resident 7 ' s Order Summary on 9/4/2024. RN 2 stated Resident 7 ' s medical records should have the printed and signed Order Summary for the last three months. RN 2 stated the medical records staff were responsible to ensure Resident 7 ' s medical records were complete and accurate. RN 2 stated Resident 7 ' s medical record was inaccurate and incomplete.

During an interview on 3/21/2025 at 10:45 a.m. with the Health Information Director (HID), the HID stated she was responsible for ensuring the

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F 842	Continued From page 66	F 842		

facility audits were done timely and the residents ' medical records were complete. The HID stated she was responsible to ensure the MDs sign the residents ' medical records. The HID stated the physicians should not sign blank consent forms. The HID stated there should be three months of printed and signed resident ' s Order Summary in the residents ' medical records. The HID stated incomplete resident medical records had the potential for residents to receive inaccurate and incomplete care. The HID stated the facility failed to ensure the residents ' medical records were complete and accurate.

During an interview on 3/21/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated Resident 5 and Resident 7 ' s physician telephone orders and Order Summary were not signed. The DON stated the MDs should review and sign the Order Summary for Resident 5 and Resident 7 every month. The DON stated unsigned physician orders had the potential for resident harm due to inaccurate or incorrect orders. The DON stated the facility failed to follow the telephone order policy and failed to ensure the physician telephone orders and the residents ' Order Summary were signed and dated.

During a record review of the facility ' s Policy and Procedure (PnP) titled, "Medication and Treatment Orders," reviewed on 4/2024, the PnP indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. The PnP indicated verbal orders must be signed by the prescriber at his or her next visit.

During a record review of the facility ' s PnP titled, "Telephone Orders," last reviewed on 4/2024, the

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F 842	Continued From page 67 PnP indicated verbal telephone orders may be accepted from each resident ' s Attending Physician. The PnP indicated telephone orders must be countersigned by the physician during his or her next visit. During a record review of the facility ' s PnP titled, "Charting and Documentation," last reviewed on 4/2024, the PnP indicated that documentation in the medical record will be objective, complete, and accurate. During a record review of the facility ' s PnP titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the physician will periodically review all medications prescribed for the resident .... The PnP indicated the physician will verify accuracy of verbal orders when they are given and will authenticate, co-sign, and date them in a timely manner no later than the next visit to the resident.	F 842		

MACLAY
HEALTHCARE CENTER

Plan of Correction
FRI# CA00951926

Maclay Healthcare Center makes every effort to comply with the State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Maclay Healthcare Center submitted this plan of correction to comply with the State and Federal regulations and does not waive any objection obtained. This plan of correction is our credible allegation of compliance for deficiency noted findings of the California Department of Public Health during the Facility reported incidents survey completed on 3/22/25.

F583 Personal Privacy/Confidentiality of Records

Immediate Corrective Action:

- On 3/21/25, the RN2 removed Resident 9's narcotic sheet that was left unattended in Nurse Station 300 and was given to the Heath information staff to file accordingly.
- On 3/21/25, RN2 logged out of the PCC access of LVN 4 who worked on 3/20/25 11-7 shift in station 3 computer to protect Resident 10, Resident 11 and Resident 12's confidential personal information
- On 3/24/25, Maintenance supervisor removed all the acrylic receptacle on the wall in the stations that stores residents' paper record and replaced it with a plastic container place near the copy machine to store paper record that needs to be filed in their chart to ensure residents confidentiality of information.
- On 3/25/25, Director of Nursing provided LVN1 with an education regarding confidentiality of residents' information including ensuring the privacy of residents EHR information.
- Per LVN 4 statement, she was given a 1:1 verbal in-service by the RN supervisor on 3/25/25 on the 11-7 shift. Director of Nursing on 4/17/25 at 3:40 PM provided a follow-up 1:1 re-education regarding resident's confidentiality and privacy of records including Security of PCC access.

Other residents affected by this deficient practice:

- On 4/8/25 and 4/9/25, the department heads assigned in their specific stations conducted rounds of nurse station 100, 200, 300 and 400 to inspect the nursing station to ensure confidential personal information of residents is not left unattended. No other residents were identified to be affected by the same alleged deficiency.

Systemic Changes and Measures:

- DON on 3/25/25, 3/27/25 and 4/9/25 had provided an in service to licensed nurses and department heads regarding confidentiality and privacy of resident's medical information and Electronic medical

records. DON reviewed the facility policy on "Electronic Medical Records," which placed focus on only authorized persons who have been issued a password and user ID code will be permitted access to the electronic medical records system. The PnP indicated the medical records system safeguards the prevent unauthorized access of electronic protected health information (e-PHI). These safeguards included administrative, technical, and physical safeguards.

- Director of Nursing on 4/17 /25 at 4:40 PM initiated an in-service to CNAs regarding confidentiality and privacy of resident's records including Security of PCC and POC access to ensure that resident's information is safe and kept private. This in-service will be ongoing till 4/18/25 and as needed for any reoccurrence finding regarding resident records confidentiality and privacy.
- During routine rounds, the RN supervisor and charge nurse on each shift shall check all the nursing stations and check the laptop of each medication cart including the computers in the nursing stations to ensure that confidential personal information of residents is not left unattended. This procedure will be ongoing to ensure confidentiality and privacy of residents' records.
- DON and the Health information Director shall conduct daily rounds (M-F) and Manager of the day (MOD) on the weekends to check all the nursing stations to conduct inspection to ensure that resident's confidential personal information is not left unattended and laptop and computer are all signed off.
- Negative findings will be corrected immediately and will be forwarded to the CEO/designee for needed follow through

Monitor for Performance:

- The CEO / designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting monthly x 3 months. If there are no negative findings reported after 3 months the issue is considered resolved.

Completion Date: 4/18/25

MACLAY
HEALTHCARE CENTER

Plan of Correction
FRI# CA00951926

Maclay Healthcare Center makes every effort to comply with the State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Maclay Healthcare Center submitted this plan of correction to comply with the State and Federal regulations and does not waive any objection obtained. This plan of correction is our credible allegation of compliance for deficiency noted findings of the California Department of Public Health during the Facility reported incidents survey completed on 3/22/25.

F-600 Free from Abuse and Neglect

Immediate Corrective Action:

1. On 3/16/25 at 8:31 AM, Resident 1 approached station 500 for assistance, RN 1 noted that he had a cut on his left thumb with bleeding, he informed RN 1 that he slipped from his wheelchair and ended up on his knees in the patio. RN 1 immediately conducted first aid and called the LVN treatment nurse to attend to Resident 1. RN 1 asked Resident 1 how he got the cut on his left thumb, Resident 1 stated "The guy is waving his knife and I tried to seize it". RN 1 immediately went to the patio to check and found Resident 2 about to go inside the facility, he did a visual check for an alleged knife and did not see any. RN 1 assisted Resident 2 back to his room and asked Resident 2 what happened in the patio, and he stated "The other resident (Resident 1) fell onto the floor in the smoking patio and cut himself on the floor. Resident denied any physical altercation".
2. RN 1-initiated Resident 1 body assessment on 3/16/25 approximately at 9:15 AM and noted abrasion on both of his knees, change of condition initiated and 911 paramedics and the police were called and came to the facility around 9:20 AM and took the patient to the hospital. MD was made aware of the 911 paramedic transfer of the patient. Resident 1 family member made aware of the incident and the residents hospital transfer. RN 1 initiated the Plan of care of Resident 1 regarding his altercation with another resident.

