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	01/12/2026

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 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 interview and record review, the facility failed to report to the California Department of Public Health (CDPH), when one of ten sampled residents (Resident 5), allegedly hit Resident 4 in the stomach since admission to the facility on [DATE].This deficient practice resulted in a delay in investigation by the CDPH and placed Resident 4 at risk for physical abuse (any intentional act causing injury or trauma to another person through bodily contact, including, but not limited to, hitting, slapping, punching, biting and kicking).Findings: a). During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (chronic condition where the body cannot regulate sugar in the body and blood sugar can become too low or too high), and hypertension (high blood pressure). During a review of Resident 4's History and Physical (H&P) dated 12/12/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 4 was able to understand and be understood by others. The MDS indicated Resident 4 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene, and personal hygiene. The MDS indicated Resident 4 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 4 required maximal assist with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sit to stand, for chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 4's clinical records for a Change of Condition (COC) and progress notes from 12/11/2025 to 12/16/2025, Resident 4's clinical records did not indicate any COC of the allegation (hitting) or any documentation in the progress notes the (hitting) allegations were reported to the CDPH. During a concurrent interview on 12/16/2025 at 11:00 a.m. with Resident 4, Licensed Vocational Nurse (LVN 2) and Assistant Administrator (AADM) in nurse's station 1, Resident 4 stated Resident 5 had been hitting her (Resident 4) in the stomach since Resident 4 got admitted to the facility on [DATE]. Resident 4 repeated that Resident 5 had been hitting her in the stomach since she got to the facility. During the interview, the AADM arrived at nurse's station 1. LVN 2 reported to the AADM regarding Resident 4's report that Resident 5 had been hitting her (Resident 4) in the stomach since she was admitted to the facility. b). During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and hypertension. During a review of Resident 5's H&P dated 10/2/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 was usually able to understand and be understood by others. The MDS indicated Resident 5 required supervision for eating. The MDS indicated Resident 5 required moderate assistance for oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 5 required maximal assistance for toileting hygiene, shower/bathe self, lower dressing and putting on/taking off footwear. The MDS indicated Resident 5 required maximal assistance with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, and was dependent for (helper does all the effort resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed to chair transfer, and toilet transfer. During a review of Resident 5's clinical records for a Change of Condition (COC) and progress notes from 12/11/2025 to 12/16/2025, Resident 5's clinical records did not indicate any COC alleging Resident 5 hitting Resident 4 or any documentation in the progress notes the (hitting) allegations were reported to the CDPH. During an interview on 12/16/2025 at 11:39 a.m. with Resident 5, Resident 5 stated she did not hit Resident 4. During an interview on 12/31/2025 at 1:00 p.m. with the AADM, the AADM stated on 12/16/2025 at 11:30 a.m., LVN 2 reported to him about Resident 5 hitting Resident 4 in the stomach since admission on [DATE]. The AADM stated he did not report the incident to the CDPH because the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) indicated that incidents by residents with dementia (a progressive state of decline in mental abilities) were not reportable to CDPH. The AADM stated he should have reported the incident because the facility's policy and procedure (P&P) and the federal law indicated to report all abuse allegations to CDPH, Ombudsman and police department. The AADM stated he should have reported the incident to CDPH to ensure a thorough investigation was carried out by CDPH. During a review of the facility's P&P titled, Reporting Guidance & Timelines for Abuse & injuries of Unknown Origin, dated 6/2022, the P&P indicated it was the facility's policy to report alleged violations related to abuse, immediately and submit a written report to the local Ombudsman or the local law enforcement agency using the California Report of Suspected Dependent Adult/ Elder Abuse Form (SOC 341).

