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	04/05/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42200 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) was free from physical abuse by failing to ensure Certified Nurse Assistant (CNA 1) did not slap Resident 1 in the face on 4/3/2022 after verbalizing he would do so. This deficient practice resulted in Resident 1 being physically assaulted. Resident 1 complained of left facial pain, had a hematoma (collection of blood) to the left preseptal area (an area of the eye) and bruising (blood or bleeding under the skin due to trauma) over the nasal (nose) bridge and left eye, and required a transfer to a general acute care hospital (GACH). Findings: During a review Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood), encephalopathy (disease that affects the brain) and dementia (a decline in mental function that affects reasoning, personality, mood, and behavior). During a review of Resident 1 ' s Minimum Data Set ([MDS], a comprehensive assessment and care screening tool) dated 1/17/2022, the MDS indicated Resident 1 had severe cognitive (ability to learn, reason, remember, understand and make decisions) impairment and required limited assistance (resident highly involved in activity; staff provided guided maneuvering of limbs) to extensive assistance (resident involved in activity, staff provide weight bearing support) for activities of daily living (ADL ' s) such as bed mobility (how resident moves in bed), transfer (how resident moves between surfaces including to and from bed, chair, standing position), walking, dressing toilet use, and personal hygiene. During a review of Resident 1 ' s History and Physical (H&P) dated 4/1/2022, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s Situation, Background, Assessment and Recommendation ([SBAR], an internal communication form) dated 4/4/2022, the SBAR indicated Resident 1 was a victim of suspected elder abuse and had a swollen and bruised left eye and eyebrow which started on 4/3/2022. The SBAR also indicated the resident had new onset of pain to the left eye. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s GACH H&P dated 4/4/2022 and timed 1:56 p.m., the H&P indicated Resident 1 was assaulted at the nursing facility. The H&P also indicated the resident complained of left facial pain, had a hematoma to the left preseptal area (an area of the eye) and bruising over the nasal bridge and left eye. During an interview on 5/17/2022 at 11:27 a.m. with Director of Staff Development (DSD), the DSD stated Certified Nursing Assistant (CNA) 1 was assigned to closely monitor Resident 1 on 4/3/2022 during the 3 p.m. - 11 p.m. shift. The DSD stated during an interview conducted on 4/4/2022 with CNA 1, CNA 1 stated Resident 1 was troublesome, and he (CNA 1) was frustrated with the resident. The DSD stated CNA 1 also stated that he had hard time with the resident during his shift, slapped the resident ' s hands and pushed Resident 1 down to his bed to prevent the resident from falling or walking around. During an interview on 5/18/2022 at 11:54 a.m. and 12:56 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when she entered Resident 1 ' s room on 4/3/2022 at around 10:45 p.m., LVN 1 stated CNA 1 was in the room with the resident and Resident 1 did not have any injuries. LVN 1 stated CNA 1 said if Resident 1 continued to be combative, he (CNA 1) would slap the resident up. LVN 1 stated she was concerned for Resident 1 ' s safety after hearing CNA 1 ' s comment but she did not remove CNA 1 from the resident ' s room immediately. LVN 1 stated she replaced CNA 1 with CNA 2 about 15 minutes later, at 11 p.m. According to LVN 1, CNA 2 called LVN 1 to the resident ' s room around 11 p.m., and she (LVN 1) discovered Resident 1 had a discoloration around his left eye and eyebrow. LVN 1 also stated CNA 1 was the last staff in Resident 1 ' s room prior to the resident ' s injury. LVN 1 also stated that CNA 1 left the facility around 11 p.m. on 4/3/2022. During an interview on 5/19/2022 at 10:27 a.m. with Director of Nursing (DON), the DON stated if staff verbalized, he or she would slap a resident, it would be necessary to investigate further, monitor the resident and not leave the resident alone with the staff for safety due to the possibility of causing harm to the resident. During an interview on 5/19/2022 at 2:18 p.m. with the Administrator (ADM), the ADM stated CNA 1 verbalized he slapped the resident because the resident was restless. ADM stated after careful investigation, ADM substantiated CNA 1 abused Resident 1. During a review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention Program dated 8/2006, the P&P indicated the facility was committed to protecting residents from abuse by anyone including facility staff and staff from other agencies providing services to residents. During a review of the facility ' s P&P titled, Abuse Prevention/Prohibition and Abuse Reporting and Investigation dated 11/2018, the P&P indicated abuse is defined as the willful infliction of injury, involuntary seclusion, physical or chemical restraint not required to treat the resident ' s symptoms, intimidating or punishment with resulting physical harm, pain, or mental anguish. If suspected perpetrator is an employee, the employee would be removed immediately from the care of the resident and immediately suspend the employee pending the outcome of the investigation in accordance with facility ' s policies.

