STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview and record review, the facility failed to: 1. Ensure call lights were placed within reach for 2 of 3 residents (Residents 2 and 3). 2. Provide oral care to 1 of 3 residents, (Resident 3) This deficient practice had the potential for the residents to not be able to call for help and assistance when needed and could result to the delay in care and interventions needed for the residents' safety. This deficient practice had the potential to cause Resident 2 the feeling of neglect, affecting psychosocial well-being and the risk of developing tooth decay and infection. Findings: 1). During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses of muscle weakness and hypertension (high blood pressure). During a review of Resident 2 ' s History & Physical (H&P) dated 1/6/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 4/19/2025, the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision for eating, and upper body dressing. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) for oral hygiene, shower/bath, upper body dressing, and personal hygiene. The MDS indicated Resident 2 was dependent (helper does all the effort and resident does none of the effort to complete activity) with toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 2 required maximal assistance with rolling left to right, and dependent with sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and for tub/shower transfer. The MDS indicated Resident 2 was always incontinent of bowel. The MDS indicated Resident 2 was at risk of developing pressure ulcers/injuries and had pressure ulcer/injury, scar over prominence or a non-removable dressing. During a review of Resident 2 ' s Care Plan titled Activities of Daily Living (ADL) Care Deficit dated 1/22/2018, the care plan indicated to assist Resident 1 with grooming and to place call light within reach. During a concurrent observation and interview on 5/21/2025 at 12:49 p.m. with Resident 2 and Certified Nurse Assistant 1 (CNA 1), Resident 2 stated he could not see the call light. Resident 2 sated it was frustrating not having the call light because when he needed someone, he could not get a hold of the staff. Resident 2 stated he did not remember the last time he received oral care. Resident 2 stated he did not have a toothbrush or toothpaste. CNA 1 stated Resident 2 could not reach the call light because he had a contracture on left arm and Resident 2 was facing away from the call light. CNA 1 stated the call light should have been placed in front of him so he can see and reach it (call light). CNA 1 stated that not having the call light at reach could lead to the resident ' s feelings of neglect. CNA 1 stated she should ensure the call light was placed within Resident 1 ' s reach. CNA 1 stated Resident 1 could fall, develop skin break down or worsen pressure on ulcers if they could not call for assistance when they needed to. CNA 1 stated she have not done Resident 1 ' s oral care today because Resident 1 was just transferred yesterday from another room. CNA 1 stated Resident 1 already had breakfast and lunch for the day and she (CNA) was supposed to perform oral care after each meal. CNA 1 stated not performing oral care could lead to infections and tooth decay. 2). During a review of Resident 3 ' sAdmission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses of hemiplegia (condition causing paralysis on one side of the body, affecting either the right or left side, due to damage to the brain or spinal cord) affecting left non-dominant side and hypertension (high blood pressure). During a review of Resident 3 ' s H&P dated 8/8/2024, H&P indicated Resident 3 did not have the capacity to understand and make decisions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 was rarely able to make self be understood by others and sometimes was understood by others. The MDS indicated Resident 3 was dependent (helper does all the effort and resident does none of the effort to complete activity) with oral hygiene, toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 3 was dependent with rolling left to right, chair/bed-to-chair transfer, and for tub/shower transfer. The MDS indicated Resident 3 was always incontinent of urine and bowel. The MDS indicated Resident 3 was at risk of developing pressure ulcers/injuries and had pressure ulcer/injury, scar over prominence or a non-removable dressing. During a review of Resident 3 ' s Care Plan titled Resident has Self-Care Deficits Dependent ADLs and Needs dated 8/17/2022, the care plan indicated to assist Resident 1 with ADLs as needed and to place call light within reach. During a concurrent observation