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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Healthcare Center	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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide emergency care (the provision of care for conditions that require rapid intervention to avoid death or permanent disability) to the resident, who had an altered mental status (a change in a resident's level of awareness, cognition, often indicating an underlying medical or neurological issue [any condition that affects the nervous system, including the brain, spinal cord, and nerves) and high blood pressure (BP- of 200/109 millimeters of mercury ([mmHg, a unit of measurement], reference range is120/80 or lower) to prevent intracerebral hemorrhage ([ICH] a type of stroke involving bleeding within the brain tissue) for one of four sampled residents (Resident 1). The facility failed to: 1. Assess Resident 1 immediately (instantly/ without delay) after Resident 1 had altered mental status on [DATE] at 2:14 p.m. 2. Immediately provide emergency interventions by sending Resident 1 to the general acute care hospital (GACH) without a delay for evaluation and treatment. 3. Implement the facility's policy and procedure (P&P) titled, Emergency Care-General, which indicated to summon help and immediately call 911 (medical emergency phone number) for medical emergency assistance for new onset of unconsciousness or unresponsiveness to verbal or physical stimuli, severe low blood sugar with impaired consciousness, or any seizure activity (a sudden, abnormal surge of electrical activity in the brain that can cause temporary changes in behavior, movement, sensation, or awareness). As a result of these failures, Resident 1 did not receive the emergency care (the immediate medical attention provided to individuals experiencing serious or life-threatening health conditions) on [DATE], from 2:14 p.m. to 5:47 p.m. (a total of three (3) hours and 33 minutes), when Resident 1 had a change in condition, resulting in Resident 1 suffering an intracerebral hemorrhage as evidenced by GACH 1's Computerized Tomography (CT, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) scan of the brain without contrast (no contrast agent used) dated [DATE], at 7:15 p.m., leading to Resident 1's intubation (when a breathing tube inserted through the mouth or nose, down to the trachea [windpipe], connected to the mechanical ventilator (a form of life support) and death on [DATE] in GACH 2. Findings: (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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension (high blood pressure), diabetes mellitus (DM- abnormal blood sugar level), hemiplegia (paralysis on one side of the body) affecting right dominant side (resident's preferred side of the body to use), and epilepsy (a neurological disorder characterized by a tendency to have recurrent, unprovoked seizures) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating and upper body dressing. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent (helper does all the effort) on shower/bath and putting on/taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance with rolling from lying on back, to left and right side, and in returning to lying on back on the bed. The MDS indicated Resident 1 required substantial/maximal assistance with sitting to lying and lying to sitting position on side of the bed. The MDS indicated Resident 1 was dependent on chair/bed-to-chair transfer, and tub/shower transfer. During a review of Resident 1's care plan titled, The resident has altered endocrine (tissue that make and release hormones that travel in the bloodstream and control the actions of other cells or organ) status, diabetes, initiated [DATE], the care plan indicated the goal for Resident 1 was not to experience any complications (problems) from diabetes and receive medications as ordered. The care plan interventions indicated to monitor Resident 1 for reports of changes to the eye (eye condition) and report to the physician as needed. During a review of Resident 1's Physician's Order Summary report dated [DATE], the Physician's Order Summary report indicated the following orders: 1. Finger stick blood sugar (FSBS, to check blood sugar level by pricking the finger and using a small drop of blood from the fingertip) as needed for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). If FSBS is less than 60 (normal blood sugar range-70 to 99 milligrams per deciliter (mg/dL, a unit of measurement) and the resident is alert/ responsive, to give snack and recheck the blood sugar after 15 minutes, hold insulin (medicine for diabetes) and call the physician immediately, every 15 minutes, as needed. 