

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

5/19/25  
48142  
Accepted

PRINTED: 05/08/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/28/2025
NAME OF PROVIDER OR SUPPLIER  MACLAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12831 MACLAY STREET SYLMAR, CA 91342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following reflects the findings of the California Department of Public Health during an abbreviated standard survey.  Complaint Number: CA00958842  The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility.  One deficiency was issued for the complaint number: CA00958842 (Refer to Ftag 880).	F 000			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

Administrator

5/9/25

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555583</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACLAY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12831 MACLAY STREET</b> <b>SYLMAR, CA 91342</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 1  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555583</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACLAY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12831 MACLAY STREET</b> <b>SYLMAR, CA 91342</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 2</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to ensure staff were not wearing gloves in the hallway after exiting the rooms of three of six sampled residents (Resident 1, Resident 2, and Resident 3).</p> <p>This deficient practice had the potential to spread infections and illnesses among residents and staff.</p> <p>Findings:</p> <p>During a review of Resident 1's Record of Admission, the Record of Admission indicated the facility admitted the resident on 6/29/2020, with a diagnosis of hemiplegia (complete paralysis [loss of muscle function] on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (also known as a stroke, damage to the brain from interruption of its blood supply).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 1's thought process was intact and required substantial assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555583</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACLAY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12831 MACLAY STREET</b> <b>SYLMAR, CA 91342</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 3  During a concurrent observation and interview, on 4/28/2025, at 8:49 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 came out from Resident 1's room wearing a glove while holding a plastic bag and entered the dirty linen room. CNA 2 stated she was wearing gloves while holding the plastic bag with dirty linens to throw the bag away in the dirty linen room and she should not wear gloves in the hallway to prevent the spread of infection.  During a review of Resident 2's Record of Admission, the Record of Admission indicated the facility admitted the resident on 2/19/2025, with a diagnosis of acute respiratory failure with hypoxia (a life-threatening condition where the lungs fail to adequately exchange oxygen and carbon dioxide, resulting in a deficiency of oxygen in the blood).  During a review of Resident 2's MDS, dated 2/26/2025, the MDS indicated Resident 2's thought process was intact and required moderate assistance from staff to complete ADLs.  During a concurrent observation and interview, on 4/28/2025, at 8:53 a.m., with CNA 3, in the hallway, CNA 3 wore gloves while transporting Resident 2 in a shower chair. CNA 3 stated she was wearing gloves while transporting Resident 2 in a shower chair and she should not be due to infection control.  During a review of Resident 3's Record of Admission, the Record of Admission indicated the facility admitted the resident on 11/30/2022 with a diagnosis of type two diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555583</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACLAY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12831 MACLAY STREET</b> <b>SYLMAR, CA 91342</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 4 control and poor wound healing).</p> <p>During a review of Resident 3's MDS, dated 3/3/2025, the MDS indicated Resident 3's thought process was intact and was dependent on facility staff to complete ADLs.</p> <p>During a concurrent observation and interview, on 4/28/2025, at 9:04 a.m., with CNA 4, CNA 4 wore gloves while holding linens and entered the dirty linen room. CNA 4 stated she was wearing gloves while holding the dirty linens. CNA 4 stated she did not place the linens in a plastic bag and carried the dirty linens to the dirty linen room. CNA 4 stated that she should put the dirty linens in a plastic bag and throw it away in the dirty linen room. CNA 4 further stated that she should not wear gloves in the hallway to prevent the spread of infection.</p> <p>During an interview, on 4/28/2025, at 9:26 a.m., with the Infection Preventionist (IP) Nurse, the IP Nurse stated staff should not wear gloves in the hallways and staff should remove their gloves inside the room and wash their hands after to prevent the spread of infection and protect other residents and staff.</p> <p>During an interview, on 4/28/2025, at 10:30 a.m., with the Director of Nursing (DON), the DON stated staff should not wear gloves in the hallway to prevent the spread of infection.</p> <p>During a review facility's policy and procedure(P&amp;P) titled, "Personal Protective Equipment - Gloves," last reviewed 4/2025, the P&amp;P indicated gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555583</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACLAY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12831 MACLAY STREET</b> <b>SYLMAR, CA 91342</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 5 performed.  During a review facility's policy and procedure(P&P) titled, "Laundry and Bedding, Soiled," last reviewed 4/2025, the P&P indicated Soiled laundry/bedding shall be handled, transported and processed according to best practices for in	F 880			



## **Plan of Correction CA00958842**

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 entity reported incident no. **CA00958842** which was conducted on **4/28/25**.

### **F880 Infection Prevention and Control =E**

#### **Immediate Corrective Action:**

- On 4/28/25, Infection Prevention Nurse provided a one-on-one in-service and review with CNA 2, on the infection control and prevention policy, focusing on the importance of not wearing gloves in the hallway to prevent the spread of infection.
- On 4/28/2025, Infection Prevention Nurse provided a one-on-one in-service and review with CNA 3 on the infection control and prevention policy, focusing on the importance of not wearing gloves while transporting residents in a shower chair to prevent the spread of infection.
- On 4/28/2025, Infection Prevention Nurse provided a one-on-one in-service and review with CNA 4 on the infection control and prevention policy, focusing on the importance of placing soiled linens in a plastic bag prior to transporting them to the soiled linen barrel and not wearing gloves in the hallway to prevent the spread of infection.
- On 4/28/25, 4/29/25, DON and IP Nurse provided an in-service to licensed nurses and CNAs regarding the use of PPE-gloves, hand hygiene/handwashing and facility policy on transporting soiled linen to the dirty linen room or soiled linen barrel to prevent the spread of infection.

#### **Other residents affected by this deficient practice:**

- On 4/28/2025 and 4/29/2025, the Infection Prevention Nurse and the assistant DSD staff conducted rounds during resident care and observed staff during and after care of residents to ensure that staff were removing gloves prior to exiting the resident room were performing hand hygiene/handwashing and that CNA staff are placing soiled linen in a plastic bag when transporting soiled linens in

the soiled linen barrel.. No other residents were observed to be affected by the same alleged deficiency.

**Systematic Changes and Measures:**

- On 4/28/2025 through 5/9/2025, the Infection Prevention Nurse and DSD and DON provided an in-service to staff regarding facility policy and procedure on the following:
  - Personal Protective Equipment - Gloves," focused on gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed
  - Laundry and Bedding, Soiled, focused on Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control.
- As part of the daily department managers room rounds (5x/week) , RN supervisors and charge nurses each shift rounds and Manager of the day (MOD ) rounds on the weekends, infection control practices will be a focus especially wearing of gloves in the hallways; proper handling of soiled linens and hand hygiene/handwashing practices will be observe. Negative findings will be corrected immediately and be forwarded to the Infection Preventionist for needed follow through.
- During daily rounds (5x/week), the Infection Preventionist and DSD will conduct rounds and will focus on proper use of gloves and removal in resident room and transporting soiled linen in the hallway by CNA staff and other department to prevent the spread of infection. Negative findings will be corrected immediately with the staff and follow-up in-service will be conducted if trends are identified.
- Upon hire, annually, and as needed, the DSD/Designee will conduct PPE skills competency assessments for staff, proper use of gloves and handwashing/hand hygiene skills competency and will be oriented on proper transport of soiled linens in the hallway to prevent the spread of infection.

**Monitor for Performance:**

- The Infection Preventionist will ensure that the above process is ongoing and sustained and shall report any infection control trends identified to the QAPI Committee monthly x 3 months or until a benchmark of 100% is reached and sustained.

**Completion Date: 5/9/2025**