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled admission to the Facility, when the admission consent for one of three residents (Resident 4), was not obtained from the resident or family representative. This deficient practice resulted in the resident's admission to the facility without consent and had the potential that the affected resident will not receive the necessary care and services the resident need.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (chronic condition where the body cannot regulate sugar in the body and blood sugar can become too low or too high), and hypertension (high blood pressure). During a review of Resident 4's History and Physical (H&P) dated 12/12/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 4 was able to understand and be understood by others. The MDS indicated Resident 4 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. MDS indicated Resident 4 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene, and personal hygiene. The MDS indicated Resident 4 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 4 required maximal assist with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sit to stand, for chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During an interview on 12/16/2025 at 12:33 p.m. with Family Member 1 (FM 1), FM 1 stated that she (FM 1) was Resident 4's conservator (court-appointed person or organization that manages the financial and health decisions for an individual). FM 1 stated prior facility (Facility 2) did not inform her (FM1) that Resident 4 was being sent to the admitting facility (Facility 1). FM 1 stated she did not give Facility 1 permission to take Resident 4. During a concurrent interview and record review on 12/17/2025 at 10:58 a.m. with the admission Coordinator (AC), the AC stated she did not follow the facility's policy when FM 1's consent was not obtained prior to admitting Resident 4. The AC stated FM 1's admission consent to admit Resident 4 should have been obtained to ensure Resident 4/FM 1 wishes were respected. During a review of the facility's P&P titled, admission to the Facility, dated 1/2023, the P&P indicated residents will be admitted to the facility on ly upon the written order of the resident's attending physician and with the resident's or responsible party's (if applicable) consent. The P&P indicated, if the resident has an appointed surrogate or representative, the identifying paperwork must be presented to the facility prior to or upon admission.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Bed-Hold (refers to the practice where a resident's bed is reserved for 7 days while temporarily away from the facility, such as during hospitalization or therapeutic visits) written notification to one of three residents (Resident 1), when Resident 1 was transferred to the general acute care hospital on [DATE], 12/8/2025, 12/11/2025, and 12/14/2025, as indicated in its policy and procedure (P&P) titled, Bed-Hold.This failure had the potential for Resident 1 not to exercise the option to use the facility's bed-hold policy and lose their bed at the facility.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included seizures (a sudden, uncontrolled electrical disturbance in the brain) and conversion disorder with seizures (a condition in which a mental health issue disrupts how the brain works).During a review of Resident 1's History and Physical (H&P), dated 12/2/2025, 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 12/4/2025, the MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADLs) such as toileting hygiene and shower/bathe self and required partial/moderate assistance to perform movements such as rolling left and right and changing positions from sitting to lying.During a concurrent interview and record review on 12/17/2025 at 2:11 p.m., with the admission Coordinator (AC), the facility's Daily Census dated 12/1/2025, 12/8/2025, 12/11/2025 and 12/14/2025 were reviewed. The AC stated the Daily Census indicated Resident 1 was on bedhold on 12/8/2025 and 12/14/2025. The AC stated Resident 1 should have signed four bed-hold notices on 12/1/2025, 12/8/2025, 12/11/2025, and 12/14/2025 as indicated in the facility's census, bedholds column and should have been filed in Resident 1's medical record. The AC stated residents should sign the Bedhold policy upon admission and when the resident was transferred to the hospital. During a concurrent interview and record review on 12/18/2025 at 11:30 a.m., with Medical Records, Resident 1's Bed-Hold Agreements were reviewed. Medical Records stated Resident 1 had a bed-hold agreement signed on 12/1/2025. The Medical Records stated there were no other Bed-Hold agreements in Resident 1's file.During a concurrent interview and record review on 12/18/2025 at 1:57 p.m., with Licensed Vocational Nurse (LVN) 2, the facility's P&P titled, Bed-Hold, dated 12/2016, was reviewed. LVN 2 stated according to the facility's policy, residents who were transferred should be provided with written information concerning the option to exercise the bed-hold policy. LVN 2 stated, if there was no other bed-hold notices in Resident 1's file, the facility did not follow its P&P. LVN 2 stated they (facility staff) were not aware of the requirement to offer the bed-hold notice to the residents