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	06/24/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Policy and Procedure (P&P) titled, Abuse and Neglect Prohibition Policy which indicated the facility will report all allegations of abuse to the Licensing and Certification Program District Office (State Agency) within two hours, for one of six sampled residents (Resident 1), after a General Acute Care Hospital (GACH) staff notified the facility on 6/4/2026 of Resident 1's allegation that unidentified staff abused her and did not feed her (date not specified). This deficient practice resulted in a delay in the investigation by the State Agency and placed Resident 1 at risk for continued abuse or neglect. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 5 diagnoses included unspecified dementia (a progressive state of decline in mental abilities), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's History and Physical examination (H&P) dated 1/24/2026, the H&P indicated Resident 1 did not have the capacity to make medical decisions but could make needs known. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 1 required substantial /maximal assistance (helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort) with Activities of Daily Living (ADLs) such as personal hygiene, bed mobility and upper body dressing. During a review of Resident 1's Progress Note dated 6/4/2026 at 2:46 p.m., the Progress Note indicated Resident 1 exhibited behavioral concerns warranting further medical and psychiatric evaluation. Resident 1 was transferred to the GACH for further assessment and management. During a review of Resident 1's Progress Note dated 6/4/2026 at 5:44 p.m., the Progress Note indicated Licensed Vocational Nurse (LVN) 1 received a phone call from the GACH coordinator and informed her (LVN 1) that Resident 1 alleged she was abused by facility staff. LVN 1 immediately communicated the allegation of Resident 1's statements to the Registered Nurse (RN) Supervisor and the Director of Nursing (DON). During an interview on 6/23/2026 at 2:53 p.m., with the DON, the DON stated he was not aware of Resident 1's allegation of abuse reported to the facility on 6/4/2026 and did not report the allegation to the State Agency. The DON stated it was important to report allegations of abuse to the State Agency for the Resident's safety. During an interview on 6/23/2026 at 3:14 p.m., with LVN 1, LVN 1 stated she received a call from the GACH on 6/4/2026 and informed her that Resident 1 alleged facility staff (unidentified) abused her and did not feed her (dates not specified). She documented the information and informed the RN Supervisor (RN 1). LVN 1 stated nurses were required to report allegations of abuse to the police, Ombudsman and California Department of Public Health (CDPH) within two hours. During an interview on 6/23/2026 at 3:30 p.m., with RN 1, RN 1 stated (on 6/4/2026) LVN 1 informed her that she (LVN 1) received a call from the GACH reporting Resident 1 alleged (unnamed) facility staff abused her. RN 1 stated she contacted the DON and informed him of the allegation (on 6/4/2026). During an interview on 6/23/2026 at 3:53 p.m., with the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Administrator (AADM), the AADM stated he was not aware of any allegation of abuse involving Resident 1. The AADM stated any phone call received from a GACH regarding an allegation of abuse must be reported to CDPH. The AADM stated nurses were mandated reporters and could report to CDPH. During a review of facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2022, the P&P indicated it is the facility's policy to prohibit abuse, mistreatment and neglect for all residents through prevention of occurrences, identification of possible incidents or allegations which need investigation and reporting of incidents. The P&P indicated, upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will report the incident to the Licensing and Certification Program District Office immediately but not later than two hours, if the alleged violation involves abuse or results in serious injury.

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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 investigate an allegation of abuse for one of six sampled residents (Resident 1), when a General Acute Care Hospital (GACH) staff reported to the facility on 6/4/2026, of Resident 1's allegation that (unidentified) staff abused her and did not feed her (date not specified). This deficient practice had the potential to result in unidentified abuse towards Resident 1 and could negatively affect the Resident's wellˆbeing.Based on interview and record review, the facility failed to investigate an allegation of abuse for one of six sampled residents (Resident 1), when a General Acute Care Hospital (GACH) staff reported to the facility on 6/4/2026, of Resident 1's allegation that (unidentified) staff abused her and did not feed her (date not specified). This deficient practice had the potential to result in unidentified abuse towards Resident 1 and could negatively affect the Resident's wellˆbeing. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 5 diagnoses included unspecified dementia (a progressive state of decline in mental abilities), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's History and Physical examination (H&P) dated 1/24/2026, the H&P indicated Resident 1 did not have the capacity to make medical decisions but could make needs known. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 1 required substantial /maximal assistance (helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort) with Activities of Daily Living (ADLs) such as personal hygiene, bed mobility and upper body dressing. During a review of Resident 1's Progress Note dated 6/4/2026 at 5:44 p.m., the Progress Note indicated Licensed Vocational Nurse (LVN) 1 received a phone call from a GACH staff and informed her (LVN 1) that Resident 1 alleged she was abused by facility staff. LVN 1 immediately communicated the allegation of Resident 1's statements to the Registered Nurse (RN) Supervisor and the Director of Nursing (DON). During an interview on 6/23/2026 at 2:53 p.m., with the DON, the DON stated he did not investigate Resident 1's abuse allegation on 6/4/2026 because he was not aware of the Resident's allegation. The DON stated it was the facility's responsibility to investigate (allegations of abuse) and to determine what happened to the resident. During an interview on 6/23/2026 at 3:53 p.m., with the Assistant Administrator (AADM), the AADM stated he was not aware of any allegation of abuse involving Resident 1. The AADM stated any phone call received from a GACH regarding an allegation of abuse must be investigated. An investigation should be conducted to ensure resident safety and to prevent further abuse. During a review of facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2022, the P&P indicated it is the facility's policy to prohibit abuse, mistreatment and neglect for all residents through prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegations and reporting of incidents, investigations and the response to the results of their investigations. The P&P indicated upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will initiate an investigation within 24 hours of an allegation of abuse, and will report findings of all completed investigations to the Licensing and Certification Program District Office via fax and other officials in accordance with state law within 5 working days of the incident.