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42200 Based on interview and record review, the facility failed to implement their abuse policies and procedures (P&P) for one of three residents (Resident 1) by failing to implement protection from abuse for Resident 1. This deficient practice resulted in Resident 1 sustaining a hematoma (collection of blood to the left preseptal area (an area of the eye) and bruising (blood or bleeding under the skin due to trauma) over the nasal (nose) bridge and left eye, and required a transfer to a general acute care hospital (GACH) . Findings: During a review Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood), encephalopathy (disease that affects the brain) and dementia (a decline in mental function that affects reasoning, personality, mood, and behavior). During a review of Resident 1 ' s Minimum Data Set ([MDS], a comprehensive assessment and care screening tool) dated 1/17/2022, the MDS indicated Resident 1 had severe cognitive (ability to learn, reason, remember, understand and make decisions) impairment and required limited assistance (resident highly involved in activity; staff provided guided maneuvering of limbs) to extensive assistance (resident involved in activity, staff provide weight bearing support) for activities of daily living (ADL ' s) such as bed mobility (how resident moves in bed), transfer (how resident moves between surfaces including to and from bed, chair, standing position), walking, dressing toilet use, and personal hygiene. During a review of Resident 1 ' s History and Physical (H&P) dated 4/1/2022, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s Situation, Background, Assessment and Recommendation ([SBAR], an internal communication form) dated 4/4/2022, the SBAR indicated Resident 1 was a victim of suspected elder abuse and had a swollen and bruised left eye and eyebrow which started on 4/3/2022. The SBAR also indicated the resident had new onset of pain to the left eye. During a review of Resident 1 ' s GACH H&P dated 4/4/2022 and timed 1:56 p.m., the H&P indicated Resident 1 was assaulted at the nursing facility. The H&P also indicated the resident complained of left facial pain, had a hematoma to the left preseptal area (an area of the eye) and bruising over the nasal bridge and left eye. During an interview on 5/17/2022 at 11:27 a.m. with Director of Staff Development (DSD), the DSD stated Certified Nursing Assistant (CNA) 1 verbalized he was frustrated with Resident 1 and slapped Resident 1 ' s hands and pushed him down to his bed. (continued on next page)

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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 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/18/2022 at 11:54 a.m. and 12:56 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when she entered Resident 1 ' s room on 4/3/2022 at around 10:45 p.m., Resident 1 did not have any injuries. LVN 1 stated CNA 1 said if Resident 1 continued to be combative, he (CNA 1) would slap the resident up. LVN 1 stated she was concerned for Resident 1 ' s safety after hearing CNA 1 ' s comment but she did not remove CNA 1 from the resident ' s room. immediately. LVN 1 stated at around 11 p.m. when she returned to the room, she (LVN 1) discovered Resident 1 had a discoloration around his left eye and eyebrow. LVN 2 added that she should have followed the facility's abuse policy and sent CNA 1 home as soon as CNA 1 stated he was going to slap Resident 1. During an interview on 5/19/2022 at 2:18 p.m. with the Administrator (ADM), the ADM stated the facility did not tolerate any form of resident abuse. The ADM also state CNA 1 was placed on a do not send list, and would never be allowed to work in the facility again. During a review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention Program dated 8/2006, the P&P indicated the facility was committed to protecting residents from abuse by anyone including facility staff and staff from other agencies providing services to residents. During a review of the facility ' s P&P titled, Abuse Prevention/Prohibition and Abuse Reporting and Investigation dated 11/2018, the P&P indicated abuse was the willful infliction of injury, involuntary seclusion, physical or chemical restraint not required to treat the resident ' s symptoms, intimidating or punishment with resulting physical harm, pain, or mental anguish. If suspected perpetrator is an employee, the employee would be removed immediately from the care of the resident and immediately suspend the employee pending the outcome of the investigation in accordance with facility ' s policies.