and interview on 5/21/2025 at 1:18 p.m. with Resident 3 and Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 3 could not reach the call light because it was hanging off the bed. LVN 3 stated the call light should always be within reach. LVN 1 stated Resident 3 was contracted from the left side and could not use the call light unless it was next to him. LVN 1 stated not having the call light at reach could cause delays in care and the staff wouldn ' t know if the resident needed help. During a review of the facility ' s policy and procedure (P&P) titled Call lights undated, the P&P indicated the policy ' s purpose was to assure residents receive prompt assistance. The P&P indicated all staff should know how to place the call light for residents. The P&P indicated nursing should ensure that the call lights are placed within residents ' reach when in their room. During a review of the facility ' s P&P titled ADL, supporting dated September 2012, the P&P indicated residents who are unable to carry out activities of daily living independently should receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview, and record review, the facility failed to ensure that one Registered Nurse had the specific competencies, and skill sets necessary to assess a newly admitted resident for one of three sampled residents (Resident 1 and Resident 2). This deficient practice led to Resident 1 to received unnecessary medications and delayed wound treatment. Findings: During a review of Resident 1 ' s General Acute Care Hospital (GACH) Flowsheet Print Request dated 4/4/2025, the record indicated Seroquel 12.5 milligrams ([mg] unit of measurement), 0.5 tablets twice a day. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities) unspecified psychosis (psychotic symptoms like delusions [false belief that a person firmly holds onto, even when there's evidence to the contrary] or hallucinations [false perception of objects or events involving the senses] but they don't fit neatly into a more specific psychotic disorder diagnosis). During a review of Resident 1 ' s History & Physical (H&P) dated 4/4/2025, H&P indicated Resident 1 had the capacity to understand and make decisions and his rehabilitation potential was good. During a review of Resident 1 ' s Order Details dated 4/5/2025, the order indicated Seroquel oral tablet 12.5 mg, give via G-tube (a soft, flexible tube surgically inserted through the belly into the stomach) two times a day for bipolar disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities and tally hash-marks for Seroquel use. During a review of Resident 1 ' s Order Details dated 4/5/2025, the order indicated to monitor for potential side effects anti-psychotic Seroquel, sedation, drowsiness, dry mouth, constipation, shuffling gait, drooling, weight gain, photosensitivity, postural hypertension, urinary retention, blurred vision. Of special [NAME], traditive dyskinesia, seizure disorder, glaucoma, chronic constipation, diabetes, skin pigmentation and jaundice. During a review of Resident 1 ' s Order Details dated 4/10/2025, the order details indicated to monitor episodes of bipolar disorder M/B uncontrollable extreme mood swings causing anger interfering with daily living activities and tally by hashmarks for Seroquel use every shift. During a review of Resident ' s Psychiatric Evaluation dated 4/11/2025, evaluation indicated Resident was on psychotropic medication and was being seen for psychiatric evaluation and medication management. Evaluation indicated staff reported the patient was cooperative and compliant with care. The evaluation indicated Resident 1 denied any psychiatric complaints. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 did not exhibited physical behavioral symptoms directed to others. The MDS indicated there were no verbal behavioral symptoms directed to others. The MDS indicated there were no other be behavioral symptoms directed towards others. The MDS indicated Resident 1 required supervision for eating, and upper body dressing. The MDS indicated Resident 1 was dependent (helper does all the effort and resident does none of the effort to complete activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and dependent for tub/shower transfer. The MDS indicated Resident 1 was always continent. The MDS indicated Resident 1 had active diagnosis of depression and bipolar disorder. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries and did not have any pressure ulcers. The MDS indicated Resident 1 was on antipsychotic (medications used to treat mental health conditions characterized by psychosis [mental health condition characterized by a loss of touch with reality], such as schizophrenia and bipolar [mental health condition characterized by extreme mood swings between periods of high energy, elevated mood, and low mood, loss of interest, and fatigue] disorder) medications. During a review of Resident 1 ' s Care Plan titled Seroquel resident has bipolar disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily livings activities dated 4/30/2025, the care plan indicated to notify physician if behavior interferes with functioning, monitor and record episodes per policy. During a review of Resident 1 ' s Admission Reassessment dated [DATE]; reassessment indicated Resident 1 had a sacrococcygeal (relating to the area where the lower hip bones meet and the tailbone) unstageable (a type of pressure ulcer where the extent of tissue damage cannot be determined because the wound bed is obscured by slough [yellow or white, often moist, tissue that is dead or damaged within a wound] or eschar [hick, leathery layer of dead tissue that forms over a wound]) pressure ulcer measuring 21.1 centimeters ([cm] unit of measure). During an interview on 5/21/2025 at 9:19 a.m. with Family Member 1 (FM 1), FM 1 stated she was worried about Resident 1 being overmedicated because he was very sleepy to do his therapy and instead of improving, he was getting worse. FM 1 stated Resident 1 was admitted to the hospital with a pressure ulcer on 5/12/2025. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/21/2025 at 2:20 pm. with Treatment Nurse (TN), Resident 1 ' s Admission assessment dated [DATE], Resident 1 ' s Treatment Administration Record dated May 2025 and Resident 1 ' s Skin Admission Reassessment dated [DATE]. TN stated that the record indicated Resident was admitted on [DATE] and the admission assessment did not indicate Resident 1 had a pressure ulcer on his sacrum. TN stated on every admission the skin assessment should be done immediately to provide treatment and prevent worsening of skin injury. TN stated she did the admission reassessment on 5/2/2025 when she was told she had a new admission, and she recorded as a deep purple area measuring about 21.1 cm all around. TN stated it could take 24-48 hours for a deep tissue injury to develop if the resident was not being turned. TN stated she entered the treatment order on 5/2/2025 and the treatment started on 5/3/2025 three days after admission. TN stated she did not remember the reason she did not call FM 1 to inform of Resident 1 ' s pressure ulcer but she should have. During a concurrent interview and record review on 5/22/2025 at 2:41 pm. with Assistant Director of Nursing (ADON), ADON stated she did not know where the admitting nurse on 4/4/2025 got the bipolar diagnosis for Resident 1 and she did not know why the order for Seroquel ' s dose was higher than the discharge Seroquel orders from GACH dated 4/4/2025 but the registered nurse should have been more cautious when transcribing diagnosis and medication for Resident 1. ADON stated the admission notes on 4/30/2025 did not indicate there was a pressure ulcer in the sacrococcygeal. DON stated there was a note from the CNA on 5/1/2025 of skin injury but it was not assessed by wound care nurse until 5/2/2025 and treatment did not start until 5/3/2025. ADON stated admitting nurse should had done a better assessment upon admitting preventing delay in treatment. During a concurrent phone interview and record review on 5/28/2025 at 12:33 p.m. with Medical Doctor (MD), Resident 1 ' s General Acute Care Hospital (GACH) Flowsheet Print Request dated 4/4/2025, the record indicated Seroquel 12.5 mg, 0.5 tablets twice a day. MD stated the record indicated half a tablet twice a day and he had not entered the order, but he signed for the order. MD stated the person who entered the order might have made a mistake entering the order. MD stated Resident 1 did not have bipolar disorder and he did not know how the diagnosis was entered in the system. MD stated he review the chart from GACH 1, and he could not find a diagnosis of bipolar disorder. MD stated it was not good for the elderly to take Seroquel because it could lead to confusion and sleepiness and that was bad for the resident ' s recovery. During a review of the facility ' s Policies and Procedures (P&P) titled Job Description, dated January 27, 2022, the P&P indicated Registered Nurse was responsible for assuring physicians' orders are followed and quality care is provided on each shift in a skilled care facility. The P&P indicated essential duties and responsibilities included assessment of new admissions, skin care and/or changes of skin condition. During a review of the facility ' s P&P titled Admission Notes, dated September 2012, the P&P indicated when a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place general condition of the resident upon admission.