2. Gvoke ([Glucagon] a prescription medicine used to treat very low blood sugar) prefilled syringe (PFS, a disposable syringe that comes with a pre-measured dose of insulin already loaded), 1 milligram ([mg] unit of mass measurement)/0.2 milliliter ([ml] unit of volume measurement), to inject 0.2 ml intramuscularly (injection into the muscles) as needed for hypoglycemia, if FSBS is less than (<) 60 and resident is unresponsive, call medical doctor (MD) immediately and recheck FSBS in 15 minutes. (hold insulin). 3. Insulin Glargine-yfgn (injection medication for diabetes) subcutaneous (SQ, fatty tissue layer just below the skin tissue) solution pen-injector 100 units, inject 15 milliliters (ml, a unit of measurement) SQ at bedtime. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4. Monitor vital signs (physiological measurements that indicate a person's basic bodily functions, includes blood pressure, heart rate, temperature and oxygen saturation (a measure of how much oxygen is in the blood, normal range 95-100%) every shift. 5. Amlodipine Besylate oral tablet 10 mg., one (1) tablet by mouth one time a day (medicine for hypertension [high blood pressure]), hold when systolic blood pressure (SBP- the top number in a BP reading) is <110. 6. Aspirin (medicine for stroke prevention) 81 mg oral tablet, delayed release, daily. 7. Atorvastatin Calcium (medicine to lower cholesterol levels) 40 mg., tablet by mouth at bedtime for hyperlipidemia (high fats or lipids in the blood). 8. Lisinopril (medicine to treat high blood pressure) 20 mg., tablet by mouth, daily. Hold when SBP <110 and heart rate (HR, normal rate between 80-100 beats per minute) <60. 9. Levetiracetam oral solution (a medication primarily used to treat epilepsy by controlling various types of seizures [sudden, temporary episodes of abnormal brain activity that can cause a variety of symptoms, including muscle spasms, loss of consciousness, and altered behavior]) 100 mg/ml, to give 15 ml by mouth two times a day. The Physician's Order Summary report indicated Resident 1 was discharged to GACH 1 via 911 on [DATE] (no reason indicated). During a review of Resident 1's Medication Administration Record (MAR) for [DATE], the MAR indicated Resident 1 was administered Amlodipine and Lisinopril on [DATE] at 9 a.m., however the MAR did not indicate a documented BP reading. The MAR indicated Resident 1 refused the Levetiracetam morning dose on [DATE], [DATE] and [DATE]. During a review of Resident 1's Licensed Nurses Progress Notes dated [DATE] at 2:14 p.m., the Licensed Nurses Progress Notes indicated Resident 1 was transferred to GACH 1 via 911 (notes did not specify date and time of transfer) due to altered mental status. The Licensed Nurses Progress Notes did not indicate documentation regarding Resident 1's condition, any assessment conducted, and interventions provided to Resident 1 after the change in condition was observed on [DATE] at 2:14 p.m. and prior to the arrival of the paramedics on [DATE] at 5:47 p.m. During a review of Resident 1's Los Angeles Fire Department (LAFD) Patient Care Report (report) dated [DATE] at 5:37 p.m., the report indicated paramedics dispatch were notified on [DATE] at 5:37 p.m. and was on scene with Resident 1 at 5:47 p.m. The report indicated Resident 1 was unconscious (unresponsive to all stimuli). The report indicated Resident 1 was hypoglycemic (with low blood sugar level). The report indicated Resident 1 had been confused for one hour in the facility (time not specified). The report indicated at 5:47 p. m. paramedics checked Resident 1's blood sugar and it was 31. The report indicated Resident 1's BP was 140/80 at 5:47 p.m. and 160/80 at 5:58 p.m. The report indicated an intravenous line ([IV] a thin, flexible tube inserted into a vein to administer fluids, medications or blood products directly into the bloodstream) was established and Resident 1 was given Glucagon which raised Resident 1's blood sugar level to 164 mg/dl. The report also indicated Resident 1 was given (administered) IV of Dextrose 10 (D10- 10% [percent]of sugar in water used to provide body with extra water and calories from sugar). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's e-interact Change of Condition (COC) Evaluation dated [DATE] at 6:21 p.m., completed by Licensed Vocational Nurse (LVN) 1, the COC indicated Resident 1 had a minor shortness of breath (the feeling of not being able to breathe deeply enough or get enough air) (time not specified). The COC indicated Resident 1 did not have any oxygen in use. The COC indicated the date and time the physician was notified was [DATE] at 2:23 p.m. The COC indicated, per medical order, Resident 1 was to be transferred to GACH due to altered mental status. During a review of Resident 1's GACH 1 record titled, Emergency Department (ED) note, dated [DATE] at 6:52 p.m., the ED notes indicated, Resident 1 had altered mental status one hour prior to the paramedic's arrival at the facility. The ED notes indicated Resident 1 was hypoglycemic and arrived at the ED still altered. The ED notes indicated Resident 1 had left sided gaze deviation (a condition where a person's eyes are deviated or turned towards the left side which can be due to various neurological conditions, including stroke). The ED notes indicated Resident 1's glucose level was 248, potassium (an essential mineral and electrolyte that plays a vital role in nerve and muscle function, including the heart) level of 3 (normal range is 3.5 to 5.2 milliequivalent per liter ([mEq/L] unit of measurement). The GACH 1 CT of the brain without contrast dated [DATE] at 7:15 p.m., indicated Resident 1 had a focal (localized) hematoma (a localized collection of blood outside of the blood vessels) at the left fronto (front of the head, behind the forehead) parietal (the top and back of the head, behind the frontal lobe and above the temporal (second largest lobe that sit behind the ears) and occipital lobe (the visual processing area of the brain) region, measuring 3.7 x 2. 6 x 3.9 centimeters ([cm] unit measure of length) for a total ICH volume of 19.5 cubic centimeters ([cc] a unit of measurement of volume] the volume of blood collected within the brain tissue following a stroke). The impression indicated a focal ICH (bleeding that is localized to a specific area within the brain or its surrounding spaces) at the left posterior (back) parietal area. The ED notes indicated Resident 1 was intubated on [DATE] at 8:43 p.m. for airway protection during transport to GACH 2 for a higher level of care with neurosurgery (the medical specialty concerned with the diagnosis and treatment of patients with injury to, or diseases/disorders of the brain, spinal cord and spinal column, and peripheral nerves within all parts of the body). The ED notes indicated Resident 1 was transferred to GACH 2 on [DATE] at 10 p.m. During a review of GACH 2's History and Physical (H&P, the physician's examination of a patient) report, dated [DATE] at 10:27 p.m., the GACH 2's H&P indicated Resident 1 was transferred from GACH 1 for the management of left parieto-occipital (the region or structures situated between the parietal (walls) and occipital lobes of the brain) intracerebral hemorrhage. The H&P report indicated, according to the nursing staff at the facility on [DATE] at around 1 p.m. to 2 p.m., Resident 1 exhibited facial abnormalities, possibly twitching or asymmetry (uneven), with left-sided gaze deviation along with movement of the resident's arms, hands and legs. The H&P indicated that despite the concerning signs, Resident 1 was not immediately sent to the GACH, rather, was transferred between 4:00-5:00 p.m. (2-3 hours after). The H&P indicated Resident 1 was intubated and was connected to a mechanical ventilator (a breathing machine). During a review of GACH 2's Discharge Documentation dated [DATE], the documentation indicated Resident 2 was compassionately extubated (the process of withdrawing mechanical ventilation from a patient at the end of life to allow for a peaceful and comfortable death) and died on [DATE] at 6:54 a.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Certificate of Death indicated, Resident 1 died on [DATE]. The Certificate of Death indicated the immediate cause of death was cardiopulmonary arrest (sudden cessation of heart function and breathing) sequentially (in succession) to cerebral edema (brain swelling), non-traumatic intracranial hemorrhage and hypertension (high blood pressure). During a phone interview on [DATE] at 3:22 p.m., with Resident 1's Family Member (FM 1), FM 1 stated when FM 2 visited Resident 1 on [DATE] around 2:30 p.m., while Resident 1 was being cleaned by Certified Nurse Assistant (CNA 1), Resident 1 was not responsive. FM 1 stated Licensed Vocational Nurse (LVN) 1 reported to FM 2 that Resident 1 had a seizure but when LVN 1 checked the BP, it was 220/138 mmHg. FM 1 stated, according to FM 2, it took the staff over one hour to send Resident 1 to GACH 1. FM 1 stated even though Resident 1 had a stroke before, Resident 1 remained alert and aware of her surroundings. FM 1 stated according to FM 2, Resident 1 was not talking or moving on [DATE]. FM 1 stated from GACH 1 Resident 1 was taken to GACH 2 because GACH 1 found a bleed in her brain and GACH 2 confirmed it was a second stroke. During an interview on [DATE] at 12:43 p.m. with CNA 1, CNA 1 stated on [DATE] around 2:30 p.m., she went to Resident 1's room because FM 2 was visiting Resident 1. CNA 1 stated when she entered Resident 1's room Resident 1 was looking blankly towards the left side and was not answering. CNA 1 stated she