

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

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Manchester Manor Conv Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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 promote the dignified existence and self-determination of 2 of 14 sampled residents (Resident 13 and 14) who required assistance with activities of daily living (ADLs), by failing to answer the resident's call lights in a timely manner. This deficient practice had the potential to result in Resident 13 and 14 feeling of angry for being ignored by nurses and could negatively affect the resident's psychosocial well-being. Findings: During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included acquired absences of left and right leg above the knee (surgical removal of the portion of the leg above the knee), muscle weakness and movement disorder (group of involuntary movements). During a review of Resident 13's History and Physical (H&P) dated 12/21/2024, the H&P indicated Resident 13 had fluctuating mental capacity to understand and make medical decisions. During a review of residents 13's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/12/2025, the MDS indicated Resident 13 has no cognitive (ability to think and reason) impairment. The MDS indicated Resident 13 was dependent on staff for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene and transfers (moving between surfaces to and from bed, chair, and walking). During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted to the facility on [DATE] with a diagnoses including quadriplegia (paralysis that affects all a person's limbs), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition and inactivity), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 14's H&P dated 5/31/2024, the H&P indicated Resident 14 had fluctuating mental capacity to understand and make medical 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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of residents 14's MDS dated [DATE], the MDS indicated Resident 14 had cognitive impairment. The MDS indicated Resident 14 was dependent on staff with ADLs such as dressing, toilet use, personal hygiene and transfers. During an observation on 4/2/2025 at 6:03 a.m., Resident 13 and Resident 14 had their call lights on. Certified Nurse Assistant (CNA) 2 was observed walking by both rooms with the call light on and did not respond or check on what assistance the residents needed. During an observation on 4/2/2025 at 6:15 a.m., Licensed Vocational Nurse (LVN) 5 was observed to answer Resident 13 and Resident 14's call light. During an interview on 4/2/2025 at 6:30 am with CNA 2, CNA 2 stated answering call lights were everyone's responsibility. CNA 2 stated it was important to answer the lights as soon as possible to prevent resident falls and accidents. CNA 2 stated it was not right to ignore Resident 13 and 14's call lights. During an interview on 4/2/2025 at 6:55 a.m. with LVN 5, LVN 5 stated all nurses must answered call lights right away. LVN 5 stated it was not acceptable for Resident 13 and Resident 14 to wait for a nurse for 12 minutes. LVN 5 stated Resident 13 and Resident 14 could feel neglected by nurses. During an interview on 4/2/2025 at 9:21 a.m. with the Director of nursing (DON), the DON stated everybody at the facility could answer the resident's call lights. The DON stated residents should not wait longer than two minutes for call lights to be answered. The DON stated answering call lights in a timely manner was very important for resident's safety. The DON also stated Resident 13 and Resident 14 may feel abandoned and neglected because staff did not answer the call lights on time. During a review of the facility's policy and procedures (P&P) titled Answering Call lights , dated 8/2017 the P&P indicated the purpose of answering call lights is to respond to the resident's request and needs. Resident's call light will be answer as soon as possible.