when being transferred out of the facility.During a concurrent interview and record review on 12/18/2025 at 3:59 p.m., with the Interim Director of Nursing (DON), the facility's P&P, titled Bed-Hold, was reviewed. The Interim DON stated the P&P indicated the facility should have the written information of the bed-hold policy for residents upon admission and transfer. The Interim DON stated the bed-hold written information should be included in the residents' chart or with Medical Records.During a review of facility's P&P titled, Bed-Hold, dated 12/2016, the P&P indicated the facility should provide a written notification to all residents, family members and/or legal representative of the bed/hold policy upon admission, and at the time of transfer, in accordance with federal and state guidelines. The P&P indicated a facility designee will provide the resident and an immediate family member, surrogate, or representative written information concerning the option to exercise the bed-hold policy upon (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission, and at the time a resident is transferred to a hospital or goes on a therapeutic leave. The P&P indicated, the written information must specify the duration of the bed-hold and be issued at the time of transfer. The P&P indicated a copy of the bed-hold notice must be sent with the resident at the time of transfer. The P&P indicated, in case of emergency transfer, a written notice to the family surrogate or representative should be provided within 24 hours of transfer.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care and services for two of three sampled residents (Residents 1 and 3) who had seizure disorders (a sudden, uncontrolled electrical disturbance in the brain), met professional standards of quality care. These failures had the potential for recurring seizures, injuries, hospitalization and death.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included seizures included seizures and conversion disorder with seizures (a condition in which a mental health issue disrupts how the brain works).During a review of Resident 1's History and Physical (H&P), dated 12/2/2025, 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 12/4/2025, the MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADLs) such as toileting hygiene and shower/bathe self and required partial/moderate assistance to perform movements such as rolling left and right and changing positions from sitting to lying.During a review of Resident 1's Order Summary Report, for the month of 12/2025, the order indicated Levetiracetam oral tablet 1000 milligrams (mg - a metric unit of measurement), one (1) tablet by mouth every 12 hours for seizure disorder. During a review of Resident 1's Medication Administration Record (MAR), for the month of 12/2025, the MAR did not indicate Resident 1 received Levetiracetam 1000 mg scheduled for 9 a.m. on 12/11/2025 and the 9 p.m. dose on 12/12/2025. During a review of Resident 1's Order Administration note, dated 12/11/2025 at 10:10 a.m., the Order Administration note indicated on 12/11/2025 at 9:00 a.m., Resident 1 did not receive the Levetiracetam 1000 mg because the facility was waiting for the medication (Levetiracetam 1000 mg) to be delivered.During a review of Resident 1's nursing progress notes, dated 12/11/2025 at 4:30 p.m., the progress notes indicated Resident 1 was sent out to a General Acute Care Hospital (GACH) due to seizure.During a review of Resident 1's nursing progress notes, dated 12/12/2025 at 9:24 p.m., the progress notes indicated Resident 1 was readmitted to the facility from GACH on 12/12/2025 at 9 p.m.During a review of Resident 1's Order Administration Notes and nursing progress notes dated 12/12/2025, there were no notes indicating why Resident 1's Levetiracetam 1000 mg. on 12/12/2025 9:00 p.m. dose was not administered.During a review of Resident 1's MAR, for the month of 12/2025, the MAR indicated Lorazepam (medication used to treat seizures) injection solution 2 mg per ml, to inject 1 ml intramuscularly ([IM] injection administered directly to a muscle tissue) every five (5) minutes as needed for seizures, times three (3). The MAR did not indicate Resident 1 received Ativan 1 ml IM on 12/11/2025 4:30 p.m. when the resident had seizure episode. During a review of Resident 1's Active and Discontinued orders for the month of 12/2025, the order did not indicate monitoring of Keppra levels.During a concurrent interview and record review on 12/17/2025 at 11:57 a.m., with Licensed Vocational Nurse (LVN) 1 the following were reviewed:Resident 1's 12/2025 MAR for Keppra and AtivanResident 1's Order Administration Note, dated 12/11/2025 at 10:10 a.m.Resident 1's nursing progress notes, dated 12/11/2025 at 4:30 p.m.LVN 1 stated if seizure medications were not available, staff should have followed up with the pharmacy because seizures are life-threatening, and the residents must receive their seizure medications on time. LVN 1 stated the facility had no documented evidence the Keppra was followed up with the pharmacy on 12/11/2025 to ensure timely delivery and Resident 1 will receive the 9 a.m. dose of Keppra on 12/12/2025. LVN 1 stated the Keppra administered on 12/11/2025 was charted on the wrong date (12/13/2025). LVN 1 stated the Keppra administered on 12/11/2025 was not documented when administered. 