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	01/26/2026

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 - 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 observation, interview, and record review, the facility failed to implement its policy and procedure (P/P) titled Abuse and Neglect Prohibition Policy, dated 6/2022, which indicated the facility prohibited abuse for all residents, for one of four sampled residents (Resident 1), who lacked the ability to consent and had severe cognitive impairment (a profound decline in thinking, memory, and reasoning, that prevents independent living). Resident 2, who had a history of sexually inappropriate behaviors sexually assaulted Resident 1.This deficient practice resulted in Resident 2 forcing penile-vaginal penetration onto Resident 1 on 1/17/2026. A sexual assault examination conducted at General Acute Care Hospital (GACH 2), on 1/17/2026, after the incident, indicated Resident 1 had brown ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) to the left medial (middle) anterior (front) labia minora (inner skin folds of the female external genitalia). Findings: a. 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 spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy, characterized by significant stiffness and limited movement in all four limbs, the trunk, and the face), depression, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). The admission Record indicated Resident 1 was conserved (deemed by a court to be incapable of managing their own personal needs, finances, or safety, necessitating the appointment of a conservator to act on their behalf). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had severe cognitive impairment (a profound decline in thinking, memory, and reasoning, that prevents independent living). The MDS indicated Resident 1 required partial to moderate assistance from staff for dressing her lower body, and to transition from a sitting to standing position, or to walk distances of 10 feet to 50 feet.During a review of Resident 1's progress note, dated 1/17/2026, the progress note indicated Resident 1 was observed engaging in sexual intercourse with Resident 2. The progress note indicated Resident 2 was asked to leave the room, and Resident 1 was observed lying on her bed with her lower body garments down. The progress note indicated Resident 1 did not respond when asked if she was in pain or if she knew what had happened. During a review of Resident 1's Change of Condition (COC) assessment, dated 1/17/2026, the COC assessment indicated an unidentified CNA informed the charge nurse that a male resident (Resident 2) was in Resident 1's room. The COC assessment did not indicate what occurred in the room prior to the residents being separated. The COC assessment indicated Resident 1 received a vaginal exam but did not specify what the exam entailed. Resident 1's physician was notified of the incident and ordered Resident 1 to be transferred to a GACH for further evaluation. During a review of Resident 1's physician order, dated 1/17/2026, the order indicated to transfer Resident 1 to the emergency room for evaluation and treatment related to an observed sexual act. During a review of Resident 1's Facility to (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 - Actual harm Residents Affected - Few	Hospital Transfer Form, dated 1/17/2026, the form indicated Resident 1 was transferred to GACH 2 on 1/17/26 at 3:27 p.m. due to a sexual act.During a review of Resident 1's GACH 2 record titled Adult/Adolescent Sexual Assault Examination - Narrative Addendum, dated 1/17/2026, the record indicated an addendum was made to the section of the assessment titled Sexual Acts Described by the Patient. The addendum indicated Resident 1 resided in a nursing facility, and per Law Enforcement and facility staff, Resident 1's roommate ran out of her room asking for help. The record indicated facility staff found Resident 2 on top of Resident 1, forcing penile-vaginal penetration.During a review of Resident 1's GACH 2 record titled Adult/Adolescent Sexual Assault Examination - Anogenital Examination Female, dated 1/17/2026, the record indicated Resident 1 had brown ecchymosis to the left medial anterior labia minora.During a review of Resident 1's GACH 2 record titled Sexual Assault Aftercare Instructions, dated 1/17/2026, the record indicated Resident 1 received the following:a. A sexual assault examination.b. Collection of a sexual assault kit (a standardized kit used by medical professionals to collect and preserve physical, forensic evidence from a survivor's body or clothing after a sexual assault).c. Preventative treatment for sexually transmitted infections (STI, an infection spread between people through direct contact during vaginal, anal, or oral sex): chlamydia, gonorrhea, and syphilis.d. Emergency contraception (medication to prevent pregnancy after unprotected sex). During a review