STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056435	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hyde Park Healthcare Center	6520 West Blvd. Los Angeles, CA 90043

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. (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 - 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 ensure a resident was free from physical abuse when was pushed to the floor by another resident and sustained an injury for one of four sampled residents (Resident 1). These deficient practices resulted in Resident 2 on 11/30/2025 pushing Resident 1 to the floor and sustaining a 1.0-inch posterior (back of the head) scalp (skin covering the head) laceration (skin tear) which required evaluation and treatment in a general acute care hospital (GACH). Resident 1 received two staples (a piece of thin wire with a long center portion and two short end pieces) for the scalp laceration. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes mellitus (DM-a condition where the body can't properly use or produce insulin [hormone to regulate blood sugar level] leading to high blood sugar levels), and paranoid schizophrenia. During a review of Resident 1's history and physical (H&P), dated 10/25/2025, the H&P indicated Resident 1 was admitted to the GACH for psychiatric evaluation due to increased agitation and aggressive behaviors. The H&P indicated Resident 1 did not have the capacity to make reasonable decisions and required redirection. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills for daily decision making and able to make needs known. The MDS indicated Resident 1 required partial assistance from staff to lift, hold, support the trunk and limbs, for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's change of condition (COC) form, dated 11/30/2025 at 11:53 p.m., the COC form indicated the charge nurse observed Resident 2 approaching Resident 1 and pushing Resident 1 to the floor. The COC form indicated Resident 1 hit the back of her head on the floor and was bleeding from the head. The COC form indicated the charge nurse placed a towel against Resident1's head to stop the bleeding and immediately called 911. During a review of Resident 1's Skilled Nursing Facility (SNF) to Hospital Transfer form, dated 12/1/2025 at 12:12 a.m., the form indicated Resident 1 was transported to the GACH after another resident pushed her resulting in Resident 1 bleeding from a head due to injury. During a review of Resident 1's GACH emergency room (ER) records, dated 12/1/2025, the ER's records indicated Resident 1 arrived at the ER after Resident 1 was pushed by another resident, Resident 1 fell and hit the back of her head on the ground which caused minor head trauma and a 1.0 inch laceration to the posterior scalp. The ER records indicated two staples were used to staple the laceration. The ER records indicated Resident 1 was discharged back to the facility on the same day (12/1/2025). During a review of Resident 1's head computerized tomography scan (CT - a type of imaging that uses X-ray techniques to create detailed images of the body) dated 12/1/2025, the CT scan indicated there was no acute intracranial abnormality with right parietal (located at the top and back of the head) skin staples. During an interview on 12/5/2025 at 12:30 p. m. with Resident 1, Resident 1 stated she was talking with Resident 4 in the hallway outside Resident 4's room (date and time unknown) when Resident 2 suddenly pushed her for no reason. Resident 1 stated, When I fell, I hit the back of my head on the floor, I had to go to the hospital, and they put two staples in the back of my head. During an interview on 12/5/2025 at 12:50 p.m. with Resident 4, Resident 4 stated a few days ago she witnessed when Resident 2 pushed Resident 1 to the ground. Resident 4 stated Resident 1's head was bleeding. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included bipolar disorder (a mental health condition causing extreme mood swings), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 2's H&P, dated 6/8/2025, the H&P indicated, Resident 2 was admitted to the GACH for psychiatric evaluation due to increase agitation, aggressive behaviors, does not have the capacity to make medical decisions, and requires redirection. During a review of Resident 2's MDS, dated [DATE], indicated Resident 2's cognition (ability to understand) was moderately impaired. The MDS indicated Resident 2 required moderate assistance from staff for all ADLs. During a review of Resident 2's COC, dated 12/1/2025, the COC indicated on 11/30/2025 Resident 2 was physically aggressive towards her peers. The COC indicated on 11/30/2025

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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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - 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 ensure licensed nurses followed up with the facility's contracted pharmacy on a physician's order dated 11/23/2025 for Seroquel (antipsychotic [medication that manage psychosis {hallucinations, delusions, disordered thinking}] medication primarily used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar [mood swings that range from the lows of depression to elevated periods of emotional highs] disorder) 25 milligrams (mg-unit of weight measurement) for one of three sampled residents (Resident 2) to ensure the medication was obtained and administered to Resident 2 in timely manner and as ordered to manage Resident 2's aggressive behavior to prevent Resident 2's angry outburst resulted in Resident 1's physical abuse. Resident 2 did not receive Seroquel for eight days. These deficient practices resulted in Resident 2 not receiving Seroquel for eight days and contributing to the resident's anger outburst on 11/30/2025, leading to pushing Resident 1 to the floor. Resident 1 sustained a 1.0-inch posterior (back of the head) scalp (skin covering the head) laceration (skin tear) which required evaluation and treatment in a general acute care hospital (GACH). Resident 1 received two staples (a piece of thin wire with a long center portion and two short end pieces) for the scalp laceration.