3. On 3/16/2025 RN 1 contacted the Administrator around 8:45 AM and Director of Nursing regarding the alleged resident to resident altercation between Resident 1 and Resident 2 as reported by Resident 1. At 9:00 AM the Administrator proceeded to drive to the facility to initiate the investigation.
4. RN 1 initiated a change of condition on Resident 2 on 3/16/25 at 9:00 AM, body check done, noted with abrasion on his left hand and wrist, first aid was done and denied any pain. Primary MD was called by RN 1 at approximately 9:00 AM and with orders to transfer Resident 1 to Olive View hospital for further evaluation. Resident 2 was assigned a sitter 1:1 for monitoring his aggressive behavior. RN 1 informed the residents' 1 family member of the resident altercation on 3/16/25 at 9:30 AM. Plan of care was initiated related to the alleged resident to resident altercation.
5. The Administrator on 3/16/25 completed the SOC 341 at 10:35 AM and was faxed to CDPH, Ombudsman and police were called.
6. Resident 2 was transferred to Southern California Hospital of Culver City for further psychiatric evaluation and treatment on 3/16/25 at 18:10 PM.
7. Resident 1 came back from the hospital on 3/16/25 at 21:05 PM. Resident alert, verbally responsive and able to communicate his needs. Body/skin assessment by RN 1, noted with 8 stitches of suture and open to air. Resident 1 with bilateral knees abrasion. Treatment for left thumb cut and left and right knee abrasions were ordered. Residents were monitored for any fall complications and symptoms of emotional distress related to the altercation for 72 hours. Resident 1 continue to receive a wellness visit from Social Services form 3/16/2025 through 3/19/2025 for emotional support and feeling of safety. Resident 1 was visited by a psychiatrist on 3/17/25 at 4;00 PM with new orders carried out. Resident 1 was visited by psychologist on 3/19/25 and according to psychologist progress notes Resident 1 stated he does not think about the incident.
8. Resident 2 was readmitted from the hospital on 3/17/25 at 2:00 AM via ambulance. The resident was provided with sitter 1:1 to monitor his aggressive behavior. Social Services staff continued wellness visit to Resident 2 on 3/17/25 at 13:17 and per resident, "he is doing well and fine in the facility". On 3/18/25 at 2:30 PM, Resident 2 was seen by the psychiatrist with new orders carried out. Four (4) police officers on 3/18/25 at 12:44 PM came to the facility and apprehended Resident 2. Per the police officers, Resident 2 will be taken to Mission Hills Police station and will be transferred to Metro detention center. Social Service staff on 3/18/25 at 12:59 PM called the resident's 2 family member and left a message on her voicemail to contact the facility regarding Resident 2.
9. The Director of Nursing (DON) on 3/16/25 at 2:30 PM via telephone had provided a 1:1 education to RN1 regarding facility policies for abuse prevention that included

all type of abuse such as: physical, verbal, emotional, financial, sexual, neglect, exploitation, isolation, and educating for facility policy and procedure on Residents supervision specifically on following the residents smoking schedule to ensure that supervision is provided to residents in the smoking patio and on the other areas of the facility like the front entrance backyard, other patio location to ensure each residents' safety. On 3/20/25, DON met with RN 1 to provide counselling regarding Residents supervision and safety. RN 1 acknowledged the safety education provided via telephone on 3/16/25. RN2, CNA 1 and CNA 2 provided 1:1 education done by the DON, on 3/21/2025 and 3/22/2025 in regard to resident safety and supervision and abuse prevention and management. LVN1 will be educated prior to coming back on the floor after his vacation.

10. On 3/17/2025 until 3/22/2025 an in service for all type of Abuse was provided to all staff by the DSD, Administrator, DON, Assistant Administrator. Facility is using two methods of in services – in person, which include education with questions and answers interaction and through SNF clinic. SNF clinic includes videos and elaborate explanations with post test at the end. The DSD send blast texts and emails to employees to inform them of the required in service through SNF Clinics. As of now (3/22/2025) we have reached 99% compliance between SNF Clinics and in person in services. 10 employees are on leave and will be off schedule until they will complete the required in services before returning to work.
11. On 3/19/2025 and 3/20/2025 the administrator made few attempts to call the detective handling the case to get information about the resident and to ask if the police obtained the knife from the resident. No call back as of 3/22/2025.
12. The following efforts were made to locate the knife:
    a. On 3/16/2025 RN 1, LVN1, attempted to search Resident 2, however, refused.
    b. On 3/16/2025 RN1, LVN1 searched the Smoking Patio to include all the planters, could not locate the knife. All facility common areas were search to include the nonsmoking patio, and outdoor areas.
    c. On 3/16/2025 the administrator asked the police officer to conduct body search on Resident 2, officer stated that they cannot conduct it at this time. Attestation letter was provided.
    d. On 3/16/2025 Room search was done by LVN2 in Resident 2 room, in all the trash cans in room 101, and all drawers, closets, inside shoes, under mattresses, and the bathroom, knife was not located. Attestation letter was provided.
    e. On 3/19/2025 Department heads conducted a search in all Residents' rooms and belonging, knife was not located.

f. On 3/19/2025 maintenance supervisor searched the roof top, no knife was located.
g. On 3/16/2025 housekeeper and laundry employees searched, all trash carts, and laundry area were searched, knife was not located. Attestation was provided.
h. On 3/21/2025 the Marketer called the hospital Resident 2 was transferred, to inquire if they have any records of the knife. They stated that they will contact us back.
i. On 3/22/2025 Administrator starting reviewing the video footage to find the location of the knife. Administrator is new, as of 12/7/2024, and was not given yet to review the surveillance camera but is now able to review as of 3/22/2025. Currently working with IT if there will be any issues in regard to video surveillance footages.
j. Administrator/designee will coordinate all efforts to exhaustedly search for the missing knife, continuously until it is found. Once the knife is found the administrator will take a picture of where the knife was found, will place it in a bag and will handle with caution, and will turn it in to the police department. A notification will be sent to CDPH.

13. On 3/21/2025 the administrator called Mission Hills Police Department to ask for the whereabouts of resident 2. The officer directed her to the Van Nuys Detention center. The administrator called the Van Nuys Detention center and was told to call the county. The Administrator asked the officer if they had the records of the knife that was used. The detective stated, "we do not have the knife here but if he was arrested, they should have had the knife". The administrator contacted the County and could not talk to an agent. The facility will assess the necessity of transfer or discharge, but any steps will be taken in accordance with applicable stated and federal laws regarding transfer or discharge.
14. The administrator conducted an online inmate search on www.lasd.org and got the arresting information and the approval that resident 2 was arrested on 3/18/2025.
15. On 3/22/2025 a letter was issued to Resident 2 to notify him of his discharge from the facility due to his violation of the admission agreement of not allowing weapon to be brought to the facility. Resident 2 will be afforded his residents rights. The Admission Inventory Information states "Our facility prohibits employees, residents, visitors, vendors or others from possessing firearms and/or other weapons while in/on our facility's premises." This notice was mailed to his last known address and to the County Jail. The letter was emailed to the Resident family member.
16. On 3/24/2025 at 6:12 PM Detective Kirk called the facility CEO, Detective Kirk

stated that when they arrested Mims, Mr. Mims. mentioned to the officers that he threw the knife. The administrator/CEO asked the detective if they had asked Mr. Mims where he threw the knife, and the detective responded that they did not. The The administrator asked the Detective if he could call the county and ask the officers in the jail to ask if they could interview Mims for where he threw the knife. The detective responded that he has no way of doing that. I asked if he could send any of his officers to the jail and conduct the interview, the detective stated, "we do not have the manpower". I asked him if he could send me an email with his statement of Mims throwing away the knife. He said he will do that.

