

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and record review, facility did not meet professional standards of quality, by failing to ensure administered medications were documented timely for one of three residents (Resident 3). This deficient practice had the potential to lead to medication errors, like double medication administration, affecting resident's health. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included hypertension (high blood pressure), dementia (loss of memory, thinking, and reasoning skills), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side. During a review of Resident 3's History and Physical (H&P) dated 8/18/2025, the H&P indicated Resident 3 was able to make decisions for activities of daily living. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 5/21/2026, the MDS indicated Resident 3 was rarely/never understood and sometimes understood others. Resident 3 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing, putting on/taking off footwear, personal hygiene, with rolling from left to right, for chair/bed to chair transfer, and tub/shower transfer. During a review of Resident 3's care plan titled, Resident is at risk for cardiac distress related to hypertension, hyperlipidemia (high cholesterol), coronary (heart) artery (blood vessels) disease with cerebrovascular accident (CVA, stroke), initiated 7/22/2019, the care plan interventions indicated to administer medications as ordered. During a review of Resident 3's care plan titled, Dementia behavioral or psychological symptoms of dementia, initiated 7/22/2019, the care plan intervention indicated to administer medication as ordered. During a review of Resident 3's care plan titled, Resident has potential for alteration in comfort/pain related to polyneuropathy (pain in hands and feet) initiated 7/22/2019, the care plan intervention indicated to administer medication as ordered. During a review of Resident 3's Order Summary Report dated 8/8/2025, the orders indicated the following: 1. Amlodipine besylate oral tablet 5 milligram (mg, unit of measurement), one (1) tablet via gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), one time a day, hold if systolic blood pressure (top number in blood pressure reading) is less than 100. 2. Gabapentin oral capsule 100 mg, 1 capsule via G-Tube three times a day for neuropathic (nerve) pain. 3. Namenda oral tablet 10 mg, 1 tablet via G-Tube two times a day for dementia. 4. Plavix oral tablet 75 mg, 1 tablet via G-Tube, one time a day for CVA prophylaxis (preventive treatment). During an interview on 7/28/2026 at 3:49 p.m., with LVN 1, LVN 1 stated on 7/28/2026, she arrived for work at the facility at 8:00 a.m., instead of 7:00 a.m. LVN 1 stated the covering nurse (not identified) did not give the residents' morning medications. During a concurrent interview and record review on 7/29/2026 at (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055753	Facility ID: 055753 If continuation sheet Page 1 of 2

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:43 p.m., with LVN 1, Resident 3's Medication Admin Audit Report, dated 7/28/2026 was reviewed. The audit report for 7/28/2026 indicated the following:Amlodipine besylate scheduled for 9:00 a.m. - was administered at 8:52 a.m., documented at 11:53 a.m. Plavix scheduled for 9:00 a.m. - was administered at 9:53 a.m.- documented at 11:53 a.m.Namenda scheduled for 9:00 a.m.- was administered at 9:53 a.m.- documented at 11:54 a.m.Gabapentin scheduled for 9:00 a.m. - was administered at 9:53 a.m.- documented at 11:54 a.m. LVN 1 stated the medication documentations when administered were late and should have been documented right after it was given to prevent medication errors, such as forgetting to document which medications were given, omitting the medication or giving the medication twice. During a review of the facility's Policy and Procedures (P&P) titled, Medication Administration - General Guidelines, dated 10/2017, the P&P indicated the individual who administered the medication, records the administration on the resident's Medication Administration Record (MAR) directly after the medication is given.		