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	04/09/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (Resident 3), was not subjected to physical abuse (the willful infliction of physical pain, injury, which includes hitting, slapping, pinching, kicking, etc.) by Resident 5.The facility failed to: Provide nursing interventions on 4/5/2026 at 8:10 a.m. to prevent resident's agitation (a state of severe restlessness, tension, or nervous excitement) from escalating (increase), when Resident 5 threw the phone at a staff at the nurse's station, then walked to his room, removed a breakfast tray from the cart and threw onto the floor, stating, I want to go to the hospital now.Ensure Resident 5 was assessed for behavior triggers (cause) and transferred to the general acute care hospital (GACH) for further evaluation and treatment, as indicated in Resident 5's care plan titled, Increased Agitation manifested by throwing object at staff and yelling.Implement its Policy and Procedure (P&P) titled Abuse and Neglect Prohibition Policy which indicated the facility will identify, correct, and intervene in situations in which abuse is more likely to occur and by supervising staff to identify inappropriate resident behaviors and by assessing, care planning, and monitoring residents with behaviors that may lead to conflict including residents with a history of aggressive behaviors. These failures resulted in Resident 5 pushing Resident 3 in the hallway floor on 4/5/2026 at 11:45 a.m. Resident 3 hit the right side of his face in the hallway rail and sustained a cut to the right eyebrow (no measurement). Resident 3 was sent to a GACH on 4/5/2026 and received six (6) stitches in his right eyebrow. These failures also placed Resident 3 at risk for severe injuries and complications, and psychological harm.Findings:a). During a concurrent observation and interview on 4/8/2026 at 9:58 a.m. with Resident 3 in the facility hallway, Resident 3's right eye was purple and swollen. The right eyebrow had steri-strips (thin, sterile adhesive bandages used to hold small wounds or surgical incisions together). Resident 3 stated, I do not know what happened to my eye. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included unspecified dementia (a progressive state of decline in mental abilities), depression (a serious, treatable mental health disorder characterized by persistent sadness, loss of interest in activities, and low energy), unspecified psychosis (a diagnosis used when a person exhibits symptoms of psychosis-such as hallucinations, delusions, or disorganized thinking). During a review of residents 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/5/2026, the MDS indicated Resident 3 had cognitive impairment. The MDS indicated Resident 3 required partial/ moderate assistance (Helper does less than half the effort) with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene The MDS indicated Resident 3 required supervision or touching assistance with transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 3's Change of Condition (COC) dated 4/5/2026 at 11:45 a.m., the COC indicated Resident 3 was walking in the corridor (hallway) when Resident 5 pushed Resident 3 from behind, and Resident 3's right-side of face hit on the hallway's hand rail. Resident 3 sustained a cut to the right eyebrow with small amount of blood. 911 (Medical emergency phone number) was (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called and Resident 3 was transferred to a GACH for further evaluation and treatment. b). During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety (the body's natural response to stress, manifesting as fear, worry, or restlessness). During a review of Resident 5's care plan titled, Risk for harm: self-directed or other-directed, dated 12/3/2025, the goal indicated the resident will not harm self or others. The interventions indicated to administer prescribed medications and notify the provider if the resident poses a potential threat to injure others. During a review of Resident 5's care plan titled, Resident does not harm self or others. New behavior potentially causing harm to self or others, dated 1/3/2026, the goal indicated resident will remain safe and undesirable behaviors will be monitored. The interventions indicated to monitor resident for signs and symptoms of agitation. During a review of Resident 5's Care Plan titled, Increased Agitation manifested by throwing object at staff and yelling, dated 3/3/2026, the interventions included to assess for triggers, notify the physician (MD) of persistent or escalating behaviors, remove resident from overstimulating environment when agitation begins, transfer to GACH for further evaluation and treatment. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had moderate cognitive impairment. The MDS indicated Resident 5 required partial/ moderate assistance with activities of daily living ADLs such as dressing, toilet use, personal hygiene The MDS indicated Resident 5 required supervision or touching assistance with transfer and bed mobility. During a review of Resident 5's Progress Notes dated 4/5/2026 timed 8:10 a.m., the progress notes indicated Resident 5 was at the nursing station using the facility phone. Resident 5 threw the phone towards the nursing staff's head who was behind nursing station without provocation (act of angering or irritating). Resident 5 then walked to his room, removed a breakfast tray from the cart and threw it onto the floor, stating, I want to go to the hospital now. The progress notes indicated Resident 5 was encouraged to self-regulate (manage own emotions, thoughts, behaviors, and actions) using deep breathing and continue to attempt to provide safe environment as much as possible with frequent checks for safety. During a review of Resident 5's clinical records, the facility did not create a COC on 4/5/2026 at 8:10 a.m., when Resident 5 threw phone at a staff at the nurse's station, and removed a breakfast tray from the cart and threw it onto the floor, stating, I want to go to the hospital now. Resident 5's progress did not indicate Resident 5 was monitored for behavioral outburst on 4/5/2026 at 8:10 a.m. onwards. The facility did not create a care plan after the incident on 4/5/2026 at 8:10 a.m. During a review of Resident 5's COC dated 4/5/2026 at 12:00p.m., the COC indicated that Resident 5 walked behind Resident 3 while in the hallway and pushed Resident 3 down. The COC indicated Resident 5 stated that Resident 3 was Evil .and deserved it. The COC indicated the physician recommended to transfer Resident 5 via 5150 (process allows designated professionals, such as peace officers or mental health professionals, to detain individuals who are experiencing mental health crisis and meet certain criteria, including being a danger to themselves or others, or being gravely disabled) for behavioral issues. During an interview on 4/8/2026 at 1:10 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated, I was walking in the hallway around 11:45 a.m., and I heard a sound. I turned and saw Resident 3 on the floor. CNA 2 stated, I got a towel because he was bleeding from the right eyebrow. CNA 2 stated, I noticed that Resident 5 was aggressive in the morning of the incident. Resident 5 had thrown breakfast trays in the hallway. CNA 2 stated after the nurses gave Resident 5 his medications, Resident 5 was walking in the hallway. During an interview on 4/9/2026 at 2:15 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that on the morning of 4/5/2026, Resident 5 came to the nurse's station asking for papers and attempted to make a phone call. LVN 4 stated Resident 5 suddenly threw the phone at the nurse's station and appeared agitated. LVN 4 stated when Resident 5 returned to his room, he tossed (threw) the breakfast tray into the hallway. LVN 4 stated Resident 5 also threw the water pitcher in (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. The facility will prevent abuse by supervising staff to identify inappropriate resident behaviors, such as the use of derogatory language, and by assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect, including residents with a history of aggressive behaviors.