17. On 3/24/2025 at 6:17 PM, Detective Kirk sent his email statement to the Administrator. Administrator informed CDPH via email of this call and conversation with the Detective on 3/24/25 at 6:36 PM .

Other residents affected by this deficient practice:

1. On 3/19/2025 department heads conducted safety rooms check for all residents' rooms in the facility. No sharp objects were found. The representative for the non-alert residents was contacted to obtain verbal consent to conduct the safety check. On 3/21/25 the bioethics committee met to discuss the safety room check for the non-alert residents with no representative. With the recommendations of the Medical Director, the resident will be referred to conservator.
2. On 3/19/2025 thru 3/22/2025 and in service conducted by the DSD, Administrator, DON, Assistant Administrator, on resident-to-resident verbal altercation and separating the residents to avoid escalation in the situation and recognizing potential threats and handling situations where a weapon may be involved. As of 3/22/2025 99% were completed. For staff that have not done the in service as of today, they will be off work until in service is complete. In services are done either through SNF Clinic or in person.
3. On 3/20/2025 department heads conducted interviews with all residents and asked them if they feel safe in the facility and if they have any concerns. For the non-alert residents, representatives were contacted to see if they have any concerns. Resident 3 stated that she does not like one of the residents in the facility though she has not contacted him. Resident 4 stated that she fell before she came to the facility and that is why she does not feel safe. According to family members, they see Resident 4 happier since she got to Maclay.

Systemic Changes and Measures:

1. Director of nursing on 3/25/25.3/27/25,4/01/25 provided and in-service to licensed nurses and with CNAs on 4/11/25 and 4/12/25 on facility policy and procedure regarding Abuse Prevention Program to include all types of abuse, such as physical, verbal, emotional, financial, sexual, neglect, exploitation, and isolation including resident-to-resident verbal altercation and separating the residents to avoid escalation in the situation and recognizing potential threats and handling situations where a weapon may be involved. Administrator on 3/25/25 provided an in-service to Department heads regarding facility policy on Abuse management. .
2. On 4/15/25, Compliagent an outside consulting company shall provide an in-person in-service to staff regarding facility policy on Abuse Prevention and management and types of Abuse. The in-services shall be given in 2 sessions, one at 2:00 PM and one at 4:00 PM. A post-test shall be administered after the in-service to validate staff understanding of the presentation. Compliagent will continue to provide the staff in-services monthly for 4 months till July 2025.
3. Licensed Vocational Nurses and RN Supervisors will ask during shift huddles with CNAs to identify incompatibility that may potentially lead to a resident altercation. For example, if staff is witnessing any arguments between residents, or if they hear any inappropriate language between residents, they should immediately separate residents and report to the charge nurse or RN supervisor. The shift huddle form was revised last 3/27/25 and was initiated on 3/28/25 and is ongoing.
4. During weekends, the Manager of the Day (MOD) will do every 2 hours rounds of checking to identify incompatibility that may potentially lead to a resident altercation. MOD reports are completed at the end of the day and reported to the Administrator/DON.
5. On 3/21/2025 a new P&P for Firearms and Other Weapons was initiated and will be presented to the Medical Director 3/24/2025 (emergency meeting). DON provided an in-service to licensed nurses on 3/25/25, 3/27/25 and 4/01/25 regarding the facility policy on Firearms and other Weapons which states that facility prohibits any employee, resident, visitor, vendor or any individual from possessing firearms or other weapons designed to do bodily harm while in or on the facility premises to ensure residents and staff safety".

Monitor for Performance:

1. Social services staff / Designee will conduct 1 resident per day interview x 7 days for the next two weeks, using our safety questionnaire that includes the following questions: Do you feel safe in the facility and do you have any concerns about any other residents or staff member. Any findings will be reported to the Administrator/DON and will be addressed as needed. This was initiated last 3/22/25 up to April 05, 2025. No residents have verbalized any concerns with other residents or facility staff
2. Department heads conducted residents' safety interviews to alert residents of their assigned room rounds while doing their room rounds, to ensure that residents feel safe, and they are not aware of any abuse occurrence. This was initiated on 3/20/25 on a daily basis (M-F) for 2 weeks until 04/03/25. Room rounds interview is currently ongoing daily till July 31, 2025 to ensure that resident is free from any abuse and feel safe.
3. For the non-alert residents, social services staff / Designee will call representatives to interview them about their experience with their loved ones in the facility. This was initiated on 3/22/25 with 2 family interviews weekly till week 4/14/25 and then monthly x 4 months thereafter until August 31, 2025
4. Quarterly or as needed, IDT will review residents with history of aggressive behavior to ensure all care plans are up to date. There were 3 residents identified with behavioral issues. The IDT team reviewed the residents with history of aggressive behavior and updated care plan starting on 3/27/25, 4/4/25 and 4/11/25 and follow-up will be quarterly and as needed for any change in behavior.
5. The Administrator / Designee will monitor staff and residents for any signs of potential abuse by randomly interviewing them. The administrator conducted resident and staff interviews randomly on 3/28/25, 3/31/25 and ongoing weekly x 4 weeks till week of April 18, 2025 then monthly x 4 months thereafter until August 2025.
6. Upon admission and during quarterly IDT meetings, the Social Services will educate residents and their representatives about the P&P for abuse and the facility protocol of not bringing any sharp objects or weapons to the facility. Resident and resident representatives will be informed of the facility policy on Out on pass. Any findings of such will be confiscated immediately and will be handed to the Administrator/Designee. This was initiated on new admissions and quarterly IDT care plan meeting starting on the week of 3/24/25 and will be ongoing to ensure the safety of residents in the facility.

7. On 3/27/25, Administrator designee provided an in-service to receptionist staff regarding checking residents who goes out in the front lawn; checking residents that are going out on pass and use of the OOP log form as documentation and checking the bags of residents and visitors belongings that are being brought back from out on pass to ensure that no contraband is included in the belongings to ensure residents and staff safety in the facility. This was initiated last 3/27/25 and is ongoing.
8. Admission Nurse and MDS nurse shall ensure the smoking assessment will be completed on admission. Smoking assessment shall be reviewed as part of the initial, quarterly and significant change in condition IDT to ensure accuracy of information and resident centered smoking care plan is in place. This was initiated on new admission/readmission for the week of 3/24/25 and on-going to ensure that residents are made aware of the facility smoking policy, smoking schedule and facility smoking contract.