cleaned the resident and kept calling Resident 1's name while she was cleaning her, but Resident 1 was not answering. CNA 1 stated Resident 1 was usually awake, alert, able to make all her needs known and move all extremities (both upper arms and both lower legs) despite being bedridden. CNA 1 stated she called LVN 1 to check on Resident 1 after she finished cleaning the resident on [DATE] (duration not specified). CNA 1 stated LVN 1 told her Resident 1 had a seizure. CNA 1 stated, when she saw Resident 1, Resident 1's one side of face (side not specified) looked droopy. CNA 1 stated it looked like Resident 1 had a stroke. CNA 1 stated it did not look like a seizure. CNA 1 stated she notified LVN 1 and LVN 1 took Resident 1's vital signs. CNA 1 stated she was not sure what time the LVN 1 took Resident 1's vital signs but after that, she believed LVN 1 called paramedics on [DATE] (time not specified). During a phone interview on [DATE] at 12:53 p.m. with LVN 1, LVN 1 stated he received a report from CNA 1 on [DATE] at around 2:15 p.m. or 2:30 p.m. that Resident 1 did not look like herself (changed) and had altered mentation from her baseline (normal status). LVN 1 stated he initially suspected a seizure because Resident 1 had a history of seizures. LVN 1 stated he checked the blood pressure, and it was 200/109 mmHg. LVN 1 stated he called the physician (MD) immediately (time not specified) and requested to send Resident 1 to GACH 1. LVN 1 stated on [DATE] in the morning (time not specified), Resident 1 was watching television with her roommate and was verbally responsive and was able to make needs known. LVN 1 stated when he went to Resident 1's room on [DATE] at around 2:15 p.m. or 2:30 p.m., Resident 1 was staring blankly and was not responding. LVN 1 stated it was a medical emergency when a resident has a blood pressure of 200. LVN 1 stated Resident 1 should have been sent to the hospital immediately. LVN 1 stated Resident 1 was at a very high risk for heart attack or stroke. LVN 1 stated he should have assessed Resident 1 for signs of stroke or heart attack like chest pain, sweating, numbness (loss of feeling or sensation), confusion, difficulty understanding and talking, vision, poor balance, facial drooping (a condition where the muscles on one side of the face become weak or paralyzed, causing them to droop or sag) or the ability to hold up arms. LVN 1 stated Resident 1 was not assessed because the resident was very stiff and was not following any commands at that time (on [DATE] at around 2:15 p.m. or 2:30 p.m.) LVN 1 stated he called 911 on [DATE] around 4:30 p.m. or 4:35 p.m. and it took the paramedics 15-25 minutes to arrive (time not specified). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:13 p.m. with LVN 1, LVN 1 stated he was not sure why the sequence of events and the time he assessed Resident 1, did not match his documentation in the COC on [DATE] at 6:21 p.m. and the progress notes on [DATE] at 2:14 p.m. LVN 1 stated he did not check Resident 1's blood sugar at all on [DATE]. LVN 1 stated the BS reading of 100 in Resident 1's clinical record on [DATE] at 4:23 p.m., was a typo on his part. LVN 1 stated the only blood sugar reading was from LAFD which indicated 30 and he was not sure if anything was given for it. LVN 1 stated FM 2 was at bedside and FM 3 arrived 10 minutes after LVN 1 had taken the blood pressure (time not specified). LVN 1 stated on [DATE] (times not specified), he checked the BP about four times, and the BP remained high (around 200's). LVN 1 stated he did not document the BP readings taken on [DATE] (times not specified) in the resident's clinical records. The LVN 1 stated he called the Director of Nursing (DON) who was off on that day (Saturday, [DATE]) at 4:30 p.m. and reported the incident (Resident 1's altered mental status) because the Registered Nurse Supervisor (RN) 1 was busy with another resident. During a concurrent phone interview on [DATE] at 1:22 p.m. with FM 1, FM 2 and FM 3, FM 1 stated FM 2 called her (FM 1) at 3:04 p.m. on [DATE] and was told Resident 1 was not talking and something was wrong (unspecified). FM 2 stated he arrived at the facility a little after 2:30 p.m. on [DATE] while CNA 1 was changing Resident 1. FM 2 stated he observed CNA 1 kept calling Resident 1's name, but Resident 1 was not responding. FM 2 stated he observed a LVN (unidentified) entered the room and checked Resident 1's BP. FM 2 stated Resident 1's BP was 220/138 mmHg. FM 2 stated LVN 1 told him Resident 1 had a seizure because of Resident 1's expression on her face. FM 2 stated he observed LVN 1 tried to give Resident 1 a pill (FM 2 was not sure what it was and LVN 1 did not tell him what it was) but the resident was not swallowing it. FM 2 stated LVN 1 crushed the pill, mixed it with