

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/16/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the physician or Medical Director (MD) was notified, for one of three sample residents (Resident 1), who had changes of condition (COC). Resident 1 had swelling to the right forearm on 6/22/2026 and a right radius fracture (a break in the larger forearm bone near the wrist) on 6/24/2026. This deficient practice resulted in a delay in care and treatment for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including lack of coordination (a loss of full control of bodily movements), muscle wasting (a gradual shrinking and loss of muscle mass, strength, and function), and Schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P) dated 4/30/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Sheet ([MDS]- a resident assessment tool) dated 5/3/2026, the MDS indicated Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for personal hygiene, shower, and lower dressing. During an observation on 7/16/2026 at 9:10 a.m., in Resident 1's room, Resident 1 had a right arm splint/immobilizer (a medical device used to immobilize, protect, or support the bones and joints). During a review of Resident 1's COC dated 6/22/2026, the COC indicated Resident 1 had right forearm swelling. The COC indicated the physician was called on 6/22/2026 and 2:02 p.m., awaiting response and will endorse to oncoming nurse to follow up with the physician. During a concurrent interview and record review on 7/16/2026 at 9:40 a.m., with the Administrator Assistant (AA), Resident 1's Xray (a medical imaging to create pictures inside the body) result dated 6/24/2026 was reviewed. The AA stated Resident 1's Xray resulted on 6/24/2026 and indicated the resident had a right radius fracture. The AA stated the physician was not notified of the Xray result until 6/29/2026 (5 days later). The AA stated the MD should have been called sooner to prevent a delay in care. The AA also stated there was a delay in care when the staff did not follow up with the results of the Xray on 6/24/2026. Resident 1 was sent to the hospital for treatment for the fracture on 6/30/2026. During a concurrent interview and record review of on 7/16/2026 at 4:39 p.m., with the Director of Nursing (DON), Residents 1's Progress Notes, dated 6/22/2026 was reviewed. The DON stated on 6/22/2026, staff initiated a COC indicating Resident 1 had right arm swelling and was waiting for a response from the physician. The DON stated there was no response from the physician on 6/22/2026. The DON stated the MD should have been notified when staff were not able to reach the physician, however, was not done. The DON stated this was a delay in care. The facility received a physician's order to obtain an Xray for Resident 1 on 6/24/2026 (two days later). The DON stated the delay placed (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 at risk of increased swelling of his forearm and could have resulted in discomfort and deformity of the resident's arm. During a review of the facility's policy and procedure (P&P) titled, Change of Condition, dated 8/2017, the P&P indicated the facility is to promptly notify the physician of the changes in the resident's medical condition. The P&P indicated the DON is the designee to implement and enforce the policy. The P&P indicated the licensed nurse will notify the physician of sudden, serious, or acute medical changes in condition. If the physician was unable to be contacted the Medical Director was to be contacted.		

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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 observation, interview, and record review the facility failed to implement the Care Plan for one of three sample residents (Resident 4), which indicated to maintain one-to-one (one staff delegated to supervise a single resident) monitoring and provide supervision and redirection for Resident 4, who had increased wandering behavior. This deficient practice resulted in Resident 5 pushing Resident 4 to the ground when Resident 4 wandered into Resident 5's room and placed Resident 4 at risk for injuries and on-going resident altercations. Findings:a. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), anxiety (a vague sense of dread, apprehension or uneasiness), and Schizophrenia (a mental illness that is characterized by disturbances in thoughts).During a review of Resident 4's History and Physical (H&P), dated 6/4/2026, the H&P indicated Resident 4 cognition (ability to learn, reason, remember, understand, and make decisions) was impaired.During a review of Resident 4's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 6/30/2026, the MDS indicated Resident 4 required supervision (helper provides verbal cues and /or touching/steadying, contact guard assistance as resident completes activity) from staff for personal hygiene, shower, and dressing.During a review of Resident 4's Wandering & Elopement Risk Assessment, dated 6/3/2026, the wandering & elopement risk assessment indicated was at moderate/actual risk for wandering.During a review of Resident 4's Change of Condition (COC), dated 6/11/2026, the COC indicated Resident 4 had increased wandering behavior. During a review of Resident 4's Care Plan titled, Resident wanders into other residents' rooms and becomes agitated, dated 6/11/2026, the Care Plan goal indicated Resident will remain safe while in the facility and will have a decrease in wandering into other resident's rooms. The Care Plan interventions indicated to maintain one-to-one monitoring and reassess the need regularly. The Care Plan indicated staff were to provide frequent supervision and redirection to appropriate areas of the facility.During a review of Resident 4's Change of Condition (COC), dated 6/29/26, the COC indicated Resident 4 wandered into Resident 5's room, and Resident 5 became agitated and pushed Resident 4 to the ground. b. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including lack of coordination (a loss of full control of bodily movements), muscle wasting (a gradual shrinking and loss of muscle mass, strength, and function), and Schizophrenia.During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognition was moderately impaired. The MDS indicated Resident 5 required supervision from staff for oral hygiene, shower, and dressing.During an interview on 7/15/2026 at 12:10 p.m., with Resident 5, Resident 5 stated (on 6/29/2026) Resident 4 kept coming into his room and touched his belongings. Resident 5 stated, he yelled at him (Resident 4) and pushed him to the ground.During a telephone interview on 7/15/2026 at 1:29 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 6/29/2026 during the evening shift (3:00 p.m.