The administrator/Designee shall ensure that the above process is sustained and ongoing. The Administrator /designee shall report any trends identified on room rounds, safety and Interview round to the monthly QA&A meeting x 3 months or until a benchmark of 100% compliance is sustained

- Completion Date: 4/17/2025

MACLAY
HEALTHCARE CENTER

Plan of Correction
FRI# CA00951926

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F610- Investigate/Prevent/Correct Alleged Violation

Immediate Corrective Action:

On 3/19/2025 and 3/20/2025 the administrator made a few attempts to call the detective handling the case to get information about the resident and to ask if the police obtained the knife from the resident. No call back as of 3/22/2025.

The following efforts were made to locate the knife:

a. On 3/16/2025 RN 1, LVN1, attempted to search Resident 2, however, refused.
b. On 3/16/2025 RN1, LVN1 searched the Smoking Patio to include all the planters, could not locate the knife. All facility common areas were searched to include the nonsmoking patio, and outdoor areas.
c. On 3/16/2025 the administrator asked the police officer to conduct body search on Resident 2, officer stated that they cannot conduct it at this time. Attestation letter was provided.
d. On 3/16/2025 Room search was done by LVN2 in Resident 2 room, in all the trash cans in room 101, and all drawers, closets, inside shoes, under mattresses, and the bathroom, knife was not located. Attestation letter was provided.
e. On 3/19/2025 Department heads conducted a search in all Residents' rooms and belonging, knife was not located.

f. On 3/19/2025 maintenance supervisor searched the roof top, no knife was located.
g. On 3/16/2025 housekeeper and laundry employees searched, all trash carts, and laundry area were searched, knife was not located. Attestation was provided.
h. On 3/21/2025 the Marketer called the hospital Resident 2 was transferred, to inquire if they have any records of the knife. They stated that they will contact us back.
i. On 3/22/2025 Administrator started reviewing the video footage to find the location of the knife. The administrator is new, as of 12/7/2024, and was not given yet to review. Administrator Currently working with IT if there will be any issues in regard to video surveillance footages. The Administrator view video footages from different areas of the facility. Based on Resident's statement to the police officers, her threw the knife.
j. Administrator/designee will coordinate all efforts to exhaustedly search for the missing knife, continuously until it is found. Based on Resident's statement to the police officers, he threw the knife. Once the knife is found the administrator will take a picture of where the knife was found, will place it in a bag and will handle with caution, and will turn it in to the police department. A notification will be sent to CDPH.

2. On 3/21/2025 the administrator called Mission Hills Police Department to ask for the whereabouts of resident 2. The officer directed her to the Van Nuys Detention center. The administrator called the Van Nuys Detention center and was told to call the county. The Administrator asked the officer if they had the records of the knife that was used. The detective stated, "we do not have the knife here but if he was arrested, they should have had the knife". The administrator contacted the County and could not talk to an agent. The facility will assess the necessity of transfer or discharge, but any steps will be taken in accordance with applicable stated and federal laws regarding transfer or discharge.
3. The administrator conducted an online inmate search on www.lasd.org and got the arresting information and the approval that resident 2 was arrested on 3/18/2025.
4. On 3/22/2025 a letter was issued to Resident 2 to notify him of his discharge from the facility due to his violation of the admission agreement of not allowing weapon to be brought to the facility. Resident 2 will be afforded his residents rights. The Admission Inventory Information states "Our facility prohibits employees, residents, visitors, vendors or others from possessing firearms and/or other weapons while in/on our facility's premises." This notice was mailed to his last known address and to the County Jail. The letter was emailed to the Resident family member.
5. On 3/24/2025 at 6:12 PM Detective Kirk called the facility administrator, Detective Kirk stated that when they arrested Mims, Mr . Mims. mentioned to the officers that he

threw the knife. The administrator/administrator asked the detective if they had asked Mr. Mims where he threw the knife, and the detective responded that they did not. The administrator asked the Detective if he could call the county and ask the officers in the jail to ask if they could interview Mims for where he threw the knife. The detective responded that he has no way of doing that. I asked if he could send any of his officers to the jail and conduct the interview, the detective stated, "we do not have the manpower". I asked him if he could send me an email with his statement of Mims throwing away the knife. He said he will do that.

6. On 3/24/2025 at 6:17 PM, Detective Kirk sent his email statement to the Administrator. Administrator informed CDPH via email of this call and conversation with the Detective on 3/24/25 at 6:36 PM.
7. On 3/22/25, the Quality Mentor provided a 1:1 in-service with the administrator regarding Abuse Reporting and Investigations.
8. On 3/24/25, the administrator completed a thorough investigation of the incident on 3/16/25 resident to resident altercation involving the use of a knife. Per Detective report on 3/24/25 to the Administrator, the perpetrator stated to the police detective that he threw the knife.

Other residents affected by this deficient practice:

On 3/25/25, the Administrator reviewed allegations of abuse in the past 90 days to ensure it is thoroughly investigated. There are no other residents identified with the same alleged deficiency.

Systemic Changes and Measures:

1. Director of nursing on 3/25/25.3/27/25,4/01/25 provided and in-service to licensed nurses and with CNAs on 4/11/25 and 4/12/25 on facility policy and procedure regarding Abuse Prevention Program to include all types of abuse, such as physical, verbal, emotional, financial, sexual, neglect, exploitation, and isolation including resident-to-resident verbal altercation and separating the residents to avoid escalation in the situation and recognizing potential threats and handling situations where a weapon may be involved.
2. On 4/15/25, Compliagent an outside consulting company shall provide an in-person in-service to staff regarding facility policy on Abuse Prevention and management and types of Abuse. The in-services shall be given in 2 sessions, one at 2:00 PM and one at 4:00 PM. A post-test shall be administered after the in-service to validate staff understanding

of the presentation. Compliagent will continue to provide the staff in-services monthly for 4 months till July 2025.

3. Licensed Vocational Nurses and RN Supervisors will ask during shift huddles with CNAs to identify incompatibility that may potentially lead to a resident altercation. For example, if staff is witnessing any arguments between residents, or if they hear any inappropriate language between residents, they should immediately separate residents and report to the charge nurse or RN supervisor. The shift huddle form was revised last 3/27/25 and was initiated on 3/28/25 and is ongoing.
4. During weekends, the Manager of the Day (MOD) will do every 2 hours rounds of checking to identify incompatibility that may potentially lead to a resident altercation. MOD reports are completed at the end of the day and reported to the Administrator/DON.
5. On 3/21/2025 a new P&P for Firearms and Other Weapons was initiated and will be presented to the Medical Director 3/24/2025 (emergency meeting).DON provided an in-service to licensed nurses on 3/25/25, 3/27/25 and 4/01/25 regarding the facility policy on Firearms and other Weapons which states that facility prohibits any employee, resident, visitor, vendor or any individual from possessing firearms or other weapons designed to do bodily harm while in or on the facility premises to ensure residents and staff safety".

