STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555273	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Manor Conv Hospital	837 W. Manchester Ave. Los Angeles, CA 90044

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1), did not wait 3 hours to get assistance from the Certified Nurse Assistant (CNA) 3 to get out of bed to the chair. This deficient practice had the potential to affect the resident ' s self-esteem, self-worth, and psychosocial well-being. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included cerebral cyst (brain lesions), hemiplegia unspecified affecting left side (total paralysis of the arm, leg, and trunk on the same side of the body), and weakness (lacking body strength.) During a review of Residents 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/30/2024, the MDS indicated Resident 1 had the ability to make self-understood and ability to understand others. The MDS indicated Resident 1 wasdependent with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). The MDS indicated Resident 1 preferred to be with a group of people and had participated in activities. During a review of Resident 1 ' s care plan for ADLs dated 3/16/2023, the care plan indicated Resident 1 had an ADL self-care performance deficit related to disease process, neurological and musculoskeletal impairment. The interventions indicated Resident 1 was totally dependent in staff assistance with ADL activities. During a review of Resident 1 ' s physician orders dated 3/27/2023, the physician orders indicated Resident 1 may use geri chair while out of bed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 9:15 a.m. with Resident 1 in Resident 1 ' s room, Resident 1 stated I depend on the nurses to help me get up from bed. Resident 1 stated I like to get up in the morning to go to activities. Resident 1 stated, last Sunday, 2/23/2025, Resident 1 asked CNA 3 to help her get up from bed after breakfast around 11:00 a.m. Resident 1 stated, she waited for CNA 3 on bed until 2:00 p.m. Resident 1 stated CNA 3 she felt anxious and sad because she felt CNA 3 did not want to help her (Resident 1). During an interview on 2/25/2025 at 10:25 a.m. with CNA 1, CNA 1stated, last 2/23/2025, Resident 1 told her (CNA 1) that she needed help to get up on chair as CNA 3 took a long time. CNA 1 stated she informed CNA 3 regarding Resident 1 wanted to get up. CNA 1 stated that CNA3 told her she would get Resident 1 up later (time not indicated). CNA 1 stated she reported Resident 1 ' s request to Registered Nurse Supervisor (RN) around 2:00 p.m. CNA 1 stated it was not acceptable to let Resident 1 wait to be gotten up on the chair for a long time. CNA 1 stated Resident 1 usually likes to get up in the morning. CNA 1 stated Resident 1 felt sad. CNA 1 stated Resident 1 had the right to get up on the time she chose. During an interview on 2/25/2025 at 2:36 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 2/23/2025 at 10:30 a.m., Resident 1 asked for CNA 3 as she wanted to get out of bed. LVN 1 stated CNA 3 responded she would get Resident 1 up after her lunch break. LVN 1 stated, Resident 1 was up on the chair after the lunch trays were passed, around 2 p.m. LVN 1 stated ignoring Resident 1 ' s wishes can cause Resident 1 anxiety and sadness. LVN 1 stated it was Resident 1 ' s right to get up the time she likes. During an interview on 2/25/2025 at 3:41 p.m. with the Director of Nursing (DON), the DON stated it was not acceptable for Resident 1 to wait 3 hours for her to get out of bed. The DON stated this could cause Resident 1 to feel neglected and depressed. During an interview on 2/26/2025 at 1:10 p.m. with CNA 3, CNA 3 stated it was not acceptable for Resident 1 to wait long to get up on the chair. CNA 3 stated, it could cause Resident 1 to feel frustrated. During a review of the facility ' s policy and procedures (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated appropriate care and services should be provided to residents who are unable to carry out independently, including mobility (transfer and ambulation, including walking).

