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	08/25/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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
	056435	A. Building B. Wing	08/25/2025

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 0627 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 a safe discharge planning process for one of four sampled residents, Resident 1. This failure had the potential for unsafe discharge by not identifying the resident's discharge needs and not thoroughly planned and prepared, and communicated to the receiving facility. This failure caused Resident 1 to feel anxious and sad and had the potential to affect the resident's highest practicable physical, mental and psychosocial well-being.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 metabolic encephalopathy (a condition where the brain does not function properly due to underlying metabolic disturbances,) mood disorders (mental health conditions that affect a person's emotions, thoughts, and behaviors) and cellulitis of left lower limb (a bacterial infection of the skin and the tissue beneath.) During a review of Resident 1's care plan titled, Readiness for enhanced self-health management related to improvement in condition and upcoming discharge, dated 8/13/2025, the plan indicated to coordinate discharge plan with IDT team, educate resident and/ or caregiver on new or continuing medications, disease process, wound care and signs and symptoms requiring medication attention, arrange for durable medical equipment, complete and provide discharge packet, confirm transportation and receiving environment. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/17/2025, the MDS indicated Resident 1 had mild cognitive impairment. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 1's Multidisciplinary Care Conference (also known as Interdisciplinary Team [IDT], group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) document dated 8/19/2025, the nursing summary indicated the IDT was held to review the plan of care, to address any concerns and recommendation for plan of care. The nursing summary indicated Resident 1 wanted to leave the facility to go see her family. The nursing summary indicated the IDT informed Resident 1 that a doctor's order for discharge was needed. The nursing summary indicated Resident 1 stated if she doesn't get it (unspecified), she would leave Against Medical Advice (AMA- leaving the hospital without the doctor's approval or order). During a review of Resident 1's health status notes from 8/18/2025 to 8/20/2025, the notes did not indicate documented evidence that the physician was contacted of the resident's request to go see her family nor discharge order was obtained. During an interview on 8/20/2025 at 10:20 a.m. with Resident 1, Resident 1 stated I will leave the facility 8/21/2025 with or without a doctors order. Resident 1 stated she was admitted for a wound in the left lower leg but now it is better. Resident 1 stated I can take care of the wound myself. Resident 1 stated on 8/18/2025, the Social Services (SS) sent the owner of an independent living facility (a housing community, often for adults 55 and older, where residents maintain their independence while benefiting from convenient services, social opportunities, and a sense of community) to talk to me and told me that a room is available when I get discharged from the facility. Resident 1 stated she informed the SS on 8/19/2025 about the available room and had requested to be discharged . Resident 1 stated the SS did not do anything for me to be discharged , and it made me anxious and sad. During an interview on 8/21/2025 at 1:22 p.m. with the Activity Director (AD), the AD stated after the IDT meeting with Resident 1 on 8/19/25 at 10:30 a.m., Resident 1 verbalized that on 8/21/2025, she will be leaving the facility. The AD stated Resident 1 verbalized that she will sign AMA if nothing is prepared for discharge. The AD stated the SS explained Resident 1 about discharge process, but Resident 1 repeatedly stated that she will leave on Thursday, 8/21/2025. During an interview on 8/21/2025 at 3:43 p.m. with LVN 4, LVN 4 stated when Resident 1 expressed her wish to be discharged by Thursday 8/21/2025, the Director of Nursing (DON) was informed, but Resident 1's doctor was not called to obtain a discharge order. LVN 4 stated the facility failed to follow Resident 1's right to be discharged . LVN 4 stated, it caused Resident 1 to feel stressed and anxious because she felt the facility did not do anything for her request to be discharged . LVN 4 stated I should have called the doctor to get an order and start the discharge planning. During an interview on 8/21/2025 at 2:17 p.m. with SS, the SS stated on 8/18/2025 the owner of an independent living facility came to the facility and spoke to Resident 1 about independent living. The SS stated the independent living facility had a room for Resident 1. The SS stated after the IDT meeting on 8/19/2025, LVN 4 was told to follow up with the doctor for a discharge order and with the treatment nurse regarding the wound condition before