Monitor for Performance:

1. Social services staff / Designee will conduct 1 resident per day interview x 7 days for the next two weeks, using our safety questionnaire that includes the following questions: Do you feel safe in the facility and do you have any concerns about any other residents or staff member. Any findings will be reported to the Administrator/DON and will be addressed as needed. This was initiated last 3/22/25 up to April 05, 2025. No residents have verbalized any concerns with other residents or facility staff
2. Department heads conducted residents' safety interviews to alert residents of their assigned room rounds while doing their room rounds, to ensure that residents feel safe, and they are not aware of any abuse occurrence. This was initiated on 3/20/25 on a daily basis (M-F) for 2 weeks until 04/03/25. Room rounds interview is currently ongoing daily till July 31, 2025 to ensure that resident is free from any abuse and feel safe.
3. For the non-alert residents, social services staff / Designee will call representatives to interview them about their experience with their loved ones in the facility. This was initiated on 3/22/25 with 2 family interviews weekly till week

4/14/25 and then monthly x 4 months thereafter until August 31, 2025

4. Quarterly or as needed, IDT will review residents with history of aggressive behavior to ensure all care plans are up to date. There were 3 residents identified with behavioral issues. The IDT team reviewed the residents with history of aggressive behavior and updated care plan starting on 3/27/25, 4/4/25 and 4/11/25 and follow-up will be quarterly and as needed for any change in behavior.
5. The Administrator / Designee will monitor staff and residents for any signs of potential abuse by randomly interviewing them. The administrator conducted resident and staff interviews randomly on 3/28/25, 3/31/25 and ongoing weekly x 4 weeks till week of April 18, 2025, then monthly x 4 months thereafter until August 2025.
6. Upon admission and during quarterly IDT meetings, the Social Services will educate residents and their representatives about the P&P for abuse and the facility protocol of not bringing any sharp objects or weapons to the facility. Any findings of such will be confiscated immediately and will be handed to the Administrator/Designee. This was initiated on new admissions and quarterly IDT care plan meeting starting on the week of 3/24/25 and will be ongoing to ensure the safety of residents in the facility.
7. Upon admission and during quarterly IDT meetings, the Social Service / Designee will educate the residents and representative about the facility protocol of identifying any items that are brought to the facility to be recorded on the inventory list. Resident and resident representatives will be informed of the facility policy on Out on pass. This was initiated on new admissions and quarterly IDT care plan meeting starting on the week of 3/24/25 and will be ongoing to ensure the safety of residents in the facility.
8. Upon returning from out on pass, if residents or representatives bring any items back to facility, charge nurse or RN supervisor will be asking for any items the resident would like to be added to the inventory list and be informed that no contraband is allowed in the facility. This was initiated on 3/27/25 and will be ongoing.
9. On 3/27/25, Administrator designee provided an in-service to receptionist staff regarding checking residents who goes out in the front lawn; checking residents that are going out on pass and use of the OOP log form as documentation and checking the bags of residents and visitors belongings that are being brought back from out on pass to ensure that no contraband is included in the belongings to ensure residents and staff safety in the facility. This was initiated last 3/27/25 and is ongoing.
10. The administrator/designee will ensure supervision in the smoking patio, front part of the facility and other resident care area. This was initiated on 3/16/25 and is ongoing to ensure and prevent any verbal or physical abuse from occurring in the smoking patio and other areas of the facility.

11. Admission Nurse and MDS nurse shall ensure the smoking assessment will be completed on admission. Smoking assessment shall be reviewed as part of the initial, quarterly and significant change in condition IDT to ensure accuracy of information and resident centered smoking care plan is in place. This was initiated on new admission/readmission for the week of 3/24/25 and on-going to ensure that residents are made aware of the facility smoking policy, smoking schedule and facility smoking contract.

The administrator/Designee shall ensure that the above process is sustained and ongoing. The Administrator /designee shall report any trends identified on review of any alleged abuse incidents to the monthly QA&A meeting x 3 months or until a benchmark of 100% compliance is sustained.

Completion Date: 4/17/2025

MACLAY
HEALTHCARE CENTER

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F644 Coordination of PASSR and Assessments

Immediate Corrective Action:

- Facility was not able to update Resident's 2 PASRR due to resident was arrested by the police and was taken to jail on 3/18/25.

Other residents affected by this deficient practice:

- On 4/4/25 till 4/9/25, the QA Nurse conducted a review of newly admitted residents from 3/24/24 till 4/09/25 which totals to 10 resident admission. Out of the 10 residents with completed PASRR on admission, 4 residents were found to have inaccurate PASRR assessment, 3 were corrected and resubmitted. 1 resident PASRR was not corrected due to resident being transferred to the hospital. No other resident was identified to be affected by this deficient practice.

Systemic Changes and Measures:

- MDS consultant on 3/24/25 provided an in-service to MDS nurses regarding PASRR policy and procedure.
- On 3/25/25 and 3/27/25, DON provided an in-service to Licensed nurses regarding PASRR policy and procedure and what is the purpose of completing an accurate PASRR.
- On 4/02/25, IDT team attended a DCHS website presentation regarding PASRR overview, Level I and Level II, Review and Determination procedure to ensure that facility is compliant with the PASRR procedure and requirements.
- On 4/08/25,the MDS Consultant provided in service to IDT team regarding facility policy and procedure on PASRR,which placed focus on status change Level I PASRR screening should be completed for a

resident if there is a change in psychiatric diagnoses or if there is a discrepancy between PASRR diagnoses and diagnoses given by the attending physician or psychiatrist.

- IDT team on a daily basis (M-F) will conduct new admission/readmissions PASRR review as part of the daily clinical meeting to ensure Level I PASRR screening is completed for a resident if there is a change in psychiatric diagnoses or if there is a discrepancy between PASRR diagnoses and diagnoses given by the attending physician or psychiatrist. Any discrepancies shall be corrected in a timely manner by QA Nurse.
- QA nurse daily (5x/week), will review new resident PASRR admissions/readmissions to ensure Level I PASRR screening is completed accurately for a resident if there is a change in psychiatric diagnoses or if there is a discrepancy between PASRR diagnoses and diagnoses given by the attending physician or psychiatrist QA nurse shall resubmit a corrected PASRR to ensure accuracy of residents data.
- On admission and annually and/or significant change, the QA nurse will ensure Level I PASRR screening is completed for a resident if there is a change in psychiatric diagnoses or if there is a discrepancy between PASRR diagnoses and diagnoses given by the attending physician or psychiatrist
- The Social Services Mentor will conduct a monthly PASRR audit to ensure accuracy of PASRR and any Level II need were completed and followed up and communicated to resident or representative. Findings shall be reported to the CEO for follow-through. This has been in place since last 10/08/24 and will be ongoing monthly. Any findings shall be reported to the Administrator for further follow-up.

Monitor for Performance:

- The CEO/designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting monthly x 3 months or until a 100 benchmark is reached and sustained.

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F689 Free of Accidents and Hazards

Immediate Corrective Action:

1. On 3/16/25 at 8:31 AM, Resident 1 approached station 500 for assistance, RN 1 noted that he had a cut on his left thumb with bleeding, he informed RN 1 that he slipped from his wheelchair and ended up on his knees in the patio. RN 1 immediately conducted first aid and called the LVN treatment nurse to attend to Resident 1. RN 1 asked Resident 1 how he got the cut on his left thumb, Resident 1 stated "The guy is waving his knife and I tried to seize it". RN 1 immediately went to the patio to check and found Resident 2 about to go inside the facility, he did a visual check for an alleged knife and did not see any. RN 1 assisted Resident 2 back to his room and asked Resident 2 what happened in the patio, and he stated "The other resident (Resident 1) fell onto the floor in the smoking patio and cut himself on the floor. Resident denied any physical altercation".
2. RN 1-initiated Resident 1 body assessment on 3/16/25 approximately at 9:15 AM and noted abrasion on both of his knees, change of condition initiated and 911 paramedics and the police were called and came to the facility around 9:20 AM and took the patient to the hospital. MD was made aware of the 911 paramedic transfer of the patient. Resident 1 family member made aware of the incident and the residents hospital transfer. RN 1 initiated the Plan of care of Resident 1 regarding his altercation with another resident.