2). During a review of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 3's diagnoses included epilepsy (a brain condition that causes seizures), unspecified, intractable without status epilepticus (a type of epilepsy where seizures are hard to control with medicine, the exact cause or type is not specified, and the person is not having a prolonged seizure).During a review of Resident 3's H&P, dated 8/8/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment (problems with the ability to think and reason) required supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes activity) for ADLs such as oral hygiene and required supervision or touching assistance to perform movements such as rolling left and right.During a review of Resident 3's Order Summary Report as of 12/17/2025, the order summary report indicated Divalproex Sodium (Depakote- medicine for epilepsy [a brain condition that causes recurring seizures, which are abnormal electrical brain activities) tablet 750 mg. twice a day for epilepsy.During a review of Resident 3's MAR, for the month of 12/2025, the MAR did not indicate Resident 3 received the 9 a.m. dose of Depakote on 12/13/2025 and 12/14/2025. During an interview on 12/18/2025 at 11:53 a.m., with LVN 3, LVN 3 stated Resident 3 had epilepsy and was prone to having seizure if the Depakote was not administered. LVN 3 stated she did not give Resident 3 the Depakote medicine 9 am doses on 12/13/2025 and 12/14/2025 because they (Depakote) were not available in the cart.During a concurrent interview and record review on 12/18/2025 at 1:57 p.m., with LVN 2, the following were reviewed: Resident 1's active, discontinued, and on hold orders for the month of 12/2025.Resident 1's MAR for Keppra, for the month of 12/2025.Resident 1's progress notes for 12/11/2025.Resident 1's Pharmacy delivery medication list for 12/11/2025.Resident 3's MAR for Depakote, for the month of 12/2025.Resident 3's progress notes for 12/13/2025 and 12/14/2025.LVN 2 stated if residents' Depakote were not available, facility staff should call the residents' doctor and obtain orders. LVN 2 stated the facility staff should have given Resident 3's 9 a.m. doses of Depakote on 12/13/2025 and 12/14/2025 to prevent seizure. LVN 2 stated if residents were sent out to GACH for seizures and came back to the facility, the facility should obtain orders to check Keppra levels to ensure resident's Keppra levels were at a therapeutic range. LVN 2 stated Resident 1 had no Keppra levels. LVN 2 stated the facility should have obtained Resident 1's Keppra levels on 12/16/2025. LVN 2 stated Resident 1 should have received their Keppra doses on 12/11/2025 and 12/12/2025 because pharmacy had delivered more than enough medication to provide to the resident. LVN 2 stated there was no reason documented in Resident 1's progress notes why the 9 p.m. dose of Keppra was not given on 12/12/2025. LVN 2 stated the dose (Keppra) should have been given to the resident if it was verified with Resident 1's doctor.During an interview on 12/18/2025 at 3:59 p.m., with the Interim Director of Nursing (DON) the Interim DON stated Resident 1 should have received Keppra as ordered and informed MD when there were delays in the administration. The Interim DON stated Resident 1's Keppra level should have been obtained on every initial assessment and readmission to the facility per facility policy. The Interim DON stated Resident 1 had no Keppra levels and should have been done to obtain baseline (a standard used to track changes over time) blood level. During a review of facility's P&P titled, Medication Administration - General Guidelines, undated, the P&P indicated, medications should be administered within 60 minutes of scheduled time unless otherwise specified by the prescriber. The P&P indicated routine medications should be administered according to the established medication administration schedule for the facility. The P&P indicated the individual who administered the medication dose should record the administration on the resident's MAR directly after the medication is given. The P&P (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident's MAR should be initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. During a review of facility's P&P titled, Care for Patients with Seizure Disorder, dated 8/2020, the P&P stated, the facility should provide comprehensive, individualized care for residents with seizure disorders, including assessment, medication management, documentation, staff education, to reduce risk of harm and support optimal quality of life. The P&P indicated the nurse should assess and document the last blood level of any anticonvulsants being given.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure admission orders (orders containing treatment and medications to be administered to the resident being admitted to the facility) for one of three newly admitted residents (Resident 4), were obtained from a physician, as indicated in its policy and procedures (P&P) titled, admission to the Facility. This deficient practice resulted in Resident 4's admitting orders not verified from the physician.This deficient practice had the potential for wrong name of medications ordered, wrong dosage, wrong route and placing the resident at risk receiving the wrong drugs, that could affect the resident's medical condition, leading to injuries, hospitalization or death. Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (DM- chronic condition where the body cannot regulate sugar in the body and blood sugar can become too low or too high), and hypertension (high blood pressure). During a review of Resident 4's History and Physical (H&P) dated 12/12/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 4 was able to understand and be understood by others. The MDS indicated Resident 4 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene, and personal hygiene. The MDS indicated Resident 4 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 4 required maximal assistance with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sit to stand, for chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 4's Progress Notes dated 12/11/2025 at 7:00 p.m., the progress notes indicated Resident 4 was admitted on [DATE] with discharge paperwork dated 11/24/2025 from General Acute Care Hospital (GACH 1). The progress notes indicated Resident 4's admitting physician's orders were not entered because the orders needed to be clarified from MD 2. The progress notes indicated GACH 1 was contacted to request updated discharge information, but GACH's staff reported Resident 4's GACH discharge records on 12/11/2025 could not be located. The progress notes indicated Resident 4's discharge paperwork dated 11/24/2025 was sent to Physician (MD 2) for review and clarification, but MD2 did not respond or called back. During a review of Resident 4's telephone order dated 12/11/2025 at 5:42 p.m., the telephone order indicated to admit Resident 4 from General Acute Care Hospital (GACH) 1. During a review of Resident 4's telephone orders dated 12/12/2025 at 3:24 a.m., indicated the following:Allopurinol (medication to treat gout [buildup of crystal in joints that lead to swelling, redness and pain]) 100 milligrams (mg: unit of measurement) by mouth (PO) in the morning - every Tuesday, Thursday and Saturday for goutAripiprazole 5mg., 1 tablet by mouth three times a day for bipolar disorder (mental health condition causing extreme mood swings making daily tasks difficult).Atorvastatin Calcium 10 mg give 1 tablet PO at bedtime for hyperlipidemia (elevated fat in the blood).Carvedilol oral tablet 25 mg, give 1 tablet by mouth in the evening for hypertension high blood pressure).Famotidine oral tablet 10 mg give 1 tablet PO one time a day for Gastroesophageal Reflux Disease (GERD- chronic condition where stomach acid (continued on next page)

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	056435	A. Building B. Wing	01/12/2026

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

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequently flows back into the food pipe)Insulin Glargine Solution 100 unit/milliliter (unit/ml: unit of measure), inject 15 units subcutaneously (under the skin) at bedtime for DM (medication to manage high blood sugar).Insulin Regular Human Injection inject as per sliding scale if 150-199 = 1 unit; 200-249 = 2 units; 250-299 = 3 units; 300-349= 4 units; 350-399= 5 units; greater than 400 give 6 units subcutaneously and call MD, give before meals and at bedtime for DM (medication to manage high blood sugar).Latanoprost Solution 0.005 % (eye medication), instill 1 drop to both eyes at bedtime for glaucoma (eye condition due to high pressure from fluid leading to gradual vision loss and blindness if untreated).Levothyroxine Sodium 25 mcg give 1 tablet PO one time a day for hypothyroidism (when thyroid gland does not produce enough thyroid hormones). Lisinopril 5 mg give 1 tablet PO one time a day for hypertension. Olanzapine 10 mg give 1 tablet by mouth every 12 hours for schizophrenia (serious, chronic mental illness that disrupts how a person thinks, feels, and behaves, causing them to lose touch with reality through symptoms like hallucinations) Quetiapine Fumarate 25 mg give 1 tablet by mouth every 12 hours for schizophrenia. Trazodone Hydrochloride (HCl) Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet PO at bedtime for depression (serious mood disorder causing persistent sadness). Glucagon Injection Solution Reconstituted (emergency medication to rapidly treat severely low blood sugar to patients who are unconscious), inject 1 mg subcutaneously every 24 hours as needed. During a concurrent interview and record review 12/17/2025 at 1:51 p.m. with Licensed Vocational Nurse (LVN 2), Resident 4's document titled, Action Summary (document containing residents' names, date and time of admission) dated 12/16/2025 11:54 a.m. was reviewed. LVN 2 stated the Action summary indicated Resident 4 was admitted to the facility on [DATE] at 5:29 p.m. LVN 2 stated it was important to verify Resident 4's admission orders from MD2 to ensure the resident have the correct medications. During an interview on 12/18/2025 at 4:39 p.m. with LVN 5, LVN 5 stated Resident 4 arrived at the facility for admission on [DATE] at 5:29 p.m. LVN 5 stated the admitting nurse did not enter any physician orders and could not remember the reason why the admission orders were not entered. LVN 5 stated she did not make a follow-up call to MD 2 because MDs do not answer facility phone calls