of Resident 1's progress note, dated 1/18/2026, the progress note indicated Resident 1 returned to the facility on 1/17/2026 at 11:45 p.m. During a review of Resident 1's progress notes, dated 1/18/2026 at 3:03 p.m., the progress note indicated Resident 1 was being monitored for alleged assault. The progress note indicated Resident 1 complained of abdominal pain.During an observation on 1/21/2026 at 8:26 a.m., Resident 1 was observed exiting her room. An attempt was made to interview Resident 1, but Resident 1 refused to speak and walked away. b. During a review of Resident 2's General Acute Care Hospital (GACH) 1 Emergency Department (ED) note, dated 12/23/2025, the ED note indicated Resident 2 was admitted to GACH 1 on 12/23/2025 for evaluation of confusion, frequent wandering, and walking around more than usual. The ED note indicated Resident 2 had a history of depression (a common, serious mood disorder characterized by persistent, intense feelings of sadness, emptiness, or a loss of interest in activities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's GACH 1 nursing narrative note, dated 12/25/2025, the note indicated Resident 2 was aggressive towards staff. The note further indicated Resident 2 displayed noticeably sexually inappropriate behavior, and began to masturbate (the deliberate self-stimulation of one's own genitalia to produce sexual pleasure) while looking at a Certified Nursing Assistant (CNA) that was present in his room. The note indicated Resident 2 was placed on precautions for sexually inappropriate behavior. During a review of Resident 2's GACH 1 physician order, dated 12/25/2025, the order indicated Resident 2 was placed on general precautions for sexually inappropriate behavior. The order indicated it was discontinued on 12/29/2025 due to Resident 2's discharge from GACH 1. During a review of Resident 2's GACH 1 nursing narrative note, dated 12/29/2025, the note indicated on 12/29/2025 at 4:40 p.m., Licensed Vocational Nurse (LVN) 1 provided report (a critical, organized exchange of patient information between nurses to ensure continuity of care, safety, and efficient management) to the facility. The note indicated Resident 2 was discharged from GACH 1 on 12/29/2025 at 5:23 p.m. During a review of an untitled and undated facility document, completed by Registered Nurse (RN) 1, the document indicated a summary of the nursing report provided to RN 1 by LVN 1. The document indicated Resident 2 had sexually inappropriate behavior. During a review of Resident 2's admission summary, dated (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE], written by RN 1, the admission Summary did not indicate Resident 2's sexually inappropriate behavior or interventions to address the resident's sexually inappropriate behavior. 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 included metabolic encephalopathy (a broad term for brain dysfunction caused by systemic illness, chemical imbalances in the blood, or toxins, rather than structural brain damage) and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 2 was usually understood and usually understood others. The MDS indicated Resident 2 had moderate cognitive impairment (noticeable memory or thinking changes that exceed normal aging but do not severely impact daily life). The MDS indicated Resident 2 required partial to moderate assistance from staff (staff do less than half of the effort to complete the task) for toileting hygiene, getting dressed, and mobility while in and out of bed. The MDS indicated Resident 2 did not have impairments to any extremities. During a review of Resident 2' progress note, dated 1/17/2026, the progress note indicated Resident 2 was observed engaging in sexual intercourse with another resident (Resident 1). The progress note indicated Resident 2 stated he had sexual intercourse with Resident 1 because she didn't tell [him] not to. The progress note indicated Resident 2 stated Resident 1 did not give consent for sexual intercourse.During a review of Resident 2's progress notes, dated 1/18/2026, the progress note indicated Resident 2 was transferred to GACH 3 for further evaluation. During a review of Resident 2's GACH 3 Emergency Physician Note, dated 1/18/2026, the note indicated Resident 2 was brought to GACH 3 following one episode of non-consensual sexual abuse. The note indicated Resident 2 stated he had sexual intercourse with another resident because she did not object. Resident 2's diagnoses included sexual behavior, danger to others, and assault.During a review of Resident 2's GACH 3 Physician Note, dated 1/21/2026, the note indicated Resident 2 was admitted to the behavioral health unit for a psychiatric admission and psychiatric hold (an involuntary 72-hour detention for mental health evaluation when a person is deemed a danger to themselves or others, or gravely disabled due to mental illness) for danger to others and grave disability (someone unable