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	07/02/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the personal funds for one of four sampled residents (Resident 1) was safeguarded from misappropriation (the deliberate misplacement, wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent) by failing to ensure the Business Office Manager (BOM) did not take Resident 1's personal funds out of the facility and kept them in her personal possession without Resident 1's authorization. This deficient practice had the potential to result in financial abuse or misappropriation of funds affecting Resident 1. 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 dementia (a progressive state of decline in mental abilities), pneumonitis (inflammation of the lung tissue), paranoid schizophrenia (a severe mental health disorder where a person loses touch with reality, experiencing paranoia, fixed false beliefs and hallucinations) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's History and Physical (H&P) dated 1/7/2026, the H&P indicated Resident 1 did not have the capacity to make medical decision but was able to make needs known.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/2/2026, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment. The MDS also indicated Resident 1 required maximal assistance (helper does more than half the effort) from staff members with Activities of Daily Living such as personal hygiene, transfers and walking 10 feet. During a telephone interview, on 7/2/2026 at 10:43 a.m., with the Business Office Manager (BOM), the BOM stated she withdrew the amount of $7,744 (date unspecified) from Resident 1's trust fund because Resident 1 was discharged to a Board and Care facility. The BOM stated $2000 of $7,744 was paid to the Board and Care and the remaining amount of 5,744 was to be given back to Resident 1. The BOM stated Resident 1's funds could not be returned to the Resident at the Board and Care because she was discharged from the Board and Care facility to a General Acute Care Hospital (GACH) due to a change in condition (on 4/23/2026). The BOM stated Resident 1 was readmitted to the facility (on 4/28/2026) after hospitalization and she was supposed to deposit the funds back into the trust account, however she did not have time to do so. The BOM stated she kept Resident 1's personal funds ($5744.00 cash), as well as two of Resident 1's Social Security checks (unspecified amount) in her purse because she did not want to leave large amount of cash in the BOMs office and did not have time to deposit the checks. She left her employment on 6/5/2026 and did not realize she still had the money and checks with her. The BOM stated she sent the two Social Security checks back to the facility; however she still had the Resident's $5744.00 cash in her possession. The BOM stated she should have immediately deposited Resident 1's personal funds back into the trust account.During an interview on 7/2/2026 at 12:11 p.m., with the Assistant Administrator (Asst Admin), the Asst Admin stated the BOM withdrew money from Resident 1's trust account in the amount of $7,744 on 4/16/2026 because the Resident was discharged to a Board and Care facility (on 4/15/2026). The Asst Admin stated a payment of $2000 went to the board and care. The facility had 7 days to refund a Resident's money from their trust fund. The Asst Admin stated he and the BOM were (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preparing to mail off Resident 1's funds ($5,744) and was informed (by the Board and Care facility) that Resident 1 was transferred to the GACH due to a change in condition. The Asst Admin stated he informed the BOM to deposit Resident 1's funds back into the resident's trust account until the resident was discharged from the GACH. The Asst Admin stated he did not check to see if Resident 1's funds were deposited since that was the role of the BOM. The Asst Admin stated he assumed the BOM deposited the funds back into the trust. The Asst Admin stated the BOM was terminated from the facility due to performance issues on 6/5/2026 and was informed by the BOM that she (the BOM) had Resident 1's Social Security checks and $5744 with her. On 6/16/2026, the BOM returned Resident 1's Social Security checks to the facility, however, did not return the Resident's $5744. The Asst Admin stated failing to return the resident's funds could result in financial abuse for the resident.During a review of the facility's policy and procedures (P&P) titled, Abuser and Neglect Prohibition Policy dated 6/2022, the P&P indicated it is the facility's policy to prohibit abuse, mistreatment and misappropriation of property through prevention of occurrences and to ensure that facility staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property for all residents.

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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 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 misappropriation of funds (the deliberate misplacement, wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent) to the Licensing and Certification Program District Office (CDPH) within two hours for one of four sampled residents (Resident 1), when Resident 1's personal funds were taken by the Business Office Manager (BOM) without the Resident's authorization. This deficient practice resulted in a delay in the investigation by the CDPH and had the potential to result in continued abuse of Resident 1. 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 dementia (a progressive state of decline in mental abilities), pneumonitis (inflammation of the lung tissue), paranoid schizophrenia (a severe mental health disorder where a person loses touch with reality, experiencing paranoia, fixed false beliefs and hallucinations) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's History and Physical (H&P) dated 1/7/2026, the H&P indicated Resident 1 did not have the capacity to make medical decision but was able to make needs known.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/2/2026, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment. The MDS also indicated Resident 1 required maximal assistance (helper does more than half the effort) from staff members with Activities of Daily Living such as personal hygiene, transfers and walking 10 feet. During a telephone interview, on 7/2/2026 at 10:43 a.m., with the Business Office Manager (BOM), the BOM stated she withdrew the amount of $7,744 (date unspecified) from Resident 1's trust fund because Resident 1 was discharged to a Board and Care facility. The BOM stated $2000 of $7,744 was paid to the Board and Care and the remaining amount of 5,744 was to be given back to Resident 1. The BOM stated Resident 1's funds could not be returned to the Resident at the Board and Care because she was discharged from the Board and Care facility to a General Acute Care Hospital (GACH) due to a change in condition (on 4/23/2026). The BOM stated Resident 1 was readmitted to the facility (on 4/28/2026) after hospitalization and she was supposed to deposit the funds back into the trust account, however she did not have time to do so. The BOM stated she kept Resident 1's personal funds ($5744.00 cash), as well as two of Resident 1's Social Security checks (unspecified amount) in her purse because she did not want to leave large amount of cash in the BOMs office and did not have time to deposit the checks. She left her employment on 6/5/2026 and did not realize she still had the money and checks with her. The BOM stated she sent the two Social Security checks back to the facility; however she still had the Resident's $5744.00 cash in her possession. The BOM stated she should have immediately deposited Resident 1's personal funds back into the trust account.During an interview on 7/2/2026 at 12:11 p.m., with the Assistant Administrator (Asst Admin), the Asst Admin stated the BOM withdrew money from Resident 1's trust account in the amount of $7,744 on 4/16/2026 because the Resident was discharged to a Board and Care facility (on 4/15/2026). The Asst Admin stated a payment of $2000 went to the board and care. The facility had 7 days to refund a Resident's money from their trust fund. The Asst Admin stated he and the BOM were preparing to mail off Resident 1's funds ($5,744) and was informed (by the Board and Care facility) that Resident 1 was transferred to the GACH due to a change in condition. The Asst Admin stated he informed the BOM to deposit Resident 1's funds back into the resident's trust account until the resident was discharged from the GACH. The Asst Admin stated he did not check to see if Resident 1's funds were deposited since that was the role of the BOM. The Asst Admin stated he assumed the BOM deposited the funds back into (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the trust. The Asst Admin stated the BOM was terminated from the facility due to performance issues on 6/5/2026 and was informed by the BOM that she (the BOM) had Resident 1's Social Security checks and $5744 with her. On 6/16/2026, the BOM returned Resident 1's Social Security checks to the facility, however, did not return the Resident's $5744. The Asst Admin stated he did not report Resident 1's missing funds to the CDPH until 6/22/2026 because he waited for the BOM to return Resident 1's funds. The Asst Admin stated failing to report an alleged misappropriation of funds in a timely manner could result in further abuse for the resident. During a review of the facility's 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, neglect and misappropriation of property for all residents through 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, the Administrator or designee will report all alleged violations to the CDPH with two hours.