Jello or pudding and gave the crushed pill to Resident 1. FM 2 stated he was not sure if Resident 1 swallowed the crushed pill because Resident 1 was not moving. FM 3 stated she spoke to LVN 1 on [DATE] around 3:30 p.m. and was told that Resident 1 had a seizure. FM 3 stated she asked LVN 1 if it was another stroke, FM 3 stated LVN 1 told her it was not a stroke. FM 3 stated LVN 1 told her that Resident 1 had high BP and that LVN 1 was getting in touch with MD. FM 3 stated she did not notice LVN 1 talking to MD but FM 3 noticed LVN 1 was seen talking to another nurse (unidentified). FM 3 stated it was the other nurse who told LVN 1 to call the paramedics. FM 3 stated Resident 1 was staring towards the left and was not talking or tracking. FM 3 stated LVN 1 was saying Resident 1 needed to go to the hospital, but he (LVN 1) did not call the paramedics until he got off the phone. During a phone interview on [DATE] at 2:36 p.m. with DON, the DON stated RN 1, who was on duty that day ([DATE]), did not see Resident 1 because RN 1 was not aware of the incident. The DON stated when she spoke to LVN 1 on [DATE] (time not specified), LVN 1 told her (DON) that RN 1 had already left for the day. During a phone interview on [DATE] at 2:39 p.m. with RN 1, RN 1 stated LVN 1 called him (RN 1) on the phone on [DATE] at around 3 p.m. while he (RN 1) was on his way to another job. RN 1 stated LVN 1 notified him (RN 1) that Resident 1 had a seizure. RN 1 stated he instructed LVN 1 to send Resident 1 to GACH if the seizure will not stop. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's Policy and Procedures (P&P) titled, Acute Condition Changes (a sudden, clinically significant deviation from a resident's normal state)- Clinical Protocol, dated 3/2018, the P&P indicated the nursing staff will contact the physician based on the urgency of the situation. The P&P indicated, before contacting the physician about someone with an acute change of condition, the nursing staff should collect pertinent details to report to the physician. The P&P indicated phone calls to the attending physician should be made by an adequately prepared nurse who had collected and organized pertinent information, including the resident's current symptoms and status. The P&P indicated the nurse shall assess and document/ report the following baseline information: a. Vital signs; b. Neurological status; c. Level of consciousness; d. Cognitive status; e. Onset, duration, severity; f. Recent labs; g. All active diagnosis h. All current medications. The P&P indicated the nursing staff should contact the physician based on the urgency of the situation. The P&P indicated, for emergencies, the nursing staff should call of page the physician and request a prompt response (within approximately one-half hour or less). The P&P indicated the attending physician should respond in a timely manner to the notification of problems or changes in condition and status and the nursing staff should contact the Medical Director for additional guidance and consultation if they did not receive a timely or appropriate response. The P&P indicated the staff will monitor and document the resident's progress and responses to treatment and the physician will help the staff monitor the resident with acute change of condition until the problem or condition has resolved or stabilized. During a review of the facility's P&P titled, Emergency Care-General, dated 10/2022, the P&P indicated emergency treatment should be given to residents who sustained illness while in the facility to preserve the resident's life, to prevent further harm, and promote recovery. The P&P indicated to summon help and immediately call 911 for medical emergency assistance for new onset of unconsciousness or unresponsiveness to verbal or physical stimuli, severe low blood sugar with impaired consciousness that did not respond to emergency or first-time seizure. The P&P indicated to document the resident's vital signs including blood pressure, pulse, respirations and temperature and notify the physician or Medical Director of the specific complaints and vital signs as soon as possible.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to implement its Policy and Procedures (P&P) titled, Insulin Administration which indicated individual administering the medication must check to verify the right dosage before giving the medication, for one of 3 sampled residents, (Resident 1), by failing to: 1). Ensure Resident 1's physician's order for Insulin Glargine-yfgn (injection medication for diabetes) was correct. 2). Ensure Resident 1's blood sugar levels were documented in the resident's electronic medical record. These failures placed the resident at risk to receive high doses of insulin and had the potential to cause complications like severe hypoglycemia (low blood sugar), coma, hospitalization and death. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension (high blood pressure), diabetes mellitus (DM- abnormal blood sugar level), hemiplegia (paralysis on one side of the body) affecting right dominant side (resident's preferred side of the body to use), and epilepsy (a neurological disorder characterized by a tendency to have recurrent, unprovoked seizures) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADLs) such as eating, personal hygiene and upper body dressing. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent (helper does all the effort) on shower/bath and putting on/taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance with rolling from lying on back, to left and right side, and in returning to lying on back on the bed. The MDS indicated Resident 1 required substantial/maximal assistance with sitting to lying and lying to sitting position on side of the bed. The MDS indicated Resident 1 was dependent on chair/bed-to-chair transfer, and tub/shower transfer. During a review of Resident 1's Order Summary report dated 4/14/2025, the Physician Order Summary report indicated Insulin Glargine-yfgn subcutaneous (SQ, fatty tissue layer just below the skin tissue) solution pen-injector 100 units, inject 15 milliliters (ml, a unit of measurement) SQ at bedtime. The physician order summary report indicated to hold if blood sugar is less than (<) 110 milligram ([mg]), a unit measurement/deciliter ([dL] unit measurement of volume). During a review of Resident 1's History and Physical (H&P) dated 4/25/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. (continued on next page)

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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Healthcare Center	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 - Few	During a review of Weights and Vitals Summary under blood sugar summary, the summary did not indicate blood sugar results on 5/2/2025, 5/5/2025 to 5/10/2025 and from 5/12/2025 to 5/16/2025. During a review of Resident 1's Medication Administration Record (MAR) for May 2025, the MAR indicated Insulin Glargine-yfgn 15 ml SQ were administered at bedtime from 5/1/2025 to 5/4/2025 and on 5/6/2025 to 5/16/2025. During a concurrent interview and record review on 6/5/2025 at 1:57 p.m. with Licensed Vocational Nurse (LVN 3), Resident 1's Order Summary Report dated 4/14/2025, MAR for 5/2025 and the Blood Sugar Summary were reviewed. LVN 3 stated the order for Insulin Glargine was incorrect because the order should have been written in units not ml. LVN 3 stated 1 ml has 100 units. LVN 3 stated administering 15 ml of Insulin Glargine would mean the nurse would have administered Insulin Glargine 100 times the dose, which would have been 1,500 units instead of 15 units. LVN 3 stated administering 15 ml of insulin could lead to a severe medication error and could lead to Resident 1's coma or death. LVN 3 stated the order should have been clarified with the Medical Doctor (MD) prior to administering the medication. LVN 3 stated the MAR indicated 15 ml of Insulin Glargine were administered to Resident 1 from 5/1/2025 to 5/4/2025 and on 5/6/2025 to 5/16/2025. LVN 3 stated that the blood sugar summary did not indicate blood sugar levels on 5/2/2025, 5/5/2025 to 5/10/2025 and from 5/12/2025 to 5/16/2025. LVN 3 stated blood sugars should always be checked and recorded to ensure insulin was administered as ordered. During interview on 6/18/2025 at 1:12 p.m. with the Director of Nursing (DON), the DON stated the insulin pen can only contain maximum volume of 3 ml. The DON stated it would be impossible for the LVNs to administer 15 ml. of Insulin Glargine to Resident 1. The DON stated LVNs should have called and verified the Insulin Glargine order with the MD. The DON stated trainings will be provided for staff to ensure the physician order will have the right number of units of the insulin to prevent mistakes. During a review of the facility's P&P titled, Insulin Administration, dated 10/2022, the P&P indicated the insulin dosage requirements must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. The P&P indicated the nurse shall notify the DON and Attending Physician of any discrepancies before giving the insulin. The P&P indicated injectable insulin comes in concentrations of 100 units per mL liquid. The P&P indicated orders for insulin should always be written as Units. The P&P indicated to document resident's blood glucose result, as ordered. During a review of the facility's P&P titled, Administering Medications dated 10/2022, the P&P indicated if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. The P&P indicated the individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.