to meet their basic needs due to a mental health issue). During an interview on 1/12/2026 at 8:34 a.m., with Resident 4 (Resident 1's roommate), Resident 4 stated on 1/17/2026, she was asleep when the incident occurred between Resident 1 and Resident 2. Resident 4 stated she saw Resident 2 come into their room multiple times prior to the incident. Resident 4 stated Resident 2 would make flirtatious faces at Resident 1 and attempt to talk to her. Resident 4 stated she would yell at Resident 2 and ask him to leave their room.During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 4's diagnoses included chronic obstructive pulmonary disorder (COPD, a chronic lung disease causing difficulty in breathing) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had some difficulty with daily decision making in new situations, but did not exhibit inattention, disorganized thinking, or altered level of consciousness (ALOC, a state of reduced alertness, confusion, or lack of awareness).During an interview on 1/21/2026 at 11:05 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 1/17/2026, Resident 1's roommate (Resident 3) ran into the hallway requesting staff assistance. CNA 1 stated Resident 3 gestured staff to enter the room quietly. CNA 1 stated she entered the room without announcing herself and observed Resident 1's privacy curtain drawn. The foot of Resident 1's bed was visible. CNA 1 stated she observed shoes and jeans at the foot of the bed, and overheard moaning from behind the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	curtain. CNA 1 stated she pulled the curtain open and observed Resident 2 on top of Resident 1. CNA 1 stated the residents were facing each other and actively engaged in sexual intercourse. CNA 1 stated Resident 2 jumped from Resident 1's bed and ran out of the room. CNA 1 stated Resident 1 had her incontinence brief and pants pulled down to her knees. CNA 1 stated as soon as Resident 2 left the room, Resident 1 curled into a fetal position (lying on the side with the back curved, head bowed forward, and arms and legs drawn in toward the chest) and refused to talk. CNA 1 stated Resident 1 was placed on 1:1 monitoring (a high-level safety intervention in healthcare where a dedicated staff member provides continuous, direct, in-person supervision to a single patient) after the incident occurred. During an interview on 1/21/2026 at 11:50 a.m., with CNA 2, CNA 2 stated on 1/17/2026, she was assigned to Resident 1's care. CNA 2 stated she entered the room and observed Resident 1 lying in her bed with her incontinence brief and pants pulled down. CNA 2 stated she was familiar with Resident 1 and described her as childlike and soft-spoken. CNA 2 stated she was the CNA assigned to perform 1:1 monitoring after the incident occurred, and stated Resident 1 did not talk until she was transferred to GACH 2 later that day. CNA 2 stated she was assigned to Resident 1 the following day, 1/18/2026, and described Resident 1 as less expressive and more withdrawn than usual. CNA 2 stated Resident 1 also complained of pain to her lower abdominal region requiring pain medication. CNA 2 stated Resident 1 was not able to verbalize the cause of the pain but pointed to her lower abdomen with facial grimacing. CNA 2 stated she was also familiar with Resident 2, and stated Resident 2 had a habit of wandering around the facility. During a telephone interview on 1/21/2026 at 2:06 p.m., with LVN 2, LVN 2 stated on 1/17/2026, he was the charge nurse assigned to Resident 1's care. LVN 1 stated he performed a physical assessment of Resident 1 after the incident occurred. LVN 1 stated he observed redness to Resident 1's genital region (the externally visible reproductive and urinary organs). During a concurrent interview and record review, on 1/26/2026 at 11:03 a.m., with the Registered Dietician (RD), Resident 2's care plan titled Resident has a nutritional problem related to. sexually inappropriate behavior., dated 12/30/2025, was reviewed. The RD stated she reviewed Resident 2's admission paperwork which indicated Resident 2 had sexually inappropriate behavior. The RD stated she included the behavior problem in her care plan but did not notify any other staff. The RD stated the care plan interventions only addressed the resident's nutritional risks and did not address his behavior. The RD stated that developing interventions for the sexually inappropriate behavior were not within her scope as the dietician. The RD stated she assumed nursing staff were already aware of Resident 2's behavior since it was documented by nursing staff. Two attempts were made to reach Resident 2's admitting nurse, Registered Nurse (RN) 1, by telephone on 1/26/2026 at 11:26 a.m. and 1:28 p.m. RN 1 was not reachable by telephone for an interview. During an interview on 1/26/2026 at 1:50 p.m., with the Director of Nursing (DON), the DON stated RN 1 was aware of Resident 2's sexually inappropriate