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	06/04/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident-centered care plan with interventions were developed when: 1). Two of six residents (Residents 4 and 5) who were involved in a resident-to-resident interaction on 5/20/2026 had refused room changes. This deficient practice had the potential to result in further altercations, placing both residents at risk for serious physical injuries which could lead to hospitalizations. 2). Resident 6 had an actual fall on 5/14/2026. This failure placed the resident without safety interventions, placing the resident at risk for a recurrent fall.Findings: 1a). During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (temporary excessive worry or unease) and depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Residents 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/3/2026, the MDS indicated Resident 4 had severe cognitive impairment. Resident 4 required substantial/ maximal assistance on staff with ADLs such as dressing, toilet use, transfer and mobility. Resident 4 was dependent on staff with showers, lower body dressing, and in putting on and taking off footwear. During a review of Resident 4's Change of Condition (COC) dated 5/20/2026, the COC indicated a resident to resident altercation. The COC indicated Resident 4 turned on Resident 5's (roommate) call light and walked to the hallway. Resident 5 allegedly attacked Resident 4. During a review of Resident 4's care plan titled Resident to resident interaction (alleged victim), dated 5/20/2026, the interventions indicated to offer room change/ separation from involved residents to reduce risk for further altercation. During a review of Resident 4's Progress Notes dated 5/22/2026 and 5/26/2026, the progress notes indicated Resident 4 did not want a room change. 1b). During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included chronic kidney disease (cannot filter blood effectively for at least three months, leading to a buildup of waste, toxins, and excess fluid in the body), muscle wasting and atrophy (loss of muscle mass, strength, and size, often leading to weakness, reduced mobility, and functional decline) and depressive disorder. During a review of Residents 5's MDS dated [DATE], the MDS indicated Resident 4 had moderate cognitive impairment. Resident 5 required partial/moderate assistance on staff with ADLs such as dressing, toilet use, transfer and mobility. During a review of Resident 5's COC dated 5/20/2026, the COC indicated a resident to resident altercation. The COC indicated Resident 5 was observed bending over Resident 4 with clenched fists in an aggressive posture. Residents 4 and 5 were separated. One to One (1:1) supervision was initiated. The COC indicated room change was initiated to reduce risk for further altercations. The COC indicated Resident 5 refused room change. During a review of Resident 5's care plan titled Resident to resident interaction as evidence by aggressive posture with clinched fist over another resident, dated 5/20/2026, the intervention indicated to maintain 1:1 supervision, offer room change/ separation from involved residents to reduce risk for further altercation and redirect resident from confrontational situations. During a review of Resident 5's Progress Notes (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 5/22/2026 and 5/26/2026, the progress notes indicated Resident 5 did not want a room change. During a concurrent interview and record review on 6/3/2026 at 4:45 p.m. with the Director of Nursing (DON), Residents 4's care plan titled Resident to resident interaction (alleged victim), dated 5/20/2026, and Resident 5's care plan titled Resident to resident interaction as evidence by aggressive posture with clinched fist over another resident, dated 5/20/2026, were reviewed. The DON stated Residents 4 and 5 had no care plan addressing the refusal to change rooms. The DON added the interventions would have included monitoring the residents closely and providing redirection as needed. The DON stated that keeping both residents in the same room could lead to further altercations. 2). During a review of Resident 6's COC dated 5/14/2026, the COC indicated Resident 6 was observed lying on her side in the hallway, outside of her bedroom door, following an apparent fall. Resident 6 complained of pain in the right elbow and skin discoloration (unspecified) were noted on the right arm. Resident 6's physician ordered a radiology (xray, process of taking pictures to diagnose and treat diseases) to right hip and right elbow. During a review of Resident 6's actual fall care plan on 5/14/2026, a care plan was not found in the resident's clinical records. During a concurrent interview and record review on 6/3/2026 at 3:50 p.m. with Registered Nurse (RN) 2, Resident 6's care plan for the actual fall on 5/14/2026 was reviewed. RN 2 stated Resident 6 did not have a care plan for the fall on 3/15/2026. RN 2 stated after a resident's fall, staff must develop a care plan based on the actual fall. RN 2 stated that nurses should include interventions to prevent future falls, specify how often the resident will be monitored and the level of supervision the resident require. During a review of the facility's policy and procedures titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated to reevaluate and modify care plans as necessary to reflect changes in care services and treatment, with significant change in status assessment. Develop goals and approaches for each problem and/or conditions that are realistic, specific, measurable, and included interventions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of care by failing to carry out radiology (xray, process of taking pictures to diagnose and treat diseases) test, ordered by the physician for one of six residents (Resident 6), who fell on 5/14/2026. This failure had the potential to delay identification of any broken bones and in providing treatment necessary for the resident's care.Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's diagnoses included parkinsonism (movements are impaired by rigidity, tremor, or the slowness of motion), Alzheimer's disease (serious memory loss and affects a person's ability to do everyday tasks) and hypertension (HTN-high blood pressure). During a review of Resident 6's History and Physical (H&P), dated 5/17/2026, the H&P indicated Resident 6 lack the capacity to make medical decisions. During a review of Residents 6's Minimum Data Set (MDS - a resident assessment tool) dated 5/14/2026, the MDS indicated Resident 6 had severe cognitive impairment. Resident 6 required substantial/ maximal assistance on staff with activities of daily living (ADL) such as dressing, toilet use, transfer and mobility, shower. Resident 6 required partial /moderate assistance of toileting hygiene, shower, sit to laying, lying to sitting on side of bed. During a review of Resident 6's Change of Condition (COC) dated 5/14/2026, the COC indicated Resident 6 was observed lying on her side in the hallway, outside of her bedroom door, following an apparent fall. Resident 6 complained of pain in the right elbow and skin discoloration (unspecified) were noted on the right arm. Resident 6's physician ordered xray to right hip and right elbow. During a review of Resident 6's care plan titled At risk for pain related to actual fall, dated 5/14/2026, one of the interventions indicated to order x-ray of the right elbow and hip. During a review of Resident 6's physician's order dated 5/14/2026, the physician's order did not indicate an x-ray order of the right elbow and right hip. During a review of Resident 6's clinical records for the month of 5/2026, the clinical records did not contain x-ray results of the right elbow and right hip. During an interview on 6/3/2026 at 4:45 p.m. with the Director of Nursing (DON), the DON stated that the physician's order on 5/14/2026 for Resident 6's right elbow and right hip x-ray were never completed. The DON stated the actual x-ray order was not placed. During an interview on 6/4/2026 at 12:27 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated when a resident had a COC and had a physician's order, the nurse was responsible in entering the physician's x-ray order, faxing and in calling the radiology department. LVN 4 stated that failing to order Resident 6's right elbow and hip x-ray placed the resident at risk for undetected fractures and prevent staff from providing appropriate care. During a review of the facility's policy and procedure (P&P) titled, Change of Condition, dated 8/2017, the P&P indicated physician's orders for any treatment and medical intervention ordered, should be documented in the attending physician's order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure medications ordered by the physician for one of six residents (Resident 1), were administered within 60 minutes of the scheduled time as indicated in the facility's policy and procedure (P&P) titled Medication Administration -General Guidelines. This failure placed the residents at risk for health complications and increased risk of hospitalization.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) other epilepsy (abnormal electrical activity in the brain) and hypertension (HTN-high blood pressure). During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/19/2026, the MDS indicated Resident 1 had moderate cognitive impairment. Resident 1 required substantial to maximal assistance on staff with activities of daily living (ADL) such as dressing, toilet use, transfer and mobility. During a review of Resident 1's physician's orders and the Medications Administration Record (MAR) for the month of 5/2026, indicated the following:Coreg 25 milligram (mg, a unit of measurement) by mouth two times a day (BID) for HTN- scheduled at 8:00 a.m., and 5:00 p.m.Keppra 1000 mg by mouth BID for epilepsy- scheduled at 8:00 a.m., and 5:00 p.m.Metformin Hydrochloride (HCl) 500 mg by mouth BID for type 2 DM- scheduled at 8:00 a.m., and 5:00 p.m.Depakote delayed release 250 mg BID for mood stabilizer manifested by verbal aggressiveness, dated 4/24/2026- scheduled at 9:00 a.m., and 5:00 p.m.Hydralazine 50 mg., 2 tablets by mouth three times a day (TID) for HTN, dated 4/30/2026- scheduled at 9:00 a.m., 1PM and 5:00 p.m. During a review of Resident 1's MAR Audit Report, the audit report indicated Resident 1 received the following:Coreg for 5/19/2026 scheduled for 8:00 a.m., was administered on 5/19/2026 at 9:30 a.m.Depakote for 5/18/2026 and 5/19/2026 scheduled for 9:00 p.m., was administered on 5/18/2026 at 12:01 p.m., and at 11:13 p.m. on 5/19/2026.Hydralazine for 5/18/2026 and 5/19/2026 scheduled 9:00 a.m., was administered on 5/18/2026 at 12:01 p.m., and at 11:13 a.m. on 5/19/2026. Keppra for 5/18/2026 and 5/19/2026 at 11:13 a.m. 8:00 a.m., was administered on 5/18/2026 at 12:01 p.m., and at 9:33 a.m. on 5/19/2026.Metformin for 5/18/2026 and 5/19/2026 scheduled 8:00 a.m., was administered on 5/18/2026 at 12:01 p.m., and at 9:33 a.m. on 5/19/2026. During interview on 6/2/2026 at 3:30 p.m., LVN 1 stated that the facility's P&P for administering medications is to give them one hour before or one hour after the scheduled time. LVN 1 stated it was important to follow the physician's orders to avoid medication overdose or loss of medication effectiveness. During a concurrent interview and record review on 6/2/2026 at 3:35 p.m., with Registered Nurse (RN) 1, Resident 1's Medication Administration Audit report was reviewed. RN 1 stated that the medications (indicated above) were administered to Resident 1 past the scheduled time. RN 1 stated that not administering Metformin on time can result in uncontrolled blood glucose levels. Missing or delayed blood pressure (BP) medication can place Resident 1 at risk for a hypertensive crisis (critically high blood pressure), and not giving seizure medications on time can result in an epileptic episode and the potential need for hospital transfer. RN 1 stated it was important to follow the physician's orders, noting that medications have different therapeutic ranges and that failing to administer them at the correct time can reduce their effectiveness. During an interview on 6/4/2026 at 1:25 p.m. with the Director of Nursing (DON), the DON stated that medications can be administered one hour before or one hour after the scheduled time. The DON stated that when a licensed nurse cannot administer medications on time, the nurse must communicate with the physician to obtain an order to either administer the medication late or hold it until the next scheduled dose. The DON stated that Resident 1 could be at risk for medication overdose if medications are administered too close together and could also be at risk for adverse reactions. The DON stated that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failing to administer medications on time can cause them to be ineffective and place Resident 1 at risk of hospitalization. During a review of the facility's P&P titled, Medication Administration -General Guidelines, dated 3/2024, the P&P indicated medications should be administrated in accordance with written orders of the attending physician. Medications shall be administrated within 60 minutes of scheduled time except before or after meals orders, which are administrated based on mealtimes. Routine medications shall be administrated according to the established medication administration schedule for the facility.