at night shift. LVN 5 stated Resident 4's physician orders entered on 12/11/2025 were not verified from MD 2. LVN 5 stated the medication lists written in the physician's order were obtained from Resident 4's discharge paperwork from GACH 1 dated 11/24/2025 the resident came with. LVN 5 stated she was told by an Administrator (could not remember who) to enter physician orders without calling MD because night shift nurses enter orders without calling the MDs. During an interview on 1/5/2026 at 2:30 p.m. with MD 1, MD 1 stated she was not the on-call (coverage after 5p.m.) physician for MD 2 on 12/11/20205 after 5 p.m. MD 1 stated she have not given orders for Resident 4 on 12/11/2025. MD 1 stated she did not cover MD 2 the nightshift on 12/11/2025. MD 1 stated the facility had after-hours physicians to cover for nighttime. MD 1 stated it was important for nurses to call the physician for any newly admitted residents to clarify orders. MD 1 stated nurses could enter the wrong dosage or wrong medication, and it could lead to harming the residents. MD 1 stated physicians typically respond to staff within 1- 2 hours of calling. MD 1 stated if there were urgent matters, the facility was provided with two (2) phone numbers to call. During an interview on 1/8/2026 at 3:51 p.m. with MD 2, MD 2 stated she have not given admission orders for Resident 4 on 12/11/2025 (time not specified). MD 2 stated she could not find out if a physician that worked after hours had given the admission order for Resident 4. MD 2 stated Facility 1's process was to take a picture of the new resident's transfer orders and send it to the MD. MD 2 stated the MD would review the orders and accept or decline the orders over the phone. MD 2 stated she could not find Resident 4's admission orders sent to her for verification on 12/11/2025 and could not remember verifying admission orders for Resident 4. MD (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 stated it was important for MD to review admission orders to prevent medication errors, duplicate drugs or giving contraindicated drugs to the residents. During a review of the facility's P&P titled, admission to the Facility, dated 1/2023, the P&P indicated residents will be admitted to the facility on ly upon the written order of the resident's attending physician. During a review of the facility's P&P titled, Pharmaceutical Services Policy and Procedure Manual, dated 1/2025, the P&P indicated medications orders should be signed by a licensed physician lawfully authorized to prescribe medications.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was called to follow up admission medication orders for one of three newly admitted residents (Resident 4), for timely administration. This deficient practice resulted in the delayed administration of medications due and had the potential to affect the resident's medical condition, leading to complications, hospitalization and death. Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (chronic condition where the body cannot regulate sugar in the body and blood sugar can become too low or too high), and hypertension (high blood pressure).During a review of Resident 4's History and Physical (H&P) dated 12/12/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 4 was able to understand and be understood by others. The MDS indicated Resident 4 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene, and personal hygiene. The MDS indicated Resident 4 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 4 required maximal assist with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sit to stand, for chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 4's telephone order dated 12/11/2025 at 5:42 p.m., the telephone order indicated to admit Resident 4 from General Acute Care Hospital (GACH) 1. During a review of Resident 4's telephone orders dated 12/12/2025 at 3:24 a.m., indicated the following:Allopurinol (medication to treat gout [buildup of crystal in joints that lead to swelling, redness and pain]) 100 milligrams (mg: unit of measurement) by mouth (PO) in the morning - every Tuesday, Thursday and Saturday for goutAripiprazole 5 mg., 1 tablet by mouth three times a day for bipolar disorder (mental health condition causing extreme mood swings making daily tasks difficult).Atorvastatin Calcium 10 mg give 1 tablet PO at bedtime for hyperlipidemia (elevated fat in the blood).Carvedilol oral tablet 25 mg, give 1 tablet by mouth in the evening for hypertension high blood pressure).Famotidine oral tablet 10 mg give 1 tablet PO one time a day for Gastroesophageal Reflux Disease (GERD- chronic condition where stomach acid frequently flows back into the food pipe)Insulin Glargine Solution 100 unit/milliliter (unit/ml: unit of measure), inject 15 units subcutaneously (under the skin) at bedtime for DM (medication to manage high blood sugar).Insulin Regular Human Injection inject as per sliding scale if 150-199 = 1 unit; 200-249 = 2 units; 250-299 = 3 units; 300-349= 4 units; 350-399= 5 units; greater than 400 give 6 units subcutaneously and call MD, give before meals and at bedtime for DM (medication to manage high blood sugar).Latanoprost Solution 0.005 % (eye medication), instill 1 drop to both eyes at bedtime for glaucoma (eye condition due to high pressure from fluid