STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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 observations, interviews and record reviews, the facility failed to prevent resident to resident physical altercation for two of sampled residents (Resident 1 and Resident 2). This physical altercation led to Resident 1 sustaining mild injuries to his face. This deficient practice not only resulted in Resident 1 sustained mild injuries to his face but also potentially leads to emotion, psychosocial, physical distress, create negative impact to Resident 1's well-being and quality of life. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses including but not limited to unspecified hydronephrosis (a medical term used when a diagnostic test shows that one or both kidneys are swollen due to a backup of urine, but the doctor or radiologist hasn't yet identified the specific underlying cause or location of the blockage), essential hypertension (high blood pressure with no identifiable medical cause), and difficulty in walking, not elsewhere classified (a term used when a patient experiences mobility or walking impairments that cannot be pinpointed to a more specific underlying condition). During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 6/9/2026, the MDS indicated Resident 1 had no impairment for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 1 needed partial or moderate assistance, (helper does less than half the effort) with toilet hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 1 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses including but not limited to encephalopathy, unspecified (a broad medical term for any diffuse brain disease or malfunction where a specific cause has not yet been determined), type 2 diabetes mellitus with unspecified complications (high sugar level in the blood stream that there has no documented the exact secondary health issues), and dementia in other diseases classified elsewhere (an umbrella term for a decline in memory, reasoning, and cognitive skills severe enough to interfere with daily life, this is not a standalone disease, but rather a symptom caused by another specific, pre-existing medical condition). During a review of Resident 2's Minimum Data Set (MDS, resident assessment tool), dated 5/29/2026, the MDS indicated Resident 2 had moderate impairment (decisions poor, cues/supervision required) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 2 needed supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 2 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating, oral hygiene, shower/bathe self, upper body dressing and personal hygiene. During a review of Resident 2's Care Plan on dementia care, initiated on 2/25/2026, indicated to monitor Resident 2 for agitation, wondering, or behavioral (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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(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	changes and implement safety measures as indicated. During a concurrent observation and interview on 6/30/2026 at 9:45 AM with Resident 1 in Resident 1's room, observed there were no wounds on his face but a darkened area near his left lower eye corner. There was no wound on his lips. Resident 1 stated he told Resident 2 to take a shower because Resident 2 was filthy. Resident 1 stated Resident 2 then kicked the privacy curtain into his face and Resident 2 repeatedly punched him with his fists from Resident 1's left side. Resident 1 then struck Resident 2 with one fist. Resident 1 stated he wasn't sure if Resident 2 landed on the floor next to his bed or he landed on his bed. Resident 1 stated he felt some blood on his left eye corner and left lips, but they are all healed now. Resident 1 stated staff came to him after Resident 2 stopped punching him. During an interview on 6/30/2026 at 2:39 PM with the Certified Nursing Assistant (CNA1), CNA 1 stated it was Resident 2's shower day, she went to talk to Resident 2 and prepare him for his shower, but Resident 2 refused to be shower. CNA 1 then went to get the linen, and she heard a noise from Resident 1 and Resident 2's room. CNA 1 stated she saw Resident 2 was on the floor next to his own bed and Resident 1 was in his bed. CNA 1 also stated she saw small amount of blood on Resident 1's left eye corner and his lips. During an interview on 6/30/2026 at 2:23 PM with the Licensed Vocational Nurse (LVN 1), LVN 1 stated it he separated Resident 1 and Resident 2 right away after they have arrived at the resident's room. LVN 1 stated Resident 2 was able to stand up but not Resident 1. LVN 1 stated he saw blood on Resident 1's face, he then called physician for wound care and treatment, he then filed the change of condition (COC) report for both residents, notified all the related department head, health and police department. During an interview on 7/1/2026 at 12:39 PM with the Director of Nursing (DON), The DON stated she got a report from his staffs about the incident of Resident 2 hitting Resident 1. DON stated they did their best to prevent the incident, but this was unpreventable and unprecedented. DON stated both residents have no psychiatric issues and they both do not take any medications for psychiatric problems. They have been roommates for a few months; Resident 2 has been easy going and he never has any problem with his roommates and other residents in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention and Management, revision date 1/14/2026, the P&P indicated: Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment which is physical punishment used to correct and/or control behavior.Prevention:The Facility maintains adequate staffing on all shifts to ensure that each resident's needs are reasonably met.The Facility identifies, corrects, and intervenes in situations in which abuse, neglect, exploitation, misappropriation of resident property and/or mistreatment is more likely to occur.