3. On 3/16/2025 RN 1 contacted the Administrator around 8:45 AM and Director of Nursing regarding the alleged resident to resident altercation between Resident 1 and Resident 2 as reported by Resident 1. At 9:00 AM the Administrator proceeded to drive to the facility to initiate the investigation.
4. RN 1 initiated a change of condition on Resident 2 on 3/16/25 at 9:00 AM, body check done, noted with abrasion on his left hand and wrist, first aid was done and denied any pain. Primary MD was called by RN 1 at approximately 9:00 AM and with orders to transfer Resident 1 to Olive View hospital for further evaluation. Resident 2 was assigned a sitter 1:1 for monitoring his aggressive behavior. RN 1 informed the residents' 1 family member of the resident altercation on 3/16/25 at 9:30 AM. Plan of care was initiated related to the alleged resident to resident altercation.
5. The Administrator on 3/16/25 completed the SOC 341 at 10:35 AM and was faxed to CDPH, Ombudsman and police were called.
6. Resident 2 was transferred to Southern California Hospital of Culver City for further psychiatric evaluation and treatment on 3/16/25 at 18:10 PM.
7. Resident 1 came back from the hospital on 3/16/25 at 21:05 PM. Resident alert, verbally responsive and able to communicate his needs. Body/skin assessment by RN 1, noted with 8 stitches of suture and open to air. Resident 1 with bilateral knees abrasion. Treatment for left thumb cut and left and right knee abrasions were ordered. Residents were monitored for any fall complications and symptoms of emotional distress related to the altercation for 72 hours. Resident 1 continued to receive a wellness visit from Social Services for emotional support and feeling of safety. Resident 1 was visited by a psychiatrist on 3/17/25 at 4;00 PM with new orders carried out. Resident 1 was visited by psychologist on 3/19/25 and according to psychologist progress notes Resident 1 stated he does not think about the incident.
8. Resident 2 was readmitted from the hospital on 3/17/25 at 2:00 AM via ambulance. The resident was provided with sitter 1:1 to monitor his aggressive behavior. Social Services staff continued wellness visit to Resident 2 on 3/17/25 at 13:17 and per resident, "he is doing well and fine in the facility". On 3/18/25 at 2:30 PM, Resident 2 was seen by the psychiatrist with new orders carried out. Four (4) police officers on 3/18/25 at 12:44 PM came to the facility and apprehended Resident 2. Per the police officers, Resident 2 will be taken to Mission Hills Police station and will be transferred to Metro detention center. Social Service staff on 3/18/25 at 12:59 PM called the resident's 2 family member and left a message on her voicemail to contact the facility regarding Resident 1.
9. The Director of Nursing (DON) on 3/16/25 at 2:30 PM via telephone had provided a 1:1 education to RN1 regarding facility policies for abuse prevention that included

all type of abuse such as: physical, verbal, emotional, financial, sexual, neglect, exploitation, isolation, and educating for facility policy and procedure on Residents supervision specifically on following the residents smoking schedule to ensure that supervision is provided to residents in the smoking patio and on the other areas of the facility like the front entrance backyard, other patio location to ensure each residents' safety. On 3/20/25, DON met with RN 1 to provide counselling regarding Residents supervision and safety. RN 1 acknowledged the safety education provided via telephone on 3/16/25. RN2, CNA 1 and CNA 2 provided 1:1 education done by the DON, on 3/21/2025 and 3/22/2025 in regard to resident safety and supervision and abuse prevention and management. LVN1 will be educated prior to coming back on the floor after his vacation.

10. On 3/17/2025 until 3/22/2025 an in service for all type of Abuse was provided to all staff by the DSD, Administrator, DON, Assistant Administrator. Facility is using two methods of in services – in person, which include education with questions and answers interaction and through SNF clinic. SNF clinic includes videos and elaborate explanations with post test at the end. The DSD send blast texts and emails to employees to inform them of the required in service through SNF Clinics. As of now (3/22/2025) we have reached 99% compliance between SNF Clinics and in person in services. 10 employees are on leave and will be off schedule until they complete the required services before returning to work.
11. On 3/19/2025 and 3/20/2025 the administrator made a few attempts to call the detective handling the case to get information about the resident and to ask if the police obtained the knife from the resident. No call back as of 3/22/2025.
12. The following efforts were made to locate the knife:
    a. On 3/16/2025 RN 1, LVN1, attempted to search Resident 2, however, refused.
    b. On 3/16/2025 RN1, LVN1 searched the Smoking Patio to include all the planters, could not locate the knife. All facility common areas were searched to include the nonsmoking patio, and outdoor areas.
    c. On 3/16/2025 the administrator asked the police officer to conduct body search on Resident 2, officer stated that they cannot conduct it at this time. Attestation letter was provided.
    d. On 3/16/2025 Room search was done by LVN2 in Resident 2 room, in all the trash cans in room 101, and all drawers, closets, inside shoes, under mattresses, and the bathroom, knife was not located. Attestation letter was provided.
    e. On 3/19/2025 Department heads conducted a search in all Residents' rooms and belongings, knife was not located.

f. On 3/19/2025 the Maintenance supervisor searched the roof top; no knife was located.
g. On 3/16/2025 housekeeper and laundry employees searched, all trash carts, and laundry area were searched, knife was not located. Attestation was provided.
h. On 3/21/2025 the Marketer called the hospital Resident 2 was transferred, to inquire if they have any records of the knife. They stated that they will contact us back.
i. On 3/22/2025 Administrator started reviewing the video footage to find the location of the knife. The administrator is new, as of 12/7/2024, and was not given access to review the surveillance camera but is now able to review as of 3/22/2025. I am currently working with IT if there will be any issues in regard to video surveillance footages.
j. The administrator/designee will coordinate all efforts to exhaustedly search for the missing knife, continuously until it is found. Once the knife is found the administrator will take a picture of where the knife was found, will place it in a bag and will handle it with caution, and will turn it in to the police department. A notification will be sent to CDPH.

13. On 3/21/2025 the administrator called Mission Hills Police Department to ask for the whereabouts of resident 2. The officer directed her to the Van Nuys Detention center. The administrator called the Van Nuys Detention center and was told to call the county. The Administrator asked the officer if they had the records of the knife that was used. The detective stated, "we do not have the knife here but if he was arrested, they should have had the knife". The administrator contacted the County and could not talk to an agent. The facility will assess the necessity of transfer or discharge, but any steps will be taken in accordance with the applicable stated and federal laws regarding transfer or discharge.
14. The administrator conducted an online inmate search on www.lasd.org and got the arresting information and the approval that resident 2 was arrested on 3/18/2025.
15. On 3/22/2025 a letter was issued to Resident 2 to notify him of his discharge from the facility due to his violation of the admission agreement of not allowing weapon to be brought to the facility. Resident 2 will be afforded his residents rights. The Admission Inventory Information states "Our facility prohibits employees, residents, visitors, vendors or others from possessing firearms and/or other weapons while in/on our facility's premises." This notice was mailed to his last known address and to the County Jail. The letter was emailed to the Resident family member.

