

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Longwood Manor Conv.Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Novolin insulin (medication used to control blood sugar levels in residents with diabetes [DM- a disorder characterized by difficulty in blood sugar control and poor wound healing]) was stored in the medication cart with the correct label (information including resident name, medication name, dosage and directions of the medication) for one of three sampled residents (Resident 1). This deficient practice had the potential for medication administration errors that could lead to hypoglycemia (low blood sugar), altered mental status and hospitalization 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 DM and hypertension (HTN- high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 1/18/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Physician's Order dated 4/22/2025, the order indicated to administer Novolin 70/30 subcutaneous (SQ- method of administering medication by injecting into the fatty tissue layer beneath the skin) suspension 100 units/milliliter (u/ml- unit of measurement), inject 40 u SQ one time a day and inject 20 U SQ at bedtime for DM. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/26/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required setup or clean-up assistance for eating. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for oral hygiene, upper body dressing and bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 1's Physician's Order dated 7/13/2025, the order indicated to administer Novolin 70/30 SQ suspension (70/30) 100 u/ml, inject 20 u SQ every 12 hours for DM. During a concurrent observation and interview on 7/16/2025 at 3:37 p.m., with Licensed Vocational Nurse (LVN) 1, Medication Cart 2 was observed with Resident 1's Novolin labeled with Resident 1's name and indications to administer Humulin (Novolin) 70-30 Kwikpen (prefilled insulin pen) 40 u SQ one time a day and 20 U at bedtime for DM. LVN 1 stated the order was discontinued by the physician on 7/13/2025. LVN 1 stated the nurse should have discarded the medication and called the pharmacy for the new prescription or asked the pharmacy for a new label with the new prescription for the resident. LVN 1 stated keeping the medication with the old label could lead to medication administration errors that could cause hypoglycemia, hospitalization and coma (state of prolonged unconsciousness, like a very deep sleep, where a person is alive but unresponsive to the world around them) for the resident. During an interview on 7/22/2025 with the Pharmacist (Pharm 1), Pharm 1 indicated Resident 1's order (for Novolin) was changed by the physician on 7/13/2025, to administer Novolin 20 u every 12 hours to the resident. Pharm 1 stated licensed nurses should have notified the pharmacy of the new physician's order on 7/13/2025. Pharm 1 stated, a new medication request was submitted to pharmacy and sent on 7/16/2025. Pharm 1 also stated, licensed nurse(s) should have put a direction change on the medication to ensure there were no errors. During a review of the facility's Policy and Procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy Medication Labels dated 4/2014, the P&P indicated medications are labeled in accordance with facility requirements and state and federal laws. The P&P indicated only the dispensing pharmacy can modify or change prescription labels. The P&P also indicated if the physician's directions for use change or the label is inaccurate, the nurse may place a change of order label on the container indicating there was a change in direction for use, taking care not to cover important label information. When such a label appears on the container, the medication nurse checks the resident Medication Administration Record (MAR) or the physician's order for current information. During a review of the facility's P&P titled, Medication Storage in the Facility dated 1/2025, the P&P indicated, outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.</p>		