leading to gradual vision loss and blindness if untreated).Levothyroxine Sodium 25 mcg give 1 tablet PO one time a day for hypothyroidism (when thyroid gland does not produce enough thyroid hormones). Lisinopril 5 mg give 1 tablet PO one time a day for hypertension. Olanzapine 10 mg give 1 tablet by mouth every 12 hours for schizophrenia (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(serious, chronic mental illness that disrupts how a person thinks, feels, and behaves, causing them to lose touch with reality through symptoms like hallucinations) Quetiapine Fumarate 25 mg give 1 tablet by mouth every 12 hours for schizophrenia. Trazodone Hydrochloride (HCl) Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet PO at bedtime for depression (serious mood disorder causing persistent sadness). Glucagon Injection Solution Reconstituted (emergency medication to rapidly treat severely low blood sugar to patients who are unconscious), inject 1 mg subcutaneously every 24 hours as needed. During a concurrent interview and record review 12/17/2025 at 1:51 p.m. with Licensed Vocational Nurse (LVN 2), the facility's Action Summary document for 11/24/2025 to 12/31/2025 (document containing residents' names and date of actual admissions) was reviewed. LVN 2 stated the Action Summary document indicated Resident 4's Resident 4's actual admission date was 12/11/2025 at 5:29 p.m. LVN 2 stated Resident 4 did not receive the night medications that were due on 12/11/2025 at 9:00 p.m. which included Carvedilol, Insulin Glargine, Trazodone HCl because the medication orders were not verified by the prescribing physician (MD 2). LVN 2 stated Resident 4 missing the medications could lead to high blood pressure, high blood sugar which could lead to coma, and behavioral episodes. LVN 2 stated Resident 4's medication administration history indicated Resident 4 received all her 9 a.m. medications on 12/12/2025 at 12:21 p.m. (three hours and 21 minutes late). LVN 2 stated delayed in administering Aripiprazole could lead to behavioral episodes, famotidine could lead to heartburn and discomfort. LVN 2 stated if the blood sugar was not checked and not given Insulin Regular Human Injection per sliding scale (a varied dose of insulin based on blood glucose level), it could lead to high blood sugar, lisinopril could lead to high blood pressure, Olanzapine, Quetiapine Fumarate, and Trazodone HCl, could lead to behavioral crisis. During an interview on 12/18/2025 at 4:39 p.m. with LVN 5, LVN 5 stated Resident 4 arrived at the facility for admission on [DATE] at 5:29 p.m. LVN 5 stated the admitting nurse did not enter any physician orders and could not remember the reason why the admission orders were not entered. LVN 5 stated she did not make a follow-up call to MD 2 because MDs do not answer facility phone calls at night shift. LVN 5 stated Resident 4's physician orders entered on 12/11/2025 were not verified from MD 2. LVN 5 stated the medication lists written in the physician's order were obtained from Resident 4's discharge paperwork from GACH 1 dated 11/24/2025 the resident came with. LVN 5 stated she was told by an Administrator (could not remember who) to enter physician orders without calling MD because night shift nurses enter orders without calling the MDs. During an interview on 1/8/2026 at 3:51 p.m. with MD 2, MD 2 stated she have not given admission orders for Resident 4 on 12/11/2025 (time not specified). MD 2 stated she could not find out if a physician that worked after hours had given the admission order for Resident 4. MD 2 stated it was important for MD to review admission orders to prevent medication errors, duplicate drugs or giving contraindicated drugs to the residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure telephone orders given by the ordering physician, telephone orders obtained by staff from the ordering physician and other orders given by the ordering physician, were entered under the prescriber's name. This failure resulted in the difficulty in identifying the ordering physician's name, had the potential to mislead the healthcare system and potential for fraud.Findings:During an interview on 1/5/2026 at 2:30 p.m. with the physician (MD 1), MD 1 stated when telephone orders were given to the facility by the medical team under her practice (MDs, Nurse Practitioners [NP]), the facility staff receiving the telephone order would use her name (MD1) as the ordering physician. MD1 stated she was informed that the electronic medical record system (the electronic program the facility used) does not have the options of the other medical team members' names to use being the ordering physician. During an interview on 1/8/2026 at 3:51 p.m. with MD 2, MD 2 stated the computer program used at the facility to enter orders does not allow the ordering physician to enter orders under their name (ordering MD). MD2 stated the order only has the option of the attending physician's name. MD2 stated it would be difficult to identify which covering MD gave the order because the record will not indicate the ordering MD's name but only the attending MD. During a review of the facility's P&P titled, Pharmaceutical Services Policy and Procedure Manual, dated 1/2025, the P&P indicated medications telephone orders should be countersigned by the prescriber.