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	09/15/2025

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

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	09/15/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three sampled residents (Resident 1). On 8/29/2025 at approximately 4:15 p.m., while Resident 1 and Resident 2 were both in Room A (Resident 1 and Resident 2's shared room), Resident 2, using his (Resident 2) three fingers (did not specify which hand), pushed Resident 1's back, between the shoulder blades (a large, triangular-shaped bone located on the back of the upper rib cage, one on each side of the body). This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. As a result, Resident 1 fell on the floor in a semi-sitting position (a partially upright body position) leaning on his (Resident 1) right side.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 2/28/2025 with diagnoses including schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (mental health illness causing a persistent feeling of sadness, loss of interest, and can interfere with daily life), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 2/20/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance) with toilet transfer, chair to bed transfers, and walking 150 feet (ft-unit of measurement). During a review of Resident 1's Care Plan, initiated on 8/29/2025, the Care Plan indicated Resident 1 was pushed by roommate (Resident 2) and landed on his (Resident 1) right side. The Care Plan indicated Resident 1 was at risk for physical injury, pain, and emotional distress. b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/12/2024 with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 2's H&P, dated 1/13/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive functioning was intact. The MDS indicated Resident 2 required moderate assistance from the facility staff with showers and lower body dressing. The MDS indicated Resident 2 was independent with ambulating 50 ft and required supervision with ambulating 150 ft. During a review of Resident 2's Care Plan (not titled), initiated on 8/27/2024, the Care Plan indicated Resident 2 had a history of behavioral and emotional challenges such as verbal disagreements with his (Resident 2) roommate (name not indicated). During a review of Resident 2's Care Plan (not titled), initiated on 8/29/2025, the Care Plan indicated Resident 2 was involved in a physical altercation (confrontation or argument that escalates to physical aggression, involving physical force or contact between individuals) with another resident (Resident 1), resulting in the resident (Resident 1) being pushed and found on the floor. During a review of Resident 2's change of condition (COC - when there is a sudden significant change in a resident's health status) form, dated 8/29/2025, the COC form indicated on 8/29/2025 (time not indicated), Resident 2 had an episode of physical altercation with another resident (Resident 1). The COC form indicated that Resident 2 admitted to pushing another resident (Resident 1) that resulted in the other resident (Resident 1) to be found sitting down on the floor on his (Resident 1) right side. c. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 1/18/2025 and readmitted on [DATE] with diagnoses including type 2 DM, muscle weakness, and personal history of other (healed) physical injury and trauma. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive functioning was intact. The MDS indicated Resident 3 was independent and was using a wheelchair. During an interview on 9/15/2025, at 10:40 a.m. with Resident 3, Resident 3 stated on the day of the incident between Resident 1 and Resident 2 (Resident 3 could not recall the exact date but