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	08/28/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse (the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability) for one of three sampled residents (Resident 1). On 8/23/2025 at around 6:30 a.m., Certified Nursing Assistant (CNA) 1 flipped off (describes the act of extending the middle finger as a rude and offensive gesture to express anger, contempt, or annoyance toward someone, particularly in a non-verbal way) using two middle fingers of both hands, yelled obscenities, and called a derogatory and racial insult at Resident 1. This deficient practice resulted in Resident 1 being subjected to verbal abuse by CNA 1 while under the care of the facility.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 12/27/2023 with diagnoses including type 2 diabetes (a group of diseases that result in too much sugar in the blood), polyneuropathy (nerve damage), hypertension (elevated blood pressure), and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required substantial to maximal assistance (helper does more than half the effort) with showering, toileting, and lower body dressing. During a record review of Resident 1's Care Plan, dated 8/27/2025, the Care Plan indicated Resident 1 had potentially a psychosocial (relating to the interrelation of social factors and individual thought and behavior) well-being problem due to a verbal incident with staff member (CNA 1). During a record review of Resident 1's Progress Notes, dated 8/28/2025, the Progress Notes indicated on 8/23/2025, at around 5 p.m., Resident 1 went to the Staff Developer (DSD) and the Administrator (ADMIN), and reported that on 8/23/2025, at around 6:30 a.m., CNA 1 called him (Resident 1) a derogatory and racial insult. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/15/2025 with diagnoses including history of falling, acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood, and hypertension (elevated blood pressure). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 required substantial to maximal assistance (helper does more than half the effort) with showering, toileting, and lower body dressing. During an interview with Resident 1 on 8/28/2025 at 10:10 a.m., Resident 1 stated on 8/23/2025, at around 6:30 a.m., Resident 1 pressed the call light because he (Resident 1) wanted to be changed. Resident 1 stated CNA 1 answered his (Resident 1) call light, and he (Resident 1) told CNA 1 he wanted a different CNA to change him (Resident 1). Resident 1 stated CNA 1 flipped off at him (Resident 1) using two middle fingers of both hands. Resident 1 stated CNA 1 called him (Resident 1) a derogatory and racial insult. Resident 1 stated CNA 1 continued to yell obscenities at him (Resident 1). Resident 1 stated he (Resident 1) called the RN Supervisor 1 (RN 1) from his (Resident 1) cell phone to come to his (Resident 1) room to help him (Resident 1). Resident 1 stated he (Resident 1) told RN 1 that CNA 1 was yelling obscenities at him (Resident 1). During an interview with Resident 2 on 8/28/2025 at 12:10 p.m., Resident 2 stated on 8/23/2025 at 6:30 a.m., his roommate (Resident 1) pressed the call light and CNA 1 came inside the room to answer the call light. Resident 2 stated he (Resident 2) heard Resident 1 told CNA 1 that Resident 1 wanted a different CNA to change Resident 1. Resident 2 stated he (Resident 2) heard CNA 1 yell out obscenities and a derogatory and racial insult at Resident 1. Resident 2 stated CNA 1 should have walked away and called the RN 1, instead of staying in the room and yelling out obscenities at Resident 1. During an interview with RN 1 on 8/28/2025 at 12:30 p.m., RN 1 stated on 8/23/2025 at 6:30 a.m., Resident 1 called her because he (Resident 1) did not want CNA 1 to change him. RN 1 stated Resident 1 reported to her (RN 1) that CNA 1 called him (Resident 1) a derogatory and racial insult. RN 1 stated she (RN 1) did not report this verbal abuse allegation to anyone because she (RN 1) did not think anything of it. RN 1 stated she (RN 1) realized this was verbal abuse and should have reported to the abuse coordinator within two hours. RN 1 stated she (RN 1) was very sorry for not reporting the verbal abuse right away. During an interview with the ADMIN and Director of Nurses (DON) on 8/28/2025 at 3:30 p.m., the ADMIN stated Resident 1 reported to her (ADMIN) and the DSD that on 8/23/2025 at 6:30 a.m., CNA 1 went to answer his (Resident 1) call light, and Resident 1 requested for a different CNA. The ADMIN stated Resident 1 reported that CNA 1 yelled a derogatory and racial insult at him (Resident 1). The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of verbal abuse (the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability) within two hours to the State Survey Agency (SSA). On 8/23/2025 at around 6:30 a.m., Certified Nursing Assistant (CNA) 1 flipped off (describes the act of extending the middle finger as a rude and offensive gesture to express anger, contempt, or annoyance toward someone, particularly in a non-verbal way) using two middle fingers of both hands, yelled obscenities, and called a derogatory and racial insult at Resident 1. The facility reported the verbal abuse incident on 8/26/2025 to the SSA. This deficient practice resulted in a delay in the investigation and placed Resident 1 at risk for further verbal abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 12/27/2023 with diagnoses including type 2 diabetes (a group of diseases that result in too much sugar in the blood), polyneuropathy (nerve damage), hypertension (elevated blood pressure), and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required substantial to maximal assistance (helper does more than half the effort) with showering, toileting, and lower body dressing. During a record review of Resident 1's Care Plan, dated 8/27/2025, the Care Plan indicated Resident 1 had potentially a psychosocial (relating to the interrelation of social factors and individual thought and behavior) well-being problem due to a verbal incident with staff member (CNA 1). During a record review of Resident 1's Progress Notes, dated 8/28/2025, the Progress Notes indicated on 8/23/2025, at around 5 p.m., Resident 1 went to the Staff Developer (DSD) and the Administrator (ADMIN), and reported that on 8/23/2025, at around 6:30 a.m., CNA 1 called him (Resident 1) a derogatory and racial insult. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/15/2025 with diagnoses including history of falling, acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood, and hypertension (elevated blood pressure). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 required substantial to maximal assistance (helper does more than half the effort) with showering, toileting, and lower body dressing. During an interview with Resident 1 on 8/28/2025 at 10:10 a.m., Resident 1 stated on 8/23/2025, at around 6:30 a.m., Resident 1 pressed the call light because he (Resident 1) wanted to be changed. Resident 1 stated CNA 1 answered his (Resident 1) call light, and he (Resident 1) told CNA 1 he wanted a different CNA to change him (Resident 1). Resident 1 stated CNA 1 flipped off at him (Resident 1) using two middle fingers of both hands. Resident 1 stated CNA 1 called him (Resident 1) a derogatory and racial insult. Resident 1 stated CNA 1 continued to yell obscenities at him (Resident 1). Resident 1 stated he (Resident 1) called the RN Supervisor 1 (RN 1) from his (Resident 1) cell phone to come to his (Resident 1) room to help him (Resident 1). Resident 1 stated he (Resident 1) told RN 1 that CNA 1 was yelling obscenities at him (Resident 1). During an interview with Resident 2 on 8/28/2025 at 12:10 p.m., Resident 2 stated on 8/23/2025 at 6:30 a.m., his roommate (Resident 1) pressed the call light and CNA 1 came inside the room to answer the call light. Resident 2 stated he (Resident 2) heard Resident 1 told CNA 1 that Resident 1 wanted a different CNA to change Resident 1. Resident 2 stated he (Resident 2) heard CNA 1 yell out obscenities and a derogatory and racial insult at Resident 1. Resident 2 stated CNA 1 should have walked away and called the RN 1, instead of staying in the room and yelling out obscenities at Resident 1. 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