

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  03/11/2026
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to update one of three residents' (Resident 1's) care plan after the diet order was changed. This failure had the potential for Resident 1's care team to follow an old intervention resulting to providing the incorrect diet texture, placing the resident at risk for choking, hospitalization and death. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included cerebral palsy (a condition marked by impaired muscle coordination and/or other disabilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and dysphagia (difficulty swallowing). The admission Record indicated Resident 1 was not self-responsible and had a conservator (person appointed by the Probate Court to oversee the financial or personal affairs of an adult). During a review of Resident 1's History and Physical (H&amp;P), dated 2/23/2026, the H&amp;P indicated Resident 1 could not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/26/2026, the MDS indicated Resident 1 was sometimes understood and able to make requests. The MDS indicated Resident 1 had short and long-term memory problems and severe cognitive impairment to make decisions regarding tasks of daily life. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) to eat. The MDS indicated Resident 1 lost liquids/solids from mouth when eating or drinking and coughed or choked during meals or when swallowing medications. During a review of Resident 1's Change of Condition (COC- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/26/2026, the COC indicated Resident 1 experienced an episode of aspiration while eating in the morning of 2/26/2026. The COC indicated Resident 1 was coughing with difficulty clearing throat after swallowing and shortness of breath. The COC indicated Resident 1 had not experienced this condition in the past. The COC indicated the primary physician recommended downgrading Resident 1's diet. During a review of Resident 1's Physician Orders, dated 2/26/2026, the order indicated Resident 1's diet was minced and moist (foods that are soft, moist, and chopped into bite-sized with pieces)/ International Dysphagia Diet Standardization Initiative (IDDSI - system of standardized food textures) Level 5 texture (foods that are soft, moist, and chopped into bite-sized with pieces no larger than 1.5 centimeters by 1.5 centimeters). During a review of Resident 1's Speech Language Pathology (SLP) Evaluation and Plan of Treatment, dated 2/27/2026, the evaluation indicated Resident 1 had anterior (front) to posterior (rear) transit delay, decreased bolus (mass) formation, and overstuffed her mouth. The plan indicated the SLP recommended minced and moist texture, as tolerated, with advanced diet texture trials to be provided only through the SLP. During a review of Resident 1's Care Plan titled [Resident 1] has nutritional problem or potential nutritional problem related to metabolic encephalopathy, seizures, cerebral palsy, protein-calorie malnutrition, hypothyroidism, schizophrenia, anxiety, psychosis, dysphagia, dated 11/13/2026, the care plan included an intervention for Certified Nurses Assistants (CNAs), Licensed Professional Nurses (LPNs), and Registered Nurses (RNs) to provide diet and serve as ordered, (continued on next page)</p>

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 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	regular diet, regular easy to chew (soft and tender)/ IDDSI Level 7 Texture (regular diet designed to meet the nutritional needs of residents who do not need dietary modification or have restrictions). During a concurrent interview and record review on 3/10/2026 at 10:30 a.m., with Licensed Vocational Nurse (LVN 3), Resident 1's COC, dated 2/26/2026, Resident 1's Physician Orders, dated 2/26/2026, and Resident 1's Care Plan titled [Resident 1] has nutritional problem or potential nutritional problem related to metabolic encephalopathy, seizures, cerebral palsy, protein-calorie malnutrition, hypothyroidism, schizophrenia, anxiety, psychosis, dysphagia, dated 11/13/2026, were reviewed. LVN 3 stated Resident 1's coughing and shortness of breath on 2/26/2026 indicated Resident 1 potentially aspirated on her meal. LVN 3 stated Resident 1's physician ordered to change her diet to prevent further choking and aspiration. LVN 3 stated care plans should have been updated to indicate Resident 1's new physician orders and to ensure the care team provided an appropriate diet and prevent complications. During a concurrent interview and record review on 3/10/2026 at 2:45 p.m., with Speech Language Pathologist (SLP 1), Resident 1's SLP Evaluation and Plan of Treatment, dated 2/27/2026, and Care Plan titled [Resident 1] has nutritional problem or potential nutritional problem related to metabolic encephalopathy, seizures, cerebral palsy, protein-calorie malnutrition, hypothyroidism, schizophrenia, anxiety, psychosis, dysphagia, dated 11/13/2026, were reviewed. SLP 1 stated