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes mellitus (DM-a condition where the body can't properly use or produce insulin [hormone to regulate blood sugar level] leading to high blood sugar levels), and paranoid schizophrenia. During a review of Resident 1's History and Physical (H&P), dated 10/25/2025, the H&P indicated Resident 1 was admitted to the GACH for psychiatric evaluation due to increased agitation and aggressive behaviors. The H&P indicated Resident 1 did not have the capacity to make reasonable decisions and required redirection. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills for daily decision making and able to make needs known. The MDS indicated Resident 1 required partial assistance from staff to lift, hold, support the trunk and limbs, for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's change of condition (COC) form, dated 11/30/2025 at 11:53 p.m., the COC form indicated the charge nurse observed Resident 2 approaching Resident 1 and pushing Resident 1 to the floor. The COC form indicated Resident 1 hit the back of her head on the floor and was bleeding from the head. The COC form indicated the charge nurse placed a towel against Resident1's head to stop the bleeding and immediately called 911. During a review of Resident 1's Skilled Nursing Facility (SNF) to Hospital Transfer form, dated 12/1/2025 at 12:12 a.m., the form indicated Resident 1 was transported to the GACH after another resident pushed her resulting in Resident 1 bleeding from a head due to injury. During a review of Resident 1's GACH emergency room (ER) records, dated 12/1/2025, the ER's records indicated Resident 1 arrived at the ER after Resident 1 was pushed by another resident, Resident 1 fell and hit the back of her head on the ground which caused minor head trauma and a 1.0 inch laceration to the posterior scalp. The ER records indicated two staples were used to staple the laceration. The ER records indicated Resident 1 was discharged back to the facility on the same day (12/1/2025). During a review of Resident 1's head computerized tomography scan (CT - a type of imaging that uses X-ray techniques to create detailed images of the body) dated 12/1/2025, the CT scan indicated there was no acute intracranial abnormality with right parietal (located at the top and back of the head) skin staples. During an interview on 12/5/2025 at 12:30 p.m. with Resident 1, Resident 1 stated she was talking with Resident 4 in the hallway outside Resident 4's room (date and time unknown) when Resident 2 suddenly pushed her for no reason. Resident 1 stated, When I fell, I hit the back of my head on the floor, I had to go to the hospital, and they put two staples in the back of my head. During an interview on 12/5/2025 at 12:50 p.m. with Resident 4, Resident 4 stated a few days ago she witnessed when Resident 2 pushed Resident 1 to the ground. Resident 4 stated Resident 1's head was bleeding. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included bipolar disorder (a mental health condition causing extreme mood swings), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought) and Parkinson's disease (a progressive

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to:Ensure Seroquel 25 mg (antipsychotic-class of medications) was obtained, available, and administered as ordered for one out of three sampled residents (Resident 2). This deficient practice resulted in Resident 2 missing eight (8) consecutive days of Seroquel, placing the resident at risk for increased agitation, behavioral escalation, and harm to others, and contributed to a resident-to-resident altercation resulting in injury. Findings:During a review of Resident 2's admission Record, the admission Record indicated, Resident 2 was originally admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 2's History and Physical (H&P), dated 6/8/2025, the H&P indicated Resident 2 lacked the capacity to make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/27/2025, the MDS indicated Resident 2's cognitive skills were severely impaired, and Resident 2 required partial to moderate assistance with activities of daily living such as bathing, dressing and toileting a person performs daily. During a review of Resident 2's Physician's Order Summary Report, dated 11/23/2025, the report indicated Seroquel 25 mg by mouth to be administered three times daily for schizophrenia manifested by angry outburst, to be started on 11/24/2025. During a review of Resident 2's care plan dated 11/24/25, titled Care Plan Report indicated the resident uses psychotropic (drugs that affect a person's mental status) medications. The interventions included administering psychotropic medications as ordered by the physician. During a review of the pharmacy consolidated delivery sheets, dated 12/1/2025, confirmed Resident 2's Seroquel 25 mg was received by the facility on 12/2/2025 at 12:50 a.m. During an interview on 12/5/2025 at 4:15 p.m., with the Pharmacy Technician, the Pharmacy Technician stated the pharmacy did not receive a medication request for Resident 2's Seroquel 25 mg three times daily until 12/1/2025 at 2:28 p.m., despite the physician's order dated 11/23/2025. The Pharmacy Technician stated the medication was filled and delivered on 12/2/2025 at 12:50 a.m. During a concurrent interview and record review on 12/8/2025 at 3:45 p.m. with the Director of Nursing (DON), Resident 2's Medication Administration Record (MAR), dated November 2025 and December 2025 were reviewed. The DON stated Resident 2's new order for Seroquel 25 mg three times daily was ordered by the physician on 11/23/2025 and was not available in the facility until 12/2/2025. The DON confirmed Resident 2 did not receive Seroquel 25 mg three times daily from 11/24/2025 until 12/1/2025. The DON stated Resident 2 was involved in a resident-to-resident altercation on 11/30/2025, during which Resident 2 pushed another resident to the ground, resulting in the other resident sustaining a laceration to the back of the head requiring two staples. The DON acknowledged nursing staff failed to ensure the ordered antipsychotic medication was obtained and administered in a timely manner and stated the absence of Seroquel in the days leading up to the incident could have contributed to Resident 2's behavior escalation. During a review of the facility's policy and procedures (P&P), titled Medication Error and Adverse Drug Reaction Reporting, undated, the P&P defined a medication error as the omission of a prescribed medication due to a prescribing, dispensing or administering error.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 ensure Registered Nurses (RN), RN 1, RN 2, and Licensed Vocational Nurses (LVN), LVN 3, LVN 4, LVN 5, LVN 6, LVN 7 did not willfully falsify Resident 2's medical records when the staff documented administration, resident refusal, and awaiting pharmacy of ordered psychotropic medication that was not available in the facility for Resident 2. This deficient practice resulted in Resident 2 having inaccurate medical records that did not reflect the actual care provided or his actual clinical condition. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 2's history and physical (H&P), dated 6/8/2025, the H&P indicated Resident 2 did not have the capacity to make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/27/2025, the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 required moderate assistance from staff for activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 2's Order Summary Report, dated 11/23/2025, indicated Seroquel (antipsychotic [medication that manage psychosis {hallucinations, delusions, disordered thinking}] medication primarily used to treat schizophrenia and bipolar disorder) 25 milligrams (mg- unit of weight measurement) by mouth to be administered three times daily for schizophrenia manifested by angry outbursts. During a review of Resident 2's care plan titled Resident 2 uses psychotropic medications (Seroquel) related to behavior management, dated 11/24/2025, the care plan's interventions indicated to administer psychotropic medications as ordered by physician. During a review of Resident 2's Medication Administration Record (MAR), for the months of November and December 2025, the MARs indicated Seroquel was administered on 11/24/2025 at 9 a.m. and 1 p.m., on 11/25/2025 at 1 p.m. and 5 p.m., on 11/26/2025 at 5 p.m., on 11/27/2025 at 9 a.m. and 1 p.m., on 11/28/2025 at 5 p.m., on 11/29/2025 at 5 p.m., on 11/30/2025 at 9 a.m., 1 p.m. and 5 p.m., and on 12/1/2025 at 5 p.m. The MARs indicated Resident 2 refused Seroquel on 11/25/2025 at 9 a.m., on 11/26/2025 at 9 a.m. and 1 p.m., and on 12/1/2025 at 9 a.m. and 1 p.m. The MARs indicated the licensed nurses documented 9 (which indicated other/see progress notes) on 11/24/2025 at 5 p.m., on 11/27/2025 at 5 p.m., on 11/28/2025 at 9 a.m. and 1 p.m., and on 11/29/2025 at 1 p.m. During a review of Resident 2's Administration progress notes, the administration progress notes indicated Seroquel was not administered on the following dates and times due to pending pharmacy delivery: 11/24/2025 at 5 p.m., 11/27/2025 at 5 p.m., 11/28/2025 at 9 a.m. and 1 p.m., and on 11/29/2025 at 9 a.m. and 1 p.m. During an interview on 12/5/2025 at 4:15 p.m., with the Pharmacy Technician, the Pharmacy Technician stated the pharmacy did not receive a medication request for Seroquel on 11/23/2025. The Pharmacy Technician stated the medication was not filled and delivered until 12/2/2025. During a review of the pharmacy consolidated delivery sheets, dated 12/1/2025, the delivery sheets indicated Seroquel 25 mg was received by the facility on 12/2/2025 at 12:50 a.m. During an interview on 12/8/2025 at 3:45 p.m. with the Director of Nursing (DON), the DON stated Resident 2's order for Seroquel 25 mg three times daily was ordered by the physician on 11/23/2025. The DON stated Seroquel was not available until 12/2/2025 causing Resident 2 not to receive the medication for eight days. The DON stated medication administration was not documented accurately when nursing staff documented Resident 2 was awaiting response from the pharmacy. The DON stated Seroquel was documented as administered or refused when the medication was not available. The DON stated the nursing staff failed to ensure Resident 2's Seroquel was obtained and administered in a timely manner and documented correctly. During a phone interview on 12/9/2025 at 2:41 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 11/24/25 while passing the morning medications to Resident 2, Resident 2's Seroquel was not available despite an active order. LVN stated there were other days she administered medication to Resident 2. LVN 3 stated she documented that Seroquel was administered or refused despite the medication not being available in the facility. LVN 3 stated she should not have documented administration or refusal when the medication was not present. LVN 3