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and records review, the facility failed to ensure, 1 of 3 residents (Resident 1): 1). Had documented assessment to support the diagnosis of bipolar disorder in the resident ' s clinical records. 2). Had an adequate indication for the use of Seroquel (antipsychotic medications that treat several kinds of mental health condition including schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions)] and bipolar disorder [a mental health condition characterized by extreme shifts in mood, energy, and behavior]) for 1 of 3 residents (Resident 1). This failure had the potential that resident received unnecessary drug, causing the resident to suffer altered mental state, affecting his participation with the rehabilitation services and the potential to cause adverse reactions from the medications. This failure had the potential to affect the resident in maintaining the highest practicable physical, mental and psychosocial well-being. Findings: During a review of Resident 1 ' s General Acute Care Hospital (GACH 1) History and Physical Report (HPR) dated 3/9/2025, the HPR indicated Resident 1 had a past medical history (PMH) of hypertension (high blood pressure). During a review of Resident 1 ' s GACH 1 Medication orders dated 3/25/2025, the order indicated Seroquel 12.5 milligrams (mg- a unit of measurement), 0.5 tablet via gastric tube gastric tube ([G-tube] a soft, flexible tube surgically inserted into the stomach for administration of medications and nutrition) once (one time) to treat acute agitation/ delirium. 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 major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities) and unspecified psychosis (psychotic symptoms like delusions [false belief that a person firmly holds onto, even when there's evidence to the contrary] or hallucinations [false perception of objects or events involving the senses]). During a review of Resident 1 ' s History & Physical (H&P) dated 4/4/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions and his rehabilitation potential was good. During a review of Resident 1 ' s GACH 1 Flowsheet Print Request for 4/3/2025 to 4/5/2025, the GACH 1 flowsheet indicated Seroquel 12.5 mg., 0.5 tablet twice a day, with a stop date of 5/30/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s facility Order Details dated 4/5/2025, the order indicated Seroquel oral tablet 12.5 mg, give via gastrostomy tube (G-tube- a surgical opening in the stomach for nutrition and medication administration), two times a day for bipolar disorder manifested by (M/B) uncontrollable extreme mood swings causing anger interfering with daily living activities. During a review of Resident 1 ' s facility Order Details dated 4/10/2025, the order details indicated to monitor episodes of bipolar disorder M/B uncontrollable, extreme mood swings causing anger, interfering with daily living activities. The order details indicated to tally behaviors by hashmarks for Seroquel use every shift. During a review of Resident 1 ' s MAR from 4/11/2025 to 4/24/2025, the monitoring of bipolar disorder behaviors did not indicate the resident had manifested any of the behaviors. During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 did not exhibit physical behavioral symptoms directed to others. The MDS indicated there were no verbal behavioral symptoms directed to others. The MDS indicated there were no other behavioral symptoms directed towards others. The MDS indicated Resident 1 required supervision for eating, and upper body dressing. The MDS indicated Resident 1 was dependent (helper does all the effort and resident does none of the effort to complete activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and dependent for tub/shower transfer. The MDS indicated Resident 1 was always continent. The MDS indicated Resident 1 had active diagnosis of depression and bipolar disorder. The MDS indicated Resident 1 was on antipsychotic medications. During a review of Resident 1 ' s psychiatric evaluation dated 4/11/2025, the notes indicated the psychiatrist was asked to see Resident 1 for psychiatric evaluation and medication management. The evaluation indicated Resident 1 was currently on Seroquel. The evaluation indicated staff reported Resident 1 was cooperative and compliant with care. The evaluation indicated Resident 1 denied any psychiatric complaints, anxiety, depression, obsessive compulsive disorder (mental health condition characterized by persistent, intrusive thoughts [obsessions] and/or repetitive behaviors [compulsions]), panic attack, psychosis, suicidal ideation, or violent thoughts. During a review of Resident 1 ' s clinical records, the record indicated the resident had started Physical Therapy (PT) and Occupational Therapy (OT) on 4/7/2025 and Speech Therapy (ST) started on 4/9/2025. During an interview on 5/21/2025 at 9:19 a.m. with Family Member 1 (FM 1), FM 1 stated she was worried about Resident 1 being overmedicated because he was very sleepy to do his therapy and instead of improving, he was getting worse. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2025 at 12:44 p.m. with Director of Rehabilitation (DOR), Resident 1 ' s Occupational Therapy Evaluation and Plan of Treatment dated 4/7/2025 was reviewed. The DOR stated the note indicated Resident 1 was able to follow two step commands. The DOR stated Resident 1 used to follow commands but during the later therapies, Resident 1 was not following commands anymore. During a phone interview on 5/22/2025 at 1:00 p.m. with OT, the OT stated Resident 1 was able to follow two step commands upon initial assessment. The OT stated, as time went on, Resident 1displayed periods of confusion with difficulty answering questions, and he required cues to communicate. The OT stated he did not remember if he had reported to nursing but the DOR was aware. The OT stated that if a resident is too lethargic and unable to participate in rehabilitation, it interferes with improvement and recovery. During a phone interview on 5/22/2025 at 2:18 p.m. with ST, the ST stated Resident 1 was very lethargic and was not able to participate on his initial visit (date not specified). During a phone interview on 5/27/2025 at 2:40 pm. with Registered Nurse (RN 1), RN 1 stated Resident 1 was talking okay with moments of confusion upon admission. RN 1 stated Resident 1 was able to answer most of the questions. RN 1 stated she entered the order for Seroquel, but did not notice that the order was only for acute agitation. RN 1 stated she did not remember the indication on the discharge orders for Seroquel. RN 1 stated she believed the Seroquel was ordered for mood swings or bipolar. RN 1 stated she wrote down the list of diagnosis and orders but was needed to be verified from the doctor. RN 1 stated Resident 1 had no episodes of trying to get out of bed and have not attempted to pull out G-tube on admission. RN 1 stated, when she returned to work (date not specified) after few days, she received a report that Resident 1 tried to get out of bed. RN 1 stated she did not know if there was a note indicating Resident 1 ' s behavioral issues. RN 1 stated some side effects of Seroquel includes irritability, mood swings, lethargy, drowsiness and speech problems. RN 1 stated that given the side effects of medication (Seroquel) Resident 1 received, the medication could interfere with Resident 1 ' s rehabilitation and recovery. During a concurrent phone interview and record review on 5/28/2025 at 12:33 p.m. with the Medical Doctor (MD), Resident 1 ' s GACH 1 Flowsheet Print Request dated 4/3/2025 to 4/5/2025, was reviewed. The MD stated the GACH 1 flowsheet indicated Resident 1 should receive half tablet of Seroquel 12.5.mg, twice a day. The MD stated he did not enter the order but signed it. The MD stated he reviewed Resident 1 ' s chart from GACH 1 and could not find a diagnosis of bipolar disorder. The MD stated Resident 1 did not have bipolar disorder, and he did not know how the diagnosis was entered in the system. The MD stated Resident 1 did not demonstrate mania, or delirium when he saw him on 4/4/2025. The MD stated he had a full conversation with Resident 1 and determined that day (4/4/2025), Resident 1 was able to make decisions and can be self-responsible. The MD stated he wanted to continue the medication orders from GACH 1 because he is not a psychiatrist. The MD stated the nurse who entered the order might have mistakenly entered the order. The MD stated Resident 1's mental status was better on his first visit than his current mental status (5/28/2025). The MD stated Seroquel is not good for the elderly population because it could lead to confusion and sleepiness and was bad for the resident ' s recovery. (continued on next page)

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Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, the P&P indicated psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which included but was not limited to antipsychotics. The P&P indicated facility should not use psychotropic medications to address behaviors without first determining if there was a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. The P&P indicated all medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect.