STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555583	A. BUILDING _____ B. WING _____	**06/10/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) was free from abuse, after a certified nurse assistant (CNA)1 hit Resident 1's right arm with the mechanical lift remote control and covered Resident 1's mouth with her hands to keep her from screaming on two separate occasions. This deficient practice resulted in Resident 1's transfer to a General Acute Care Hospital (GACH) for an evaluation and complaints of a headache and pain in her right arm. This failure had the potential to cause Resident 1 emotional distress and/or fear due to the abusive treatment. Findings: A review of Resident 1's Admission Record, dated 11/4/19, indicated an original admission to the facility on [DATE] and a readmission on 10/15/19, with [DIAGNOSES REDACTED].(mood disorder that affects daily life). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 7/27/19, indicated a Brief Interview for Mental Status (used to assess cognitive status in the elderly and may provide useful information as a possible referral for dementia diagnosis) score of zero, indicating severe cognitive (having a very hard time remembering things, making decisions, concentrating, or learning) impairment. Resident 1 required extensive assistance with bed mobility, eating and was totally dependent on staff members, for transferring, dressing, toilet use, and personal hygiene. The MDS indicated Resident 1 also needed the physical assistance of two people to transfer from surface to surface (bed to wheelchair, etc.). A review of Resident 1's Nurses' Progress Note, dated 10/14/19, indicated two certified nurses' assistants (CNAs) 2 and 3, on Friday 10/11/19, saw CNA 1 transferring Resident 1 from the bed to the Geri-chair (a reclining chair). Resident 1 was screaming loudly during the transfer. CNAs 2 and 3 heard the screams and came to Resident 1's room to help CNA 1. CNAs 2 and 3 told the director of staff development (DSD), CNA 1 hit Resident 1's right arm with the mechanical lift remote control and CNA 1 used her hand to cover Resident 1's mouth to prevent the resident from screaming. A review of Resident 1's physician's telephone order, dated 10/14/19, indicated to transfer the resident to the general acute care hospital (GACH) for further evaluation. A review of Resident 1's GACH emergency department (ED) notes, dated 10/14/19, indicated the resident presented in the ED, from a skilled nursing facility, for an evaluation for generalized weakness and injury status [REDACTED]. Resident 1 complained of a mild headache and right forearm pain. A review of the facility's Investigation and Interview Record, dated 10/15/19, documented another incident involving CNA 1 again putting her hands over Resident 1's mouth. CNA 4 stated, The last week of September, around 10:00 a.m., I (CNA 4) saw CNA 1 put her hand on Resident 1's mouth. During an observation, on 11/4/19, at 11:06 a.m., Resident 1 was in her room, lying in bed, screaming loudly and unintelligibly while the CNAs were getting her ready for the day. According to the Director of Nursing (DON), Resident 1 has behaviors of screaming and laughing uncontrollably. On 11/4/19, at 11:11 a.m., during an interview CNA 2, a witness to the incident on 10/14/19, stated on a Friday (date not specified), Resident 1's door was closed. CNA 2 and CNA 3 thought they could assist, because Resident 1 was screaming. When CNA 2 entered Resident 1's room, CNA 1 had Resident 1 in the mechanical lift. CNA 2 asked CNA 1 if she needed help, because Resident 1 needs more help. While CNA 1 and CNA 2 were transferring Resident 1 to the chair, Resident 1 tried to grab CNA 1. CNA 1 used the mechanical lift remote control to hit Resident 1 on the right bicep (upper arm) twice. During concurrent interviews, on 11/4/19, at 11:33 a.m., the DON and DSD stated on 10/14/19, CNA 3 reported (to the DSD) that she saw CNA 1 put both hands, on Resident 1's mouth to prevent her from screaming. The DON and DSD acknowledged the incident as physical abuse; stating, Placing your hands over Resident 1's mouth is not appropriate. The DON also admitted , in September (date not indicated), CNA 4 also witnessed CNA 1 placing her hands over Resident 1's mouth to prevent her from screaming. During an interview on 11/4/19, at 12:39 p.m., CNA 4 confirmed in September (date not indicated) around 10:00 a.m., she witnessed CNA 1 placing her hands over Resident 1's mouth to keep her quiet. A record review of the facility's investigation, for the incident on 10/14/19, the facility suspended CNA 1 pending an investigation. A review of the facility's policy, titled Abuse Prevention Program, revised November 2019, indicated our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to report a witnessed abuse incident immediately after one of three residents (Resident 1), experienced two accounts of physical abuse, but did not report the incidents immediately to the Department of Public Health (Department) and local Ombudsman (an official appointed to investigate individuals' complaints) office. This failure of not immediately reporting abuse, delayed an abuse investigation and placed Resident 1, and other residents, at risk to encounter further physical abuse. Findings: A review of Resident 1's Admission Record, dated 11/4/19, indicated an original admission to the facility on [DATE] and a readmission on 10/15/19, with [DIAGNOSES REDACTED].(mood disorder that affects daily life). A review of Resident 1's Minimum Data Set (MDS,) a standardized assessment and care-screening tool, dated 7/27/19, indicated a Brief Interview for Mental Status (used to assess cognitive status in the elderly) score of zero, indicating severe cognitive (having a very hard time remembering things, making decisions, concentrating, or learning) impairment. Resident 1 required extensive assistance with bed mobility, eating and was totally dependent on staff members, for transferring, dressing, toilet use, and personal hygiene. The MDS indicated Resident 1 also needed the physical assistance of two people to transfer from surface to surface (bed to wheelchair, etc.). A review of Resident 1's Nurses' Progress Note, dated 10/14/19, indicated two certified nurses' assistants (CNAs) 2 and 3, on Friday 10/11/19, saw CNA 1 transferring Resident 1 from the bed to the geri-chair (a reclining chair). Resident 1 was screaming loudly during the transfer. CNAs 2 and 3 heard the screams and came to Resident 1's room to help CNA 1. CNAs 2 and 3 told the director of staff development (DSD), CNA 1 hit Resident 1's right arm with the mechanical lift remote control and CNA 1 used her hand to cover Resident 1's mouth to prevent the resident from screaming. A review of Resident 1's physician's telephone order, dated 10/14/19, indicated to transfer the resident to the general acute care hospital (GACH) for further evaluation. A review of Resident 1's GACH emergency department (ED) notes, dated 10/14/19, indicated the resident presented in the ED, from a skilled nursing facility, for an evaluation for generalized weakness and injury status [REDACTED]. Resident 1 complained of a mild headache and right forearm pain. A review of the facility's Investigation and Interview Record, dated 10/15/19, documented another incident involving CNA 1 again putting her hands over Resident 1's mouth. CNA 4 stated, The last week of September, around 10:00 a.m., I (CNA 4) saw CNA 1 put her hand on Resident 1's mouth. During an observation, on 11/4/19, at 11:06 a.m., Resident 1

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

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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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) was in her room, lying in bed, screaming loudly and unintelligibly while the CNAs were getting her ready for the day. According to a concurrent interview with the Director of Nursing (DON), Resident 1 has behaviors of screaming and laughing uncontrollably. On 11/4/19, at 11:11 a.m., during an interview CNA 2, a witness to the incident on 10/14/19, stated on a Friday (date not specified), Resident 1's door was closed. CNA 2 and CNA 3 thought they could assist, because Resident 1 was screaming. When CNA 2 entered Resident 1's room, CNA 1 had Resident 1 in the mechanical lift. CNA 2 asked CNA 1 if she needed help, because Resident 1 needs more help. While CNA 1 and CNA 2 were transferring Resident 1 to the chair, Resident 1 tried to grab CNA 1. CNA 1 used the mechanical lift remote control to hit Resident 1 on the right bicep (upper arm) twice. During concurrent interviews, on 11/4/19, at 11:33 a.m., the DON and DSD stated on 10/14/19, CNA 3 reported (to the DSD) that she saw CNA 1 put both hands, over Resident 1's mouth to prevent her from screaming. The DON and DSD acknowledged the incident as physical abuse; stating, Placing your hands over Resident 1's mouth is not appropriate. The DON also admitted , in September (date not indicated), CNA 4 also witnessed CNA 1 placing her hands over Resident 1's mouth to prevent her from screaming. The DON and DSD stated the witnessed physical abuse (on 10/11/19), was not reported immediately or within two hours. The DON also admitted CNA 4 witnessed account of CNA 1 putting her hands over Resident 1's mouth in September, was not reported to the Department or the local Ombudsman. The DON stated the CNA should have reported the abuse incident to the charge nurse but did not. During an interview on 11/4/19, at 12:39 p.m., CNA 4 confirmed in September (date not indicated) around 10:00 a.m., she witnessed CNA 1 placing her hands over Resident 1's mouth to keep her quiet. CNA 4 admitted she did not report the witnessed incident to the charge nurse but should have reported the incident immediately. A review of the policy, Reporting Abuse to Facility Management, revised in April 2012, indicated, any staff member or person affiliated with this facility who witnessed or believes that a resident has been a victim of mistreatment, abuse, neglect, or criminal offense shall immediately report, or cause a report to be made of the mistreatment or offense.