- 11:00 p.m.), Resident 4 wandered into Resident 5's room and Resident 5 pushed Resident 4 to the ground. CNA 1 stated Resident 4 was wandering into other resident rooms that evening and required continuous redirection during her shift. CNA 1 stated she did not provide 1:1 monitoring and stepped away to assist another resident prior to the incident. During a concurrent interview and record review on 7/15/2026 at 2:56 p.m., with the Director of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON), Resident 4's COC, dated 6/11/2026 was reviewed. The DON stated the COC indicated Resident 4 had increased wandering behavior and needed to be closely monitored. During a concurrent interview and record review on 7/16/2026 at 1:31 p.m., with the DON, Resident 4's Care plan titled, Resident Wanders into other Residents' Rooms and becomes agitated, dated 6/11/2026 was reviewed. The Care Plan interventions indicated to maintain one-to-one monitoring and reassess the need regularly. The Care Plan indicated Resident 4 was to have frequent supervision and redirection to appropriate areas of the facility. Resident 4 was to be closely monitored when wandering into other residents' rooms. The DON stated when CNA 1 stepped away from the resident and monitoring stopped, this increased the risk for Resident 4 to enter Resident 5's room which resulted in Resident 4 getting pushed to the ground by Resident 5 and could have been seriously hurt. 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 facility was to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives to meet their medical, nursing, psychosocial needs identified during comprehensive assessment. The P&P indicated the comprehensive care plan must describe services that were provided to the resident to attain the resident's highest practicable well-being. The P&P indicated to include interventions to attempt to manage risk factors. The P&P indicated to ensure that interventions specify the frequency of service provided.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two residents (Resident 4), the facility failed to review, revise or provide interventions in the resident's care plan titled, Wound Management Post-Surgical right hand index finger-General, to achieve goals for the resident's care. This failure had the potential for Resident 4 to receive poor quality care and placing the right-hand index finger post-surgical wound at risk for delayed wound healing and infection. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar levels) and chronic diastolic (congestive) heart failure (a condition when the heart muscle becomes stiff). During a review of Resident 4's Minimum Data Set (MDS), dated [DATE], the MDS (a tool used to evaluate the health status, functional abilities, and healthcare needs) indicated Resident 4 had intact cognition. Resident 4 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, upper body dressing and rolling left to right side. Resident 4 required Partial/moderate assistance (Helper does less than half the effort) with toileting hygiene, shower/bathing self, lower body dressing, putting on/taking off footwear, sitting to lying position, lying-to-sitting on side of bed, sit to stand and chair/ bed-to-chair transfer. During a record review of Resident 4's Change in Condition Evaluation (COC), dated 7/4/2026, the COC indicated on 7/4/2026, Resident 4's when the right index finger was caught in a closing door during a resident-to-resident incident (unspecified) and sustained a laceration with active bleeding. Resident 4 was sent to a General Acute Care Hospital (GACH). During a review of Resident 4's Order Summary Report, dated 7/9/2026, the Order Summary Report indicated to wrap Resident 4's right hand index finger with roll gauze to stabilize, every 72 hours for 14 days. During a review of Resident 4's Multidisciplinary Care Conference (IDT, group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) note, dated 7/10/2026, the notes indicated the IDT meeting regarding Resident 4's readmission was completed and no concerns were identified. During a concurrent interview and record review on 7/15/2026 at 2:37 p.m. concurrent with the Treatment Nurse (TN) and Director of Nursing (DON), Resident 4's care plan titled, Wound Management Post-Surgical right hand index finger - General, dated 7/15/2026, was reviewed. The goal indicated that the resident will be free of signs or symptoms of infection and the wound will show signs of improvement. The column under interventions was blank. The TN stated the care plan had no listed interventions. If the care plan was not completed, staff would not know how to care for Resident 4's right hand index finger surgical wound (wound). The TN stated the wound could be infected. The DON stated if the interventions were not checked and saved, the care plan was not completed. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated, it was the policy of this facility to provide each resident with a comprehensive plan of care developed that include goals, measurable objectives and timetables to meet the residents' medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive plan of care should reflect interventions to meet both short and long-term resident goals to prevent avoidable decline in function or functional level.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three residents' (Resident 4) urinal (a portable, handheld urine bottle used by bedridden or immobile individuals in healthcare settings) was labeled. This failure had the potential for accidental use of the urinal for another resident, leading to the spread of bacterial infections or cross contamination (the process by which bacteria (germs) or other micororganisms (germs) are unintentionally transferred from one substance or object to another, with harmful effect). Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar levels) and chronic diastolic (congestive) heart failure (a condition when the heart muscle becomes stiff). During a review of Resident 4's Minimum Data Set (MDS), dated [DATE], the MDS (a tool used to evaluate the health status, functional abilities, and healthcare needs) indicated Resident 4 had intact cognition. Resident 4 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, upper body dressing and rolling left to right side. Resident 4 required Partial/moderate assistance (Helper does less than half the effort) with toileting hygiene, shower/ bathing self, lower body dressing, putting on/taking off footwear, sitting to lying position, lying-to-sitting on side of bed, sit to stand and chair/ bed-to-chair transfer. During an observation on 7/15/2026 at 1:15 p.m., in Resident 4's room, a urinal with no name or date was observed hanging at Resident 4's foot part of the bed. During a concurrent observation and interview on 7/15/2026 at 1:33pm with the Registered Nurse Supervisor (RNS), in Resident 4's room, a urinal was observed unlabeled (no name and no date). RNS stated the urinal could be used by another resident if it was not labeled with the resident's name and date. RNS stated the urinal should be changed every night shift for sanitation (maintain hygienic conditions and prevent disease) and infection control (practices designed to prevent the spread of infectious diseases [illnesses caused by harmful germs (pathogens) like bacteria]) reasons. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting Commode Pan, Urinal & Bedpan, dated 8/2017, the P&P indicated the facility should provide the disposable, multiple use, single resident equipment labeled with resident's name.		