behavior upon his admission to the facility. The DON stated a care plan should have been developed to ensure all staff were aware of Resident 2's behavior and interventions were in place to address it. The DON stated this would include behavior monitoring to identify patterns in frequency, and identification of potential for escalation in the behavior. The DON stated the RD was also a department head and should have notified the multidisciplinary team of the behavior to ensure that the team was aware and a plan of care was developed. During an interview on 1/26/2026 at 1:55 p.m., with the Assistant Director of Nursing (ADON), the ADON stated there was no documentation in Resident 2's medical record indicating staff, aside from RN 1 and the RD, were aware of his inappropriate sexual behavior. The ADON stated there was also no documentation in Resident 2's medical record indicating any interventions were implemented to address the behavior, including the development of a care plan (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	or behavior monitoring. The ADON stated the incident that occurred on 1/17/2026 was preventable. The ADON stated staff should have monitored Resident 2 for sexually inappropriate behavior and monitored his whereabouts more frequently. The ADON stated staff should have also notified Resident 2's psychologist (a person who specializes in the study of mind and behavior) to determine if modifications were needed to his plan of care. The ADON stated these interventions were important for the safety of Resident 1, and all other facility residents.During a review of the facility's policy and procedure (P&P) titled Protection of Resident, dated 12/2017, the P&P indicated the facility was to provide a safe resident environment from abuse. The P&P indicated risk for abuse may increase when a resident exhibited wandering into others' rooms and sexually aggressive behavior, and indicated staff should monitor for those behaviors. During a review of the facility's P&P titled Resident Safety, dated 4/2021, the P&P indicated residents were to be evaluated upon admission to identify circumstances that pose a safety risk. The P&P indicated Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) members were to assess the resident's safety risk (including behavioral issues) and develop a resident-centered care plan to mitigate safety risk factors.During a review of the facility's P&P titled Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated it was the facility's policy to prohibit abuse for all residents through prevention of occurrences. The P&P indicated staff were to do all that was in their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property for all residents. The P&P defined sexual abuse as non-consensual sexual contact of any type, including sexual assault. The P&P indicated that to prevent occurrences of abuse, staff were to assess, care plan, and monitor residents with needs and behaviors that could lead to conflict. The P&P indicated indicators of potential sexual abuse included bruises around the breast, genital area, or inner thighs. During a review of the facility's P&P titled Comprehensive Plan of Care, dated 12/2026, the P&P indicated it was the facility's policy to provide each resident with a comprehensive plan of care to meet their needs, including psychosocial needs. The P&P indicated the interdisciplinary team (IDT), including the RD, was to discuss and prioritize the resident's needs and develop goals and approaches for each problem and/or condition identified. During a review of the facility's job description titled Registered Nurse - Supervisor, dated 5/2017, the job description indicated the RN was to work collaboratively with the IDT to develop an individualized plan of care for each resident, and coordinate care to meet their individualized needs. The job description indicated the RN was to demonstrate sound clinical judgement in the implementation of the nursing aspects of interdisciplinary resident plan of care. During a review of the facility's job description titled Registered Dietician, dated 5/2017, the job description indicated the RD was expected to maintain two-way communication with the ADM and nursing services. The job description indicated the RD was expected to concern his/herself with the safety of all residents to minimize the potential for accidents. The job description indicated the RD was to ensure residents received the highest quality of service, in a caring and compassionate atmosphere, recognizing the individuals' needs and rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation following an allegation of staff-to-resident sexual misconduct for one of four sampled residents (Resident 4). This deficient practice placed Resident 4, and all other facility residents, at risk for the occurrence of repeat staff-to-resident sexual misconduct. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 4's diagnoses included chronic obstructive pulmonary disorder (COPD, a chronic lung disease causing difficulty in breathing) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 4 had some difficulty with daily decision making in new situations, but did not exhibit inattention, disorganized thinking, or altered level of consciousness (ALOC, a state of reduced alertness, confusion, or lack of awareness). During a review of Resident 4's progress note, dated 1/20/2026, the progress note indicated on 1/202/2026, Resident 4 reported she had a sexual encounter with a tall black African man. During an interview on 1/21/2026 at 8:45 a.m., with Resident 4, Resident 4 stated an unidentified male staff was changing her bed linens and providing perineal care (the act of cleansing the genital and anal areas). Resident 4 stated the male staff exposed his genitals and placed his penis on her hand. Resident 4 stated she and the male staff had unprotected sexual intercourse (the penetration of the vagina/anus by the penis) in her bed then he left. During a concurrent observation and interview on 1/22/2026 at 11:35 a.m., with Resident 4, in Resident 4's room, Resident 4 stated the alleged sexual encounter occurred around 2:30 a.m., a night before her most recent hospitalization (1/2/2026). Resident 4 described the staff as tall, of African descent, with dark skin, and an accent. Resident 4 could not state his name or describe any other physical features. Resident 4 stated she reported the alleged sexual encounter to facility staff upon her return from the hospital. The Assistant Director of Nursing (ADON) then entered the room to respond to another resident's call light. Resident 4 was observed pointing to the ADON. Resident 4 stated ADON was the staff member she first reported the encounter to. During an interview on 1/22/2026 at 12:42 p.m., with the ADON, the ADON stated Resident 4 informed her of the alleged sexual encounter. The ADON stated Resident 4 described the staff member as tall, of African descent, with dark skin, and an accent. The ADON stated that during the investigation into the allegation, she was unable to identify any male staff matching Resident 4's description. The ADON stated she tried to recall the characteristics of the facility's male staff from memory, and she determined that no one matched Resident 4's description. During an interview on 1/22/2026 at 1:15 p.m., with the Director of Social Services (DSS), the DSS stated Resident 4 described the alleged perpetrator as an African male. The DSS stated there were no male staff who matched Resident 4's description. During an interview on 1/22/2026 at 2:57 p.m., with the ADON, the ADON stated Resident 4 reported that the incident occurred before her most recent hospitalization on 1/2/2026. The ADON stated the Administrator (ADM) and Assistant Administrator (AADM) were notified on 1/19/2026 of Resident 4's allegation, including her report of when the incident occurred and the description of the alleged perpetrator. During an interview on 1/23/2026 at 10:36 a.m., with the AADM, the AADM stated he was responsible for conducting the investigation into Resident 4's alleged sexual encounter with an unidentified male staff. The AADM stated he conducted interviews with Resident 4 and Certified Nursing Assistant (CNA) 3. The AADM stated during his interview with the resident, Resident 4 described the alleged perpetrator as tall, of African descent, and with dark skin. The AADM stated CNA 3 was the only staff member he felt (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matched Resident 4's description. The AADM stated he did not consider Resident 4's report of the date or time the incident occurred to identify other potential staff. The AADM stated all other investigation interviews of staff were conducted by the Director of Staff Development (DSD). During an interview on 1/23/2026 at 11:08 a.m., with the DSD, the DSD stated she was present during the ADON's interview with Resident 4 on 1/19/2026 regarding the alleged sexual encounter. The DSD stated Resident 4 described the alleged perpetrator as tall, African or African American, and with an accent. The DSD stated Resident 4 reported the incident occurred at night, about two weeks ago, the day before she went to the hospital. The DSD stated that as of 1/23/2026, she had had not conducted any interviews with male staff matching Resident 4's description who were working on or around 1/2/2026 (the date of Resident 4's hospitalization). The DSD stated the AADM was aware she had not started the interviews yet. During an interview on 1/23/2026 at 11:31 a.m., with the AADM, the AADM stated on 1/21/2026, a conclusion letter was submitted to the State Agency (SA) District Office (DO) because the investigation was concluded. The AADM stated the conclusion letter was a summary of his investigation into Resident 4's allegation and the actions taken by staff. The AADM stated no employees were