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	07/07/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a written informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident and/or conservator (a person appointed by court to manage a person deemed unable to manage their life, such as health, and medical treatment) prior to treatment with Olanzapine (a psychotropic medication [a medication that affect brain activities associated with mental processed and behavior]) for one of four sampled residents (Resident 1). The deficient practice of failing to obtain informed consent prior to initiating treatment with psychotropic medication could have prevented Resident 1 from exercising their right to decline treatment with antipsychotic medications. This increased the risk that Resident 1could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) leading to impairment or decline in his mental or physical condition or functional or psychosocial status. 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 which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a brain disorder), and hypertension ([HTN]- high blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. The MDS indicated Resident 1 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 received antipsychotic medication. During a review of Resident 1's Order Summary Report, dated 7/1/2025, the Order Summary Report indicated on 4/12/2025, Resident 1's attending physician prescribed Olanzapine 10 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for schizoaffective disorder manifested by outburst of anger. During a review of Resident 1's Medication Administration Record (MAR), dated 4/1/2025 through 7/1/2025, the MAR indicated Resident 1 received Olanzapine a total of 113 times. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/7/2025 at 9:45 a.m., with the Director of Nursing (DON), Resident 1's available informed consent for the use of psychotropic medication and clinical records, were reviewed. The DON stated the facility's licensed staff were responsible for verifying that informed consent for the use of psychotropic medication was obtained by the physician, followed by completion of a written informed consent to be placed in the resident's clinical record. The DON stated informed consent was not present in Resident 1's clinical records for the use of Olanzapine. The DON stated she could not explain why the informed consent was not completed; it was a possibility that the informed consent was misplaced or not presented to the resident and/or conservator at the time of admission to the facility. The DON stated as a result of an uncompleted informed consent form for Olanzapine, Resident 1 and/or his conservator were not given the opportunity to make an informed decision about whether to accept or refuse the prescribed medication. The DON stated Resident 1 and/or his conservator should have been given the opportunity to make informed decisions regarding the resident's care and treatment, as it was their right. During a review of the facility's policies and procedures (P&P) titled Informed Consent, dated 10/1/2023, the P&P indicated: 1. The Attending Physician must obtain informed consent before the facility initiates a medical intervention that requires informed consent. 2. An informed consent is required for the administration of psychotherapeutic drugs. 3. The resident or representative must sign an informed consent prior to administration of treatment. 4. The facility staff will verify that informed consent was obtained by the Attending Physician, and the informed consent will be documented and placed in the resident's medical records.

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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 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** Based on interview, and record review, the facility failed to develop a comprehensive care plan with interventions that addressing the resident's schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) for one of four sampled residents (Resident 1). This deficient practice had the potential to negatively affect Resident 1's physical well-being and placed the resident at risk of not receiving care and resident-centered interventions to meet and address Resident 1's needs. 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 which included schizoaffective disorder, epilepsy (a brain disorder), and hypertension ([HTN]- high blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. The MDS indicated Resident 1 required moderate (helper does less than half the effort) assistance form staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1's schizoaffective disorder as an active diagnosis. During a concurrent interview and record review on 7/3/2025 at 12:30 p.m., with the Director of Nursing (DON), Resident 1's Order Summary Report, dated 7/1/2025, and Care Plans, dated 4/2025 through 7/2025, were reviewed. The Order Summary Report indicated Resident 1 was ordered Zyprexa (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]) 10 milligrams ([mg)- metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth two times a day, for schizoaffective disorder manifested by (m/b) outburst of anger. This order was started on 4/12/2025. The DON stated there were no care plan interventions and goals addressing Resident 1's schizoaffective disorder or the associated behavior symptoms, such as outburst of anger. The DON stated there were no care plan interventions related to the use of Zyprexa. The DON stated the care plans are intended to identify resident specific needs and ensure personalized care, based on diagnoses, behavior patterns, and prescribed medications. The DON stated Resident 1's diagnosis, psychotropic medication Zyprexa, and behavioral symptoms should have been included in the care plan through measurable goals and person-centered interventions. The DON stated care plans served as a communication tool among staff to ensure consistent, individualized, and effective care. The DON stated that without a care plan in place, staff could not adequately provide care that meets the residents' individual needs. During a review of the facility's policies and procedures (P&P) titled Care Planning, dated 10/1/2023, the P&P indicated the facility would ensure that a comprehensive person-centered Care Plan was developed for each resident based on their individual needs. The P&P indicated a comprehensive care plan would include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.

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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** Based on interview and record review, the facility failed to ensure the Situation, Background, Assessment, Recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents) was completed for one of four sampled residents (Resident 1) when Resident 1 had a change of condition and eloped (the act of leaving a facility unsupervised and without prior authorization) on 7/1/2025. This deficient practice had the potential to result in miscommunication among staff and Resident's 1 attending physician to have a detailed explanation of what happened to Resident 1 before he eloped on 7/1/2025, and lack of appropriate response. 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 which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a brain disorder), and hypertension ([HTN]- high blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. The MDS indicated Resident 1 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 7/3/2025 at 10:10 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's progress note, dated 7/1/2025 at 9:26 a.m., was reviewed. LVN 1 stated the progress note indicated on 7/1/2025 at approximately 8:25 a.m., Resident 1 was nowhere to be found within the facility. LVN 1 stated he and other (unidentified) staff began searching the facility perimeter, but Resident 1 was not located. LVN 1 stated he notified Resident 1's physician by phone, but did not complete the SBAR form. LVN 1 stated he was busy and forgot due to being preoccupied with the resident search. During an interview on 7/3/2025 at 12:30 p.m., with the Director of Nursing (DON), the DON stated that the SBAR form should have been completed in response to Resident 1's change in condition and elopement on 7/1/2025. The DON stated the SBAR was a critical tool used to ensure clear communication among staff and with the resident's physician. The DON stated failure to complete the SBAR not only resulted in an incomplete clinical record but also miscommunication between nursing staff and Resident 1's physician. During a review of the facility's policies and procedures (P&P) titled Change in a Resident's Condition or Status, revised 5/2017, the P&P indicated the nurse will notify the resident's Attending Physician when there has been an incident involving the resident and/or a significant change in the resident's physical, emotional, and mental condition. The P&P indicated prior to notifying the physician, the nurse would make detailed observations and gather relevant information for the provider, including the SBAR communication form. (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 the facility's P&P titled Charting and Documentation, revised 7/2017, the P&P indicated: 1. Any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 2. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response care. 3. Documentation in the medical record would be complete, and accurate.