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on observation, interview, and record review, the facility failed to develop a care plan for two of twelve sampled residents (Resident 7 and Resident 9) who were a high risk for elopement (the act of leaving a facility unsupervised and without prior authorization). This deficient practice had a potential to result in unidentified interventions which could lead to Resident 7 and Resident 9 eloping from the facility leading to accidents and death. Findings: a. During a review of Resident 7 ' s Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that is characterized by disturbances in thought) and lack of coordination (difficulty in controlling and coordinating muscle movements). During a review of Resident 7 ' s History and Physical (H&P) dated 3/5/2025, the H&P indicated Resident 7 did not have the mental capacity to understand and make medical decisions. During a review of residents 7 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/15/2025, the MDS indicated Resident 7 had cognitive (ability to think and reason) impairment. The MDS indicated Resident 7 required substantial/maximal assistance (staff does more than half the effort) with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene. The MDS indicated Resident 7 required partial to moderate assistance (staff does less than half the effort) with bed mobility (ability to roll from lying on back to left and right side and return to lying on back in bed) transfers (moving between surfaces to and from bed to chair). During a review of Resident 7 ' s Wandering Risk assessment dated [DATE], the Wandering Risk Assessment indicated Resident 7 had a moderate risk for wandering due to the resident being disoriented and diagnosis of dementia with psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 7 ' s Elopement Risk assessment dated [DATE], the Elopement Risk Assessment indicated Resident 7 was at risk for elopement due to the resident ' s history of elopement or attempted elopement while at home, wandering behavior, and exit seeking behaviors. During a concurrent observation and interview on 4/1/2025 at 12:00 p.m. with Resident 7, Resident 7 was observed walking by herself toward her room. Resident 7 stated I have schizophrenia, and my mind was telling me to go to the bank to get some money and pay for this place. Resident 7 stated, she left the facility (date unknown) through the front door and a staff member brought her back inside. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 9 ' s Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder, and muscle weakness. During a review of Resident 9 ' s H&P dated 3/27/2025, the H&P indicated Resident 9 did not have the mental capacity to understand and make medical decisions. During a review of residents 9 ' s MDS dated [DATE], the MDS indicated Resident 9 makes self-understood and had the ability to understand others. The MDS indicated Resident 9 required substantial/maximal assistance with ADLs such as dressing, toilet use and personal hygiene. The MDS indicated Resident 9 required partial to moderate assistance for bed mobility and transfers. During a review of Resident 9 ' s Elopement Risk assessment dated [DATE], the Elopement Risk Assessment indicated Resident 9 was at risk for elopement due to the resident ' s wandering behavior During a review of Resident 9 ' s Wandering Risk assessment dated [DATE], the Wandering Risk Assessment indicated Resident 9 had moderate risk for wandering and exhibited/expressed fear and/or anxiety. During an interview on 4/1/2025 at 4:20 p.m. with the Director of Nursing (DON), the DON stated Resident 7 and Resident 9 should have a care plan to address the resident ' s risk for elopement, however the nurses failed to develop a care plan for residents. The DON stated it was important to develop a care plan, that included interventions to monitor Resident 7 and Resident 9 ' s safety. The DON stated nurses failing to develop a care plan, placed Resident 7 and Resident 9 be at risk of injury, accidents, and actual elopement. During a review of the facility ' s policy and procedures (P&P) titled, Care Plan, Comprehensive Person-Centered dated 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45657 Based on observation, interview and record review, the facility failed to ensure two of four exit doors were locked and had alarms turned on. This deficient practice had the potential to result in resident's eloping (the act of leaving the facility unsupervised and without prior authorization) leading to accidents and death. Findings: During a concurrent observation and interview on 4/2/2025 at 5:37 a.m., Certified Nurse Assistant (CNA) 1 was observed pushing the front door open without using the door key. The front door was unlocked from the inside and did not alarm when the door was opened. CNA 1 stated she did not know why the front door alarm was off. During a subsequent interview on 4/2/2025 at 6:20 a.m. with CNA 1, CNA 1 stated the front door alarm should always be on so residents were not able to elope. CNA 1 stated, without the door alarm being activated, nurses would not be aware if Residents were attempting to leave the facility unsupervised. During an observation on 4/2/2025 at 6:45 