identified or suspended during the course of the investigation. During a concurrent interview and record review, on 1/23/2026 at 11:49 a.m., with the AADM, the conclusion letter submitted to the SA, dated 1/21/2026, was reviewed. The conclusion letter indicated the alleged incident occurred on 1/8/2026. The AADM stated the date of the incident should have been 1/2/2026, to correlate with the date of Resident 4's most recent hospitalization. The AADM stated the conclusion letter indicated no staff matched Resident 4's description. The AADM stated Resident 4 claimed she had not seen the alleged male staff since the incident occurred, therefore he assumed this meant the staff member had been terminated. The AADM stated there was only one terminated staff member from 1/1/2026 to current which did not match Resident 4's description. The AADM stated the conclusion letter indicated interviews with current and former male staff revealed no evidence supporting Resident 4's claims. The AADM stated he did not verify with the DSD that these interviews had been completed prior to concluding his investigation. The AADM further stated that there were no documented interviews to demonstrate that an investigation had been conducted. During an interview on 1/23/2026 at 12:15 p.m., with the AADM, the AADM stated the purpose of conducting a thorough investigation was to ensure the safety of the facility's residents. The AADM stated staff interviews of any staff working on or around 1/2/2026, and matching Resident 4's description, should have been interviewed. The AADM stated that due to the incomplete investigation, there was a possibility that the unidentified male staff was still working at the facility, placing the facility residents at risk. During an interview on 1/26/2026 at 3:54 p.m., with the AADM, the AADM stated staff interviews of all male staff, regardless of shift or department worked, were in progress to ensure a thorough investigation was completed. The AADM stated these interviews should have been conducted prior to concluding the first investigation to ensure the safety of the facility's residents. The AADM was unable to provide documented proof of the staff interviews when requested. During a review of the staff assignment for the 11:00 p.m. to 7:30 a.m. shift, dated 12/31/2026, the staffing assignment indicated there were three male staff working: CNA 4 (assigned to Resident 4's care), CNA 5, and CNA 6. During a review of the staff assignment for the 11:00 p.m. to 7:30 a.m. shift, dated 1/1/2026, the staff assignment indicated there were two male staff working: CNA 5 and Licensed Vocational Nurse (LVN) 3. During a review of the facility record titled Follow-Up Investigation Report - Facility Reported Incidents, dated 1/21/2026, the record indicated the following:The investigation was submitted by the AADM.In the section titled Steps Taken to Investigate the Allegation, the record indicated a payroll report of all male staff was generated and no one fit (continued on next page)

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	01/26/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the description besides one person. It did not specify what actions were taken related to the one staff member identified. In the section titled Summary of Interview(s) with the Alleged Perpetrator(s) (staff, resident, contractor, etc.), the record indicated no one has any knowledge of the incident. In the section titled Conclusion, the record indicated no one has any knowledge of the incident or fits the description. During a review of the facility's policy and procedure (P&P) titled Protection of Resident, dated 12/2017, the P&P indicated it was the facility's policy to provide a safe resident environment. The P&P indicated all staff were expected to be in control of their own behavior and to behave professionally. The P&P indicated involved staff were to be placed on investigative leave. During a review of the facility's P&P titled Abuse - Reporting and Investigations, dated 3/2018, the P&P indicated the ADM or designated representative conducting the investigation was to interview individuals who may have information relevant to the allegation. The P&P further indicated that employees of the facility who had been accused of resident abuse were to be suspended from duty until the results of the investigation had been reviewed by the ADM. During a review of the facility's P&P titled Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated it was the facility's policy to prohibit abuse and mistreatment for all residents through investigation of incidents and allegations. The P&P defined mistreatment as inappropriate treatment of a resident. The P&P indicated that upon receiving report of suspected abuse or mistreatment of a resident, the facility was to initiate an investigation within 24 hours, and ensure the investigation was thoroughly documented on the facility's investigation form.