Resident 1 had the potential to aspirate, choke, and experience pneumonia and malnutrition because Resident 1's care plan interventions were not updated to reflect her new physician ordered diet texture. During a review of the facility's policy and procedure (P&P) titled Comprehensive Plan of Care, dated 12/2016, the P&P indicated the comprehensive care plan will address the resident's individual needs, include interventions to prevent avoidable decline in function, and include interventions to attempt to manage risk factors. The P&P indicated the comprehensive plan of care should be reviewed and revised by the interdisciplinary team as changes in the resident's care and treatment occur. The P&P indicated care plan evaluation must occur in response to changes in the resident's physical or functional status as they occur.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to meet professional standards of quality by failing to ensure the Complete Blood Count (CBC - laboratory blood test that measures the cells circulating in blood) ordered by the physician for one of three resident's (Resident 2), was done as ordered. This failure had the potential for delayed identification of the resident's current medical condition and delay the necessary care and interventions the resident will need and placed the resident at risk for worsening condition and hospitalization. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on [DATE] with diagnoses including encephalopathy (disease, damage, or malfunction that affects the brain), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's Care Plan titled Resident 2 has nutritional problem. dated 10/29/2025, the interventions indicated nursing and dietary staff will obtain and monitor laboratory/diagnostic work as ordered, report results to Resident 2's Medical Doctor (MD 2) and follow up as indicated. During a review of Resident 2's History and Physical (H&amp;P), dated 11/24/2025, the H&amp;P indicated Resident 2 did not have the capacity to consent due to her diagnosis with dementia. During a review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/27/2026, the MDS indicated Resident 2 had severe cognitive impairment, rarely understood others, and was rarely able to be understood. The MDS indicated Resident 2 did not reject care. During a review of Resident 2's Physician Orders, dated 2/8/2026, the Physician Orders indicated a CBC to be drawn. During a review of Resident 2's Progress Notes, for the month of 2/2026, there was no indication that the CBC lab draw was done, attempted, or refused. There was no indication MD 2 was notified about Resident 2's missing CBC test done. During a review of Resident 2's Change of Condition (COC - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/5/2026, the COC indicated Resident 2 exhibited cough with chest congestion. The COC indicated MD 2 ordered a CBC to be drawn. During a review of Resident 2's Physician Orders, dated 3/6/2026, the Physician Orders indicated to draw CBC, one time only within three days. During a review of Resident 2's Progress Notes, dated 3/1/2026 through 3/11/2026, there was no indication that the CBC test was done, attempted, or refused. There was no indication MD 2 was notified about Resident 2's missing CBC test done. During a concurrent interview and record review on 3/11/2026 at 10:55 a.m., with Licensed Vocational Nurse (LVN 1), Resident 2's Physician Orders, dated 2/8/2026, Resident 2's COC, dated 3/5/2026, and Physician Orders, dated 3/6/2026, were reviewed. LVN 1 stated Resident 2 had a change of condition on 3/5/2026 and developed congestion with a cough. LVN 1 stated MD 2 ordered CBC to evaluate Resident 2's blood, guide treatments, and plan care. LVN 1 stated Resident 2's CBC should have been collected and reported to MD 2 within three days. LVN 1 stated Resident 2's CBC ordered on 2/8/2026 was not collected by 2/11/2026. LVN 1 stated Resident 2's CBC ordered on 3/5/2026 was not collected by 3/8/2026. LVN 1 stated the progress notes did not indicate the CBC test was done, attempted, or refused from 2/1/2026 through 3/9/2026. LVN 1 stated there was no indication in the progress notes that MD 2 was notified about Resident 2's missing CBC orders in 2/2026 and 3/2026. LVN 1 stated there was potential for Resident 2's clinical condition to worsen and interventions delayed when the CBC orders were not done. During an interview on 3/11/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated Resident 2's CBC orders were not performed in 2/2026 or 3/2026. The DON stated the nursing staff should have contacted the lab vendor to perform the lab draw and notified MD 2 about CBC not done. The DON stated that the facility is required to provide laboratory services to provide safe care for Resident 2. During a review of the facility's policy and procedure (P&amp;P) titled, Physician Notification, dated 12/2016, the P&amp;P indicated the facility must notify physicians when laboratory results fall outside of clinical reference ranges.</p>		