a.m. at the back door next to the laundry room, CNA 2 was observed taking out containers of dirty linen. CNA 2 was able to exit through the back door without a key and the alarm did not sound. During an interview on 4/2/2025 at 9:12 a.m., with the Laundry Assistant (LA), LA stated the back door must always be locked and with the alarm on. LA stated she unlocked the door for the CNAs that morning and the key for the door was at the laundry room. LA stated, she should not have kept the door unlocked or stayed to open the door for the CNA) and not leave the unlocked door unmonitored). LA stated it was important to lock the door, to prevent residents from eloping and for the resident's safety. During an interview on 4/2/2025 at 9:20 a.m. with the Director of nursing (DON), The DON stated the facility staff had being instructed to use the key to let people in and out of the facility. The DON stated nurses must lock the front door and always turn the alarm on. The DON stated the alarms must be on as precautions for Residents who were at high risk of elopement. The DON stated if nurses failed to lock the doors, there was a potential for residents to elope and could lead to accidents or getting lost. During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Residents dated 7/2017, the P&P indicated the facility strives to make the environment as free from accidents hazard as possible. The P&P indicated, Resident safety, supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated individualized, resident centered approach to safety addresses safety and accidents hazards for individual residents.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet resident's needs for three of three sampled residents (Residents 1, 2 and 3) when Licensed Nurses: 1. Failed to administer medications within one hour of scheduled time for Residents 1, 2 and 3. 2. Failed to ensure the Catapres transdermal patch (medication applied to the skin to treat hypertension [high blood pressure]) was available and administered for Resident 1 as ordered by the physician. 3. Did not monitor Resident 1, 2 and 3 for side effects and vital lights as ordered by the physician. 4. Failed to document medication administration for Residents 1, 2 and 3. These failures resulted in Resident 1 feeling scared and sad. These failures had the potential to result in adverse side effects, medication errors, worsening of symptoms and hospitalization for Residents 1, 2 and 2. 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]. The Admission Record indicated Resident 1 had a history of paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and Hypertension. During a review of Resident 1's History and Physical (H&P) dated 9/24/2024, the H&P indicated Resident 1 was able to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/9/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment. During a review of Resident 1's Physician Orders dated 4/3/2025, the Physician Orders indicated the following: -Administer Hydralazine (medication to control blood pressure) Oral Tablet 25 milligrams (mg- unit of measurement used for medication dosage or amount) by mouth three times a day for hypertension. -Monitor for rhabdomyolysis (breakdown of muscle tissue) such as muscle weakness, fatigue and tea-colored urine related to use of atorvastatin (Lipitor - medication to treat hyperlipidemia) every shift. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor vital signs every shift. -Apply Catapres Transdermal Patch every Friday for hypertension. -Give one tablet Atenolol (medication to control blood pressure) Oral Tablet 25 mg. by mouth one time a day related to hypertension. During a review of Resident 1's Medication Administration Record (MAR) dated 3/2025, the MAR indicated the following for Resident 1: -Hydralazine administration on 3/4/2025 at 5:00 p.m. and 3/7/2025 at 5:00 p.m. were blank -Monitoring for rhabdomyolysis on 3/4/2025 evening shift (3:00 p.m.-1100 p.m.), 3/5/2025 night shift (11:00 p.m.-7:00 a.m.), and 3/7/2025 evening shift were blank. -Monitoring for vital signs on 3/1/2025 night shift, 3/4/2025 evening shift, 3/5/2025 night shift, 3/7/2025 evening shift, and 3/12/2025 night shift were blank. -Catapres Transdermal Patch was Held on 3/14/2025 (Friday) at 9:00 a.m. and indicated to see progress notes. During a review of Resident 1's Progress Note, dated 3/14/2025, the Progress Note indicated Resident 1's Catapres Transdermal Patch was not available. The Progress Note did not indicate any further action. During an interview on 3/27/2025 at 10:35 a.m. with Resident 1, Resident 1 stated his prescribed Catapres Transdermal Patch was not available on 3/14/2025. Resident 1 stated he felt scared and sad about not receiving his prescribed medication. During a concurrent interview and record review on 3/27/2025 at 3:40 p.m. with the Director of Nursing (DON), Resident 1's Progress Notes dated 3/14/2025 and MAR dated 3/2025, were reviewed. The DON stated Resident 1's hydralazine medication administration was not documented on 3/4/2025 and 3/7/2025. The DON stated Resident 1's vital signs were not monitored for five shifts and was not monitored for signs and symptoms of rhabdomyolysis for three shifts as ordered by the physician. The DON stated Resident 1 may not receive adequate and prompt care if licensed nurses were not monitoring for medication side effects or disease changes. The DON stated Resident 1's Catapres Transdermal Patch was not available and the LVN did not notify the doctor or contacted the pharmacy. The DON stated LVNs are responsible for obtaining, administering, and documenting medications. The DON stated the LVN should have monitored the resident, notified the doctor, and notified the pharmacy about the missing medication. The DON stated Resident 1's hypertension could have become unstable, resulting in hypertensive crisis (medical emergency that occurs when blood pressure suddenly and severely increases) and hospitalization . (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Medication Administration Audit Report dated 3/25/2025-4/1/2025, the Medication Administration Audit Report indicated Resident 1's hydralazine and atenolol doses were due at 9:00 a.m. The Audit Report indicated Licensed Nurses administered Resident 1's hydralazine on 3/25/2025 at 10:10 a.m., 3/26/2025 at 10:36 a.m., 3/30/25 at 11:00 a.m., 3/31/2025 at 10:27 a.m., and 4/1/2025 at 10:54 a.m. The Audit Report indicated Licensed Nurses administered Resident 1's atenolol on 3/25/2025 at 10:11 a.m., 3/26/2025 at 10:35 a.m., 3/31/2024 at 10:27 a.m. and 4/1/2025 at 10:54 a.m. During a concurrent interview and record review on 4/1/2025 at 2:00 p.m. with the DON, Resident 1's Medication Administration Audit Report dated 3/25/2025-4/1/2025 were reviewed. The DON timed medications must be administered within one hour of the prescribed time. The DON stated Resident 1's medications were administered late nine times. The DON stated, Licensed Nurses were responsible for administering medications on time. The DON stated Resident 1's blood pressure and heart rate could have become dangerously high and could have resulted in hospitalization due to the medications not being given timely. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 2's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and hypertension. During a review of Resident 2's H&P dated 2/29/2025, the H&P indicated Resident 2 had fluctuating capacity to make medical decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was unable to express ideas and wants and was sometimes able to understand others. During a review of Resident 2's Physician Orders, dated 4/3/2025, the Physician Orders indicated the following: -Administer carvedilol (medication to control blood pressure) 6.25 mg by mouth two times a day for hypertension. -Monitor vital signs ever shift. -Monitor for signs of bleeding every shift for anticoagulant medication use. During a review of Resident 2's MAR dated 3/2025, the MAR indicated the following for Resident 2: -Carvedilol tablet 6.25 mg, one tablet by mouth two times a day for hypertension on 3/6/2025, 3/10/2025, 3/14/2025, 3/19/2025, and 3/20/2025 at 9:00 p.m. were blank. -Monitoring vital signs on 3/7/2025, 3/9/2025, and 3/20/2025 during the day shift and on 3/6/2025, 3/10/2025, 3/14/2025, 3/19/2025, 3/20/2025, and 3/26/2025 during the evening shift were blank -Monitoring for signs of bleeding on 3/7/2025, 3/9/2025, and 3/20/3035 during the day shift and on 3/6/2025, 3/10/2025, 3/14/2025, 3/19/2025, 3/20/2025, and 3/26/2025 during the evening shift were blank. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor adverse reaction every shift for use of Seroquel. -Monitor for rhabdomyolysis r/t (related to) use of Lipitor. -Monitor resident for bleeding complications every shift. -Monitor vital signs every shift. During a review of Resident 3's MAR dated 3/2025, the MAR indicated the following for Resident 3: -Seroquel 50 mg medication administration and behavioral monitoring on 3/6/2025, 3/14/2025, and 3/19/2025 at 9:00 p.m. were blank. -Seroquel 37.5 mg medication administration on 3/6/2025, 3/14/2025, and 3/19/2025 at 5:00 p.m. were blank -Monitoring for behavior every shift for bipolar disorder on 3/9/2025, 3/15/2025, and 3/17/2025 during the day shift, and 3/6/2025, 3/10/2025, 3/14/2025, 3/17/2025, 3/19/2025, and 3/26/2025 during the evening shift were blank. -Monitoring for adverse reaction every shift for use of Seroquel on 3/9/2025, 3/15/2025, and 3/17/2025 during the day shift, and 3/6/2025, 3/10/2025, 3/14/2025, 3/17/2025, 3/19/2025, and 3/26/2025 during the evening shift were blank. -Monitoring for rhabdomyolysis related to use of Lipitor on 3/9/2025, 3/15/2025, and 3/17/2025 during the day shift, and 3/6/2025, 3/10/2025, 3/14/2025, 3/17/2025, 3/19/2025, and 3/26/2025 during the evening shift were blank. -Monitoring for bleeding complications every shift on 3/9/2025, 3/15/2025, and 3/17/2025 during the day shift, and 3/6/2025, 3/10/2025, 3/14/2025, 3/17/2025, 3/19/2025, and 3/26/2025 during the evening shift were blank. -Monitoring vital signs every shift on 3/9/2025, 3/15/2025, and 3/17/2025 during the day shift, and 3/6/2025, 3/10/2025, 3/14/2025, 3/17/2025, 3/19/2025, and 3/26/2025 during the evening shift were blank. During a concurrent interview and record review on 3/27/2025 at 3:40 p.m. with the DON, Resident 3's MAR dated 3/2025 and active Physician Orders dated 3/27/2025 were reviewed. The DON stated the blank spaces on Resident 3's MAR indicated the licensed nurses did not document administration (of Seroquel) or monitoring for the resident. The DON stated Resident 3's vital signs were not monitored as ordered for 9 shifts. The DON stated Resident 3 was not monitored for signs of bleeding related to anticoagulant medication, rhabdomyolysis, and behaviors for nine shifts. The DON stated Resident 2 may not have receive adequate and prompt care if the licensed nurses were not monitoring for medication side effects. During a review of Resident 3's Medication Administration Audit Report, dated 3/25/2025-4/1/2025, the Medication Administration Audit Report indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Manchester Manor Conv Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 3's norvasc dose was due at 9:00 a.m. daily. The Audit Report indicated Resident 3's Norvasc was administered on 3/26/2025 at until 10:42 a.m., 3/27/25 at 10:14 a.m., 3/28/2025 at 10:50 a.m., 3/29/2025 at 10:32 a.m., 3/30/25 at 10:41 a.m., and 3/31/2025 at 1:52 p.m. -Seroquel dose was due at 9:00 a.m. daily and was not administered until 10:43 a.m. on 3/26/2025, 10:15 a. m. on 3/27/2025, 10:50 a.m. on 3/28/2025, 10:32 a.m. on 3/29/2025, 10:41 a.m. on 3/30/2025, and 1:52 p.m. on 3/31/2025. -Seroquel dose was due at 5:00 p.m. daily and was not administered until 11:48 p.m. on 3/25/2025, 7:34 p. m. on 3/26/2025, 10:39 p.m. on 3/27/2025, and 6:21 p.m. on 3/29/2025. During a concurrent interview and record review on 4/1/2025 at 2:00 p.m. with the DON, Resident 3's Medication Administration Audit Report dated 4/1/2025 was reviewed. The DON stated the Medication Administration Audit Report indicated 16 instances of late administration of time-sensitive medication. The DON stated licensed nurses were responsible for administering medication on time. The DON stated Resident 3 was at risk for developing the conditions ordered to monitor for such as behaviors, rhabdomyolysis, and bleeding. The DON stated Resident 3's blood pressure and heart rate could have become dangerously high and could have resulted in hospitalization due to late medication administration. The DON stated administering Seroquel outside of the ordered times could result in withdrawal, worsened behaviors, continuous screaming, and psychological discomfort. During a review of the facility's Policy and Procedure (P&P) titled, Documentation of Medication Administration, dated April 2007, the P&P indicated administration of medication must be documented immediately after it is given. During a review of the P&P titled, Administering Medications, dated 12/2012, the P&P indicated medications shall be administered in a safe, timely manner and as prescribed. The P&P indication medications must be administered in accordance with the orders, including any required time frame. The P&P indicated medications must be administered within one hour of the prescribed time. During a review of the P&P titled, Resident Examination and Assessment, dated 2/2014, the P&P indicated vital signs should be documented in the resident's medical record, including blood pressure, pulse, respirations, and temperature. The P&P indicated the physician must be notified of abnormal vital signs. During a review of the P&P titled, Medication and Treatment Orders, dated 7/2016, the P&P indicated drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available.		