16. On 3/24/2025 at 6:12 PM Detective Kirk called the facility Administrator. Detective Kirk stated that when they arrested Mims, Mr . Mims. mentioned to the officers that he threw the knife. The administrator asked the detective if they had asked Mr. Mims where he threw the knife, and the detective responded that they did not. The administrator asked the Detective if he could call the county and ask the officers in the jail to ask if they could interview Mims for where he threw the knife. The detective responded that he has no way of doing that. I asked if he could send any of his officers to the jail and conduct the interview, the detective stated, "we do not have the manpower". I asked him if he could send me an email with his statement of Mims throwing away the knife. He said he will do that.
17. On 3/24/2025 at 6:17 PM, Detective Kirk sent his email statement to the Administrator. Administrator informed CDPH via email of this call and conversation

with the Detective on 3/24/25 at 6:36 PM .

Other residents affected by this deficient practice:

1. On 3/19/25 and 3/20/25, Department heads per their resident's room rounds assignments conducted Safety check of resident's belongings using the resident inventory of personal belongings log to identify presence of any weapon or sharp objects. Prior to the safety check, Department heads had obtained the consent of the self-responsible and alert residents to ensure that their rights were respected. For residents that were not self - responsible, their responsible party were contacted to obtain the consent for safety check. Out of 131 censuses, 125 had given their consents for the safety check. There were 4 residents who refused the safety check, and the 2 residents responsible party were contacted multiple times for consent but no response k. There were no identified weapons or sharp objects in any of the 125 resident's belongings. No other residents were identified as affected by the deficient practice.

2. On 3/19/25 and 3/20/25, MDS Nurse, DON and Activity staff smoking attendant conducted a 1:1 smoking observation of resident smokers. After the residents smoking observation, the MDS nurse conducted a Smoking Risks Evaluation using the VB-IDT-Smoking/Vaping evaluation to determine if a smoker requires supervision during smoking time or an independent smoker. MDS nurses have identified 8 residents who require supervision during smoking and 10 residents who can independently smoke in the smoking patio. MDS nurse on 3/19/25 and 3/20/25 reviewed and updated each resident smoker's plan of care based on their smoking risks evaluation. All of the 18 residents have the potential to be affected by the deficient practice therefore the facility shall provide residents supervision both for supervised and independent smokers to ensure residents safety.

Systemic Changes and Measures:

1.Director of Nursing (DON) on 3/25/25, 3/27/25 and 4/01/25 provided an in-service to licensed nurses and CNAs on 4/11/25 and 4/12/25 regarding the following: Facility policy on Residents Smoking; facility policy on Residents Safety and Supervision; Residents Smoking Schedule and assigned staff supervision; Reviewed procedure on shift Huddles and Residents smoking contract and non-compliance; Checking of all exit doors with alarms and facility Out on Pass policy and procedure.

2. On 4/15/25, Compliagent an outside consulting company shall provide an in-person in-service to staff regarding facility residents smoking policy and non-compliance, smoking schedule/supervision; facility policy on Residents supervision and safety to ensure that staff are aware of the importance of following residents smoking schedule and resident supervision in the smoking patio and any other areas in the facility to ensure residents safety. The in-service will be conducted in 2 sessions, one at 2:00 PM and one at 4:00 PM. A post-test will be administered after each presentation to validate staff understanding of the presentation. Compliagent will continue to provide the staff in-services monthly for 4 months till July 2025.

3.As part of the new resident admission procedure, Admission staff shall review the facility Admission Inventory Information that pertains to no firearms and or weapons allowed while in/on our facility premises for employees, residents, visitors, vendors to ensure each resident safety. Resident and or responsible party shall acknowledge the form with their signature for compliance. This is an ongoing procedure for all new resident admission to the facility. This was started on residents' new admissions last 3/26/25 and ongoing till 4/10/25 and will be ongoing as part of the facility admission procedure

4. As part of the new resident admission/readmission procedure, the licensed nurse shall evaluate resident for smoking using the VB-IDT -Smoking Risks evaluation to identify if the resident is supervised or an independent smoker. IDT shall review the new resident smoking evaluation for accuracy as part of the daily clinical meeting. MDS nurses will re-evaluate each smoker every quarter and as needed for any changes in condition to ensure any changes in resident functional capability and other risks factors are addressed. A plan of care for resident smokers will be initiated based on his/her smoking risks evaluation. All the resident smokers were assessed by the MDS nurse with the IDT team last 03/19/2025 and updated the smoking care plans to ensure that residents' risks factors and non-compliance are identified and addressed in their plan of care. Smoking risks evaluation was ongoing for residents' admission of 3/24/25 and ongoing to ensure compliance of facility with residents smoking policy.

5. Facility Department heads, as part of their room rounds, shall conduct a safety check on resident's belongings using the Inventory of resident's belongings form on a weekly basis for 4 weeks, then monthly x 3 months and quarterly thereafter. This was initiated on 3/19/25 and will be ongoing to ensure that no weapons or sharp objects are in residents' possession to ensure the safety of other residents.

6.Licensed Vocational Nurses and RN Supervisors will ask during shift huddles with CNAs to identify incompatibility that may potentially lead to a resident altercation. For example, if staff is witnessing any arguments between residents, or if they hear any inappropriate language between residents, they should immediately separate residents and report to the charge nurse or RN supervisor. The updated Huddle form was initiated last 3/28/25 and is ongoing to ensure each resident safety.

7. During weekends, the Manager of the Day (MOD) will do every 2 hours rounds of checking to identify incompatibility that may potentially lead to a resident altercation. MOD reports are completed at the end of the day and reported to the Administrator/DON. During night shift RN Supervisor will be monitoring and assessing as needed. During the holidays, RN Supervisor on all three shifts will be monitoring and assessing as needed.

8. As part of residents Out on Pass procedure, the receptionist shall check any bags the resident or representative is bringing inside the facility to ensure that no weapons or contraband is brought to the facility. Licensed nurses will also check the resident or representative items to be included in the Personal Inventory to ensure that no weapons or contraband is brought to the facility. This procedure was initiated last 3/28/25 and will be part of the facility procedure for OOP and visitors visiting a resident to ensure other residents' safety.

9. On 3/21/2025 a new P&P for Firearms and Other Weapons was initiated. The policy was reviewed and approved by the facility Medical Director on an emergency QAPI meeting on 3/24/25 with the facility IDT team. DON provided an in-service to licensed nurses on 3/25/25, 3/27/25 and 4/01/25 and CNAs on 4/11/25 and 4/12/25 regarding the facility policy on Firearms and other Weapons which states that facility prohibits any employee, resident, visitor, vendor or any individual from possessing firearms or other weapons designed to do bodily harm while in or on the facility premises to ensure residents and staff safety".

