STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Hyde Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four (4) residents (Resident 1), was provided with interventions to reduce the risk of recurrent fall, as indicated in the facility's policy and procedure (P&P) titled Fall Prevention Program. As a result, Resident 1 had a total of 4 fall incidents since admission on [DATE], 1/23/2026, 2/18/2026 and 2/21/2026, placing the resident at risk for severe injuries, including hospitalization and death.Findings: During a review of Resident 1's admission Record, dated 02/24/2026, the admission Record indicated Resident 1 was originally admitted on [DATE] and re-admitted [DATE]. Resident 1's diagnoses included chronic pulmonary edema (a condition caused by too much fluid in the lungs making it difficult to breathe), cirrhosis of liver (a condition in which the liver is scarred and permanently damaged), and morbid obesity (being over 100 pounds overweight, significantly impacting daily life and increasing risks for serious illness) due to excessive calories. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/23/2026, the MDS indicated Resident 1 had short term memory problem and severe cognitive skills impairment for daily decision making. Resident 1 required substantial assistance (helper does more than half the effort) with toileting hygiene, lower body dressing and in putting on/taking off footwear, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walking 10 feet. Resident 1 used a wheelchair and required partial moderate assistance (Helper does less than half the effort. Helper lifts, holds or support partial trunk or limbs but provides less than half the effort) in wheeling 50 feet with two turns once seated in wheelchair. During a review of Resident 1's Fall Risk Evaluation, dated 10/17/2025, the Fall Risk Evaluation indicated Resident 1 was at risk for falls. During a review of Resident 1's care plan titled, Risk for falls, dated 10/17/2025, the goal indicated for Resident 1 to be free from falls. The care plan interventions indicated to assist Resident 1 with ambulation and transfers, utilize therapy recommendations, determine resident's ability to transfer, if fall occurs, alert provider and initiate frequent neuro and bleeding evaluation per facility protocol, and if resident is at risk for fall, initiate fall risk precautions. During a review of Resident 1's Change of Condition (COC), the following were identified:1). On 12/27/2025 at 2:13 p.m., Resident 1 had an unwitnessed fall. Resident 1 was found on the hallway floor lying on his left side, complaining of a 7/10 headache (a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible). The physician ordered to send Resident 1 to the emergency room for further evaluation and treatment. 2). On 1/23/2026 at 10:53 p.m., Resident 1 had an unwitnessed fall, and sustained a laceration above the right eyebrow and a small skin tear on right forearm. 3). On 2/18/2026 at 3:19 p.m., Resident 1 was found lying on his right side on the floor. The physician ordered (a brief assessment conducted to evaluate an individual's neurological functions, motor and sensory responses, and level of consciousness) for 72 hours and to monitor.4). On 2/21/2026 at 8:44 a.m., (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 had another fall incident. The progress notes indicated on 2/21/2026 at 8:44 a.m., Resident 1 was found on the floor between the bed and the tray table by staff with bleeding in the mouth, was confused and unable to provide clear explanation. 911 (emergency medical services) was called and Resident 1 was transported to a general acute care hospital (GACH) for further evaluation and treatment.During a review of Resident 1's care plan titled Impaired Physical Mobility, dated 10/31/2025, the interventions indicated to assist resident with ambulation and transfers utilizing therapy recommendations, determine level of assistance needed based on activities of daily living (ADL), monitor for environmental barriers to mobility, observe resident's posture and gait. During a review of Resident 1's care plan titled Actual Injury related to (the resident's first) unwitnessed fall, initiated on 12/27/2025, the interventions indicated to do neurochecks, notify the physician (MD), pain assessment and send to hospital for further evaluation. On 2/18/2026 (post third fall), the interventions indicated to determine and address causative factors of the fall. On 2/21/2026 (post fourth fall), the interventions indicated to anticipate and meet resident's needs, call light within reach and encourage us when assistance is needed, ensure resident is wearing appropriate footwear, follow facility fall protocol and review information on past falls and attempt to determine causes of falls. Record possible root causes and alter or remove any potential causes. Educate the resident/ caregivers/ IDT (Interdisciplinary Team [group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents]) as to causes. During an interview on 2/25/2026 at 11:25 a.m., with the Director of Nursing (DON), the DON stated he was aware of Resident 1's falls on 12/27/2025, 1/23/2026, 2/18/2026 and 2/21/2026. The DON stated staff should have implemented new interventions to prevent fall, like rounding and assisting the resident as needed. The DON stated the interventions indicated in the resident's care plan will not prevent a fall and the revised interventions will not prevent another fall. The facility did not conduct post fall IDT meetings on 12/27/2025, 1/23/2026, 2/18/2026 and 2/21/2026, with the primary physician, or consulted the pharmacy. Failure to timely conduct IDT meetings with the primary physician and consulting the pharmacist will increase the risk of Resident 1's falling and sustaining an injury. During a review of the facility's policy and procedure (P&P) titled, Person Centered Care Plan, dated 12/2026, the P&P indicated the IDT, and resident will discuss and prioritize the resident's needs with input from the resident, develop goals and approaches for each problem that are realistic, specific, measurable and re-evaluate and modify care plans as necessary. During a review of the facility's P&P titled, Fall Prevention Program, dated 12/2016, the P&P indicated the facility will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. All residents will be assessed following incident of fall. The P&P indicated all precautions will be implemented to protect the resident according to the fall preventions and reduction program. The staff, with the input of the physician, will identify appropriate interventions to reduce the risk of falls. In conjunction with the consultant Pharmacist and Nursing staff, the attending physician will identify and adjust medications that maybe be associated with an increased risk of falling. The P&P indicated the care plan interventions should include the treatment prescribed by the physician and IDT recommendations, if any. During a review of the P&P titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated it is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive plan of care should include interventions to attempt to manage risk factors; be developed by an IDT that includes the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attending physician, a registered nurse, and other appropriate staff as determined by the resident's needs, be periodically reviewed and revised by the interdisciplinary team, as changes in the resident's care and treatment occur.