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(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 provide supervision for one of six sampled residents (Resident 5), who was a high risk for fall and required contact guard assistance (CGA- a level of physical assistance where staff maintains light, hands-on contact with the resident for stability, balance and fall prevention) from staff when walking. This deficient practice resulted in Resident 5 falling in the hallway on 6/8/2026 after walking out of the shower room unassisted and placed the Resident at risk for injury. Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] with diagnoses including muscle weakness, other symptoms and signs involving the musculoskeletal system (pain, stiffness, swelling, reduced mobility, weakness, or functional limitations affecting bones, joints, muscles, tendons, and ligaments), muscle wasting and atrophy (refers to the reduction in muscle mass and strength due to the shrinking of muscle fibers caused by loss of proteins). During a review of Resident 5's Fall Risk Evaluation dated 1/1/2026, the Fall Risk Evaluation indicated Resident 5 was a high risk of fall, required use of assistive devices (i.e. cane, wheelchair or walker), had intermittent confusion and balance problems while walking. During a review of Resident 5's Care Plan titled, the Resident is high risk for falls related to (R/T) confusion, gait (manner of walking)/balance problems, psychoactive drug (substances that affect the brain) use dated 1/1/2026, the Care Plan goal indicated the resident would be free of falls and injuries through the review date. The Care Plan interventions indicated for nursing to anticipate and meet Resident 5's needs. During a review of Resident 5's History and Physical examination (H&P) dated 1/2/2026, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Residents 5's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2026, the MDS indicated Resident 5 had severe cognitive (ability to think and reason) impairment. The MDS indicated Resident 5 required partial to moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with Activities of Daily Living (ADLs) such as toileting hygiene, chair to bed transfers and upper body dressing. Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or/contact guard assistance as resident completes activity) for walking 10 feet. During a review of Resident 5's Care Plan titled, Functional decline related to decrease strength impaired mobility dated 5/13/2026, the Care Plan interventions indicated for nursing to help Resident 5 with transfers and ambulation as needed. During a review of Resident's 5 Physical Therapy Treatment Encounter Notes dated 6/5/2026, the Notes indicated Resident 5 was confused and on fall risk precautions. Resident 5 required contact guard assistance with transfers and gait. During a review of Resident 5's SBAR Communication Form (Situation, Background, Assessment Recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) dated 6/8/2026, the SBAR indicated Resident 5 had a witnessed fall after exiting the shower room. Resident 5 lost balance and fell backward into a linen cart while ambulating (walking) and pushing her wheelchair in the hallway. During an interview on 6/24/2026 at 11:03 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 5 needed assistance with showering and dressing. CNA 4 stated on 6/8/2026, after the Resident showered, she (CNA 4) assisted Resident 5 out of the shower room and proceeded to clean the shower as Resident 5 walked down the hallway with her wheelchair. Approximately 4 minutes later, she (CNA 4) heard commotion in the hallway because Resident 5 fell. CNA 4 stated she did not witness the Resident's fall. CNA 4 stated she should have supervised the Resident and made sure she walked safely back to her room. During an interview on 6/24/2026 at 12:00 p.m., with Registered Nurse (RN) 2, RN 2 stated (on 6/8/2026), she observed Resident 5 fall backward into a linen cart as the Resident was walking from the shower room. RN 2 stated there was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no staff close to Resident 5 when she fell. During an interview on 6/24/2026 at 1:50 p.m., with the Physical Therapist (PT), the PT stated Resident 5 required CGA while walking because the Resident was impulsive with her gait and at risk for falls. The PT stated nurses were expected to ensure Resident 5 ambulated safely toward her room after a shower. During an interview on 6/24/2026 at 2:17 p.m., with the Director of Nursing (DON), the DON stated Resident 5 was ambulatory and used her wheelchair as a walker. (On 6/8/2026), Staff should have supervised and monitored Resident 5 after coming out of the shower for the resident's safety. During a review of facility's policy and procedures (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 to try to minimize complications from falling. All precautions will be implemented to protect the resident according to the fall prevention and reduction program.