Monitor for Performance:

Administrator/designee shall be responsible for the above process that is ongoing and sustained. Any trends identified on the facility rounds, safety check of resident's

belongings outcome and any issue on supervision identified shall be reported to the QAPI committee monthly x 3 months or until a benchmark of 100 % compliance is sustained.

Completion Date: 4/17/25

MACLAY
HEALTHCARE CENTER

Plan of Correction
FRI# CA00951926

Maclay Healthcare Center makes every effort to comply with the State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Maclay Healthcare Center submitted this plan of correction to comply with the State and Federal regulations and does not waive any objection obtained. This plan of correction is our credible allegation of compliance for deficiency noted findings of the California Department of Public Health during the Facility reported incidents survey completed on 3/22/25.

F712-Physician Visits-Frequency/Timeliness/Alt NPP

Immediate Corrective Action:

- On March 6, 2025 Resident 5 was seen and examined by the MD. On 4/8/25, the health information staff uploaded the progress notes on the resident electronic health record.
- On April 3, 2025 Resident 6 was seen and examined by the MD. On 4/15/25, the health information staff uploaded the progress notes on the resident electronic health record.
- On March 7, 2025 Resident 8 was seen and examined by the MD. On 4/08/25, the health information staff uploaded the progress notes on the resident electronic health record.

Other residents affected by this deficient practice:

- On 04/08/2025, the Health Information Staff generated a report of current residents from the electronic medical record and conducted an audit of Physician Visits to ensure a face-to-face visit was made by a physician or alternate visit by a NP (Nurse Practitioner) on a timely manner.
- A total of130 charts underwent inspection on 3/22/25
- From 3/21/25-4/14/25, the health information staff contacted the physicians, PAs and NPs to notify them of the above alleged deficiency through email, text messages, phone calls.
- On 3/28/25, the Medical Director was notified by the Health information staff for further follow through.

Systemic Changes and Measures:

- On 04/08/2025, the Health Information Consultant provided an in service to the Health Information staff regarding the facility Policy and Procedure (PnP) titled, "Physician Visits," which placed focus on the attending physician must visit his/her patients at least once every 30 days for the first 90 days following the resident ' s admission and then at least every 60 days thereafter. The policy indicated that after the first 90 days, if the attending physician determines that a resident need not be seen by him

every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A physician assistant or NP may make alternate visits after the initial 90 days following admission.

- On 04/08/2025, the Health Information Consultant provided an in service to the Health Information staff regarding the facility Policy and Procedure (PnP) titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the Attending Physician will visit the residents in an timely .... The PnP indicated the MD will provide progress notes in a timely manner for placement in the medical record. The PnP indicated the note should either be written of entered at the time of the visit or should be returned to the facility for placement on the chart within one week
- On 4/15/2025, MD, CMD (Corporate MD) provided direct education to physicians regarding physician visits policy and procedure and regarding the facility Policy and Procedure (PnP) titled, "Attending Physician Responsibilities," last reviewed on 4/2024, the PnP indicated the Attending Physician will visit the residents and complete notes in an timely manner and those notes are made available to be added to the medical record. The PnP indicated the MD will provide progress notes in a timely manner for placement in the medical record within one week. Attestation attached from Dr. Steinberg (Corporate MD.
- On a weekly basis, the Health Information staff will check upcoming monthly visits via PCC audit tracking of MD visits required in the next 7 days. Any identified MD will be contacted by the health information staff and be reminded of the required visit. This was initiated last 3/26/25 and ongoing weekly to ensure that residents physicians visit their residents timely to address their medical needs.
- On a weekly basis, the Health Information staff will provide an update to the Administrator on who are the MD s with overdue visit for further follow through.

Monitor for Performance:

The Administrator/designee will provide a summary trend analysis of negative findings to the monthly QAPI Committee meeting x 3 months or until a 100 % benchmark is reached and sustained. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

Completion Date: 4/18/2025

MACLAY
HEALTHCARE CENTER

Plan of Correction
FRI# CA00951926

Maclay Healthcare Center makes every effort to comply with the State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Maclay Healthcare Center submitted this plan of correction to comply with the State and Federal regulations and does not waive any objection obtained. This plan of correction is our credible allegation of compliance for deficiency noted findings of the California Department of Public Health during the Facility reported incidents survey completed on 3/22/25.

F842

Immediate Corrective Action:

- On 04/08 and 04/10/2025, Resident 5's physician telephone orders were dated and signed by the MD
- On 04/08, 04/07 and 03/31, 03/26/2025, Resident 7's physician telephone orders were dated and signed by the MD
- On 04/07/2025 Resident 5's Attending Physician (MD) reviewed and signed the Order Summary.
- On 04/03/2025 Resident 6's Attending Physician (MD) reviewed and signed the Order Summary.
- On 04/07/2025 Resident 7's Attending Physician (MD) reviewed and signed the Order Summary.
- On 04/11/2025, the Health information staff removed the blank worksheet forms and blank consent forms with Nurse Practitioner's (NP) signatures.

Other residents affected by this deficient practice:

- On 4/14/25, the Health Information Staff generated a report of current residents from the electronic medical record and conducted an audit of telephone orders to ensure they were dated and signed by the MD.
- On 4/14/25, the health information staff informed physicians about the orders review signatures for the identified 70 residents.
- On 04/14/2025, the Health Information Staff generated a report of current residents from the electronic medical record and conducted an inspection of residents' charts and removed any blank forms that did not need to be signed by the MD/Nurse Practitioner.
- A total of130 charts underwent inspection on 3/22/25
- From 3/22/25-4/14/25, the health information staff contacted the physicians, PAs and NPs to notify them of the above alleged deficiency through email, text messages, phone calls.
- On 3/28/25, the Medical Director was notified by the Health information staff for further follow through.

Systemic Changes and Measures:

- On 04/08/2025 , the Health Information Consultant provided an in service to the Health information staff regarding the facility Policy and Procedure (PnP)Attending Physician Responsibilities, "which placed focus on the physician will review all medications monthly. The PnP indicated the physician will verify accuracy of verbal orders when they are given and will authenticate, co-sign, and date them in a timely manner no later than 14 days
- On 4/17/25 the Medical Director attested that he provided an in service to the facility's MDs regarding the facility Policy and Procedure (PnP)Attending Physician Responsibilities, "which placed focus on the physician will review all medications monthly. The PnP indicated the physician will verify accuracy of verbal orders when they are given and will authenticate, co-sign, and date them in a timely manner no later than 14 days
- On a weekly basis , the Health Information staff will check upcoming MD visits via PCC audit required in the next 7 days. Any identified MD will be contacted by the health information staff and be reminded of the required visit.
- On a monthly basis, the health information staff will conduct an order summary audit, Any identified MD will be contacted by the health information staff and be reminded of the required visit.
- On a weekly basis (5x/week), the Health Information staff will inspect resident charts for blank forms that do not need to be signed by the MD. These blanks forms will be removed if necessary.
- On a weekly basis, the Health Information staff will provide an update to the Administrator on who are the MD.s with overdue visit and order summaries that are needed to be signed for further follow through.
- Negative findings will be corrected immediately and be forwarded to the Administrator for needed follow through.

Monitor for Performance:

The Administrator/designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting monthly x 3 months or until a benchmark of 100 is reached and sustained.

Completion Date: 4/17/2025