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to trim, three of six sampled Residents' (Resident 2, Resident 5 and Resident 6) long and dirty fingernails. This deficient practiced placed Resident 2, Resident 5 and Resident 6 at risk for infections, injury and bacterial growth under the fingernails. Findings: a). During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis that included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and other seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 2 ' s care plan titled, The resident has limited physical mobility related to stroke, dated, 10/11/2024, the care plan indicated to provide Resident 2 supportive care. During a review of Residents 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/26/2025, the MDS indicated Resident 1 had the ability to make self-understood and ability to understand others. The MDS indicated Resident 2 required substantial to maximum assistance with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) transfer and bed mobility. During a concurrent observation and interview on 2/26/2025 at 9:30 a.m. with Resident 2, Resident 2 bilateral hands fingernails were long and uncleaned. Resident 2 stated the nurse did not cut his fingernails this month (February). During an interview on 2/26/2025 at 12:15 p.m. with CNA 5, CNA 5 stated I check the fingernails every other day for dirtiness and length. CNA 5 stated I have not checked Resident 2 ' s fingernails today. CNA 5 stated I will trim it today. CNA 5 stated the importance of trimming the fingernails is to prevent any skin infection or skin breakdown. b). During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included heart failure (occurs when the heart muscle doesn't pump blood as well as it should), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mild cognitive impairment (decline in cognitive abilities, such as memory, attention, and language, that is not severe enough to interfere with daily life.) During a review of Resident 5 ' s care plan titled, The resident has an ADL (Activities of Daily Living) self-Care performance deficit related to musculoskeletal impairment, dated, 2/4/2022, the interventions indicated to anticipate Resident 5 ' s needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Residents 5 ' s MDS, dated [DATE], the MDS indicated Resident 1 had the ability to make self-understood and ability to understand others. The MDS indicated Resident 5 required dependent assistance with ADLs. During a concurrent observation and interview on 2/26/2025 at 10:40 a.m. with Resident 5, Resident 5 bilateral hands fingernails were long and uncleaned. Resident 5 stated her fingernail were long and wanted the nurses to cut her nails so the dirt could not get inside. c). During a review of Resident 6 ' s Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis that included dementia (a progressive state of decline in mental abilities), atrial fibrillation (heart rhythm disorder), and muscle weakness (decreased ability of muscles to contract and produce force). During a review of Resident 6 ' s care plan titled, Self-Care Deficit: Bathing, dressing, feeding, hygiene and grooming, dated, 2/19/2025, the interventions indicated to provide Resident 6 with assistance with ADLs as needed. During a review of Residents 6 ' s MDS, dated [DATE], the MDS indicated Resident 1 had the ability to make self-understood and ability to understand others. The MDS indicated Resident 6 was dependent with ADLs. During a concurrent observation and interview on 2/26/2025 at 10:45 a.m. with Certified Nurse Assistant(CNA) 4, CNA 4 was combing Resident 6 ' s hair. Resident 6 ' s bilateral hand fingernails were long and uncleaned. CNA 4 stated I think Resident 6 was admitted two weeks ago, and I had not seen her nails. CNA 4 stated yes the nails are long, and it needed to be trimmed. CNA 4 stated Resident 6 ' s fingernails were long and uncleaned. CNA 4 stated it was important to trim resident ' s nails short because the germs could get inside their fingernails and cause an infection of the skin. During an interview on 2/26/2025 at 2:20 p.m. with the Director of Nursing (DON), the DON stated CNAs should assess residents ' nails every shower day. The DON stated it was CNAs responsibility to trim residents ' fingernails. The DON stated fingernails should be kept short and clean for proper hygiene and avoid bacteria growing under the fingernails, causing skin infections. During a review of the facility ' s policy and procedures (P&P) titled ,Assisting the nurse in examine and assessing the resident, dated 9/2010 the P&P indicated grooming and dressing as nurse provide the resident with personal care needs, nurse should note: Assistance needed with bathing, hair and nail care. During a review of the facility ' s policy and procedures (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated appropriate care and services should be provided to residents who are unable to carry out independently, including hygiene (grooming).

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to maintain a complete and accurate Activities of Daily Living (ADLs) documentation for two of six sample residents, (Resident 1 and Resident 2). This deficient practice had the potential to cause miscommunication that ADLs were not provided to Resident 1 and Resident 2. Finding: a). 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] with diagnosis including cerebral cyst (brain lesions), hemiplegia unspecified affecting left side (total paralysis of the arm, leg, and trunk on the same side of the body), and weakness (lacking body strength.) During a review of Resident 1's care plan for ADLs dated 3/16/2023, indicated Resident 1 has an ADL self-care performance deficit related to disease process neurological and musculoskeletal impairment. The ADL care plan interventions indicated Resident 1 is totally dependent in staff assistance with ADL activities. During a review of Residents 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/30/2024, the MDS indicated Resident 1 had the ability to make self-understood and ability to understand ot ers. The MDS indicated Resident 1 was dependent with ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 1's ADLs documentation report for 2/2025, the ADL report for personal hygiene, indicated no documentations of ADLs sheets during: 1. Day shift - 7 a.m. to 3 p.m. for 2/2/2025, 2/3/2025, 2/7/2025, 2/8/2025, 2/10/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, 2/19/2025, 2/20/2025, 2/21/2025, 2/22/2025, 2/23/2025 and 2/25/2025. 2. Evening shift - 3 p.m. to 11 p.m. for 2/1/2025, 2/4/2025, 2/10/2025, 2/11/2025, 2/13/2025, 2/14/2025, 2/20/2025 and 2/25/2025. b). During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and other seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness.) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residents 2's MDS dated [DATE], the MDS indicated Resident 2 had the ability to make self-understood and ability to understand others. The MDS indicated Resident 2 required substantial to maximum assistance with ADLs activities, transfer and bed mobility. During a review of Resident 2's ADLs documentation report for 2/2025, the ADL report for personal hygiene, indicated no documentations of ADLs sheets during 1. Day shift - 7 a.m. to 3 p.m. dated for 2/3/2025, 2/5/2025, 2/6/2025, 2/7/2025, 2/8/2025, 2/9/2025, 2/12/20255, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, 2/20/2025, 2/21/2025, 2/22/2025, 2/23/2025, 2/24/2025 and 2/25/2025. 2. Evening shift - 3 p.m. to 11 p.m. dated for 2/3/2025, 2/4/2025, 2/5/2025, 2/6/2025, 2/10/2025, 2/11/2025, 2/15/2025, 2/19/2025 and 2/25/2025. During an interview on 2/25/2025 at 10:55 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated we document the ADLs care provided to the residents in the point click care (PCC- electronic documentation) at the end of the shift. CNA 1 stated the documentation is based on numbers that indicated the level of assistance resident needed. CNA 1 stated documentation of care provided are very important because it will indicate the resident had received ADL care. CNA 1 stated if there was no documentation, it meant the resident did not receive the care during the day or evening shift. During a concurrent interview and record review on 2/25/2025 at 3:41 p.m. with the Director of Nursing (DON), the 2/2025 ADL care records for Resident 1 and Resident 2 were reviewed. The DON verified missing ADL documentations for day and evening shift for the month of February. The DON stated CNAs need to document the ADL care two times a day. The DON stated documentations accounts for all care done for the resident in the shift. The DON stated if not documented, care was not done. During a review of the facility's policy and procedures (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated all services provided to the resident, progress toward the care goals, shall be documented in the resident's medical record. The P&P indicated, documentation in the medical record should be objective, complete, and accurate.