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	12/12/2025

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 informed consent for psychotropic medications (drugs that alter brain chemistry to manage mental health conditions like depression, anxiety, schizophrenia) prior to administering psychotropic medications to one of four sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for experiencing unexpected and/or unwanted adverse effects or complications from the medications, including increased risk of suicidal thoughts, cognitive impairment, and tardive dyskinesia (a chronic movement disorder that causes involuntary, repetitive movements in the body). Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 1's diagnoses included paranoid schizophrenia (a subtype of schizophrenia, a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior), restlessness and agitation, and emotional lability (rapid, intense, and often uncontrollable mood swings). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/7/2025, the MDS indicated Resident 2 had severe cognitive impairment (significant trouble with thinking, memory, learning, concentrating, or decision-making). The MDS indicated Resident 2 required supervision or touch assistance from staff for mobility while in and out of bed. During a review of Resident 2's History and Physical (H&P), dated 10/3/2025, the H&P indicated Resident 2 did not have the capacity to understand or make medical decisions. During a review of Resident 2's record titled Informed Consent for Psychotherapeutic Medications, dated 10/13/2025, the record indicated Resident 2 was to receive Vistaril (a prescription medication with sedative and anti-anxiety properties). The record indicated informed consent for the administration of Vistaril was obtained from Resident 2. During a review of Resident 2's record titled Informed Consent for Psychotherapeutic Medications, dated 10/17/2025, the record indicated Resident 2 was to receive trazodone (an antipsychotic medication). The record indicated informed consent for administration of trazodone was obtained from Resident 2. During an interview on 12/12/2024 at 11:13 a.m., with the Director of Nursing (DON), the DON stated Resident 2 did not have decision making capacity. The DON stated staff should not have obtained informed consent for Vistaril and trazodone from Resident 2. The DON stated that these medications were chemical restraints, and stated it was the right of the resident, or a responsible party, to consent to the administration of the medications. During a review of the facility's policy and procedure (P&P) titled Psychotherapeutic Drug Management, dated 5/2025, the P&P indicated staff were to ensure risks and benefits of psychotropic medications were explained prior to their use.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Level I Preadmission Screening and Resident Review (PASRR, a screening tool that helps identify possible serious mental illness [SMI], and if the resident requires specialized services) was submitted for one of four sampled residents (Resident 1). This deficient practice placed Resident 1 at risk of not receiving recommended or required treatments for diagnosed SMIs, or appropriate placement in a facility to meet 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]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/21/2025, the MDS indicated Resident 1 had severe cognitive impairment (significant trouble with thinking, memory, learning, concentrating, or decision-making). The MDS indicated Resident 1 required set-up or clean-up assistance for most activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's physician order, dated 8/15/2025, the order indicated Resident 1 to receive aripiprazole (antipsychotic medication). During a review of Resident 1's Level I Preadmission Screening and Resident Review (PASRR, a screening tool that helps identify possible serious mental illness [SMI], and if the resident requires specialized services), dated 8/14/2025, the screening indicated Resident 1 did not have a diagnosed serious mental illness, including schizophrenia. The screening indicated Resident 1 was not prescribed psychotropic medication (medications that treat mental health conditions like depression, anxiety, and schizophrenia). During an interview, on 12/12/2025 at 11:20 a.m., with the Director of Nursing (DON), the DON stated the facility was to review the PASRR for accuracy prior to admitting a resident and would re-submit a new PASRR if there were a discrepancy. The DON stated the purpose of an accurate PASRR was to ensure the facility could provide the care needed by the resident. During a concurrent interview and record review, on 12/12/2025 at 11:24 a.m., with the DON, Resident 1's Level I PASRR screening was reviewed. The DON stated Resident 1's Level I PASRR was not accurate and did not identify his serious mental illness of schizophrenia, or his use of psychotropics. The DON stated the discrepancy should have been caught and a new PASRR submitted. During a review of the facility's policy and procedure (P&P) titled Pre-admission Screening and Resident Review (PASRR), dated 10/2023, the P&P indicated it was the facility's policy to ensure that all facility applicants were screened for mental illness to ensure coordination with the appropriate state agencies if indicated.

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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** Based on interview and record review, the facility failed to care plan the psychiatric (relating to mental illness or its treatment) diagnoses for one of four sampled residents (Resident 2). This deficient practice prevented facility staff from identifying and developing interventions to address Resident 2's behavior of striking out at others, due to his diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 2's diagnoses included paranoid schizophrenia (a subtype of schizophrenia, a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior), restlessness and agitation, and emotional lability (rapid, intense, and often uncontrollable mood swings). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/7/2025, the MDS indicated Resident 2 had severe cognitive impairment (significant trouble with thinking, memory, learning, concentrating, or decision-making). The MDS indicated Resident 2 required supervision or touch assistance from staff for mobility while in and out of bed. During an interview on 12/11/2025 at 2:13 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated known diagnoses or behaviors should be care planned. LVN 2 stated the purpose of care planning Resident 2's diagnosis of schizophrenia, and his known behaviors of aggression and striking at others, was to prevent the behaviors from occurring and to protect other facility residents. During an interview on 12/12/2025 at 10:46 a.m., with the Director of Nursing (DON), the DON stated that when a resident has psychiatric diagnoses such as schizophrenia, with known aggressive behavior, the behavior and the diagnosis should be care planned. The DON stated the care plan would address and prevent the behaviors through monitoring, and both medication and non-medication interventions. The DON stated all licensed nursing staff were responsible and able to update the resident care plans. During a concurrent interview and record review, on 12/12/2025 at 10:49 a.m., with the DON, all of Resident 2's care plans created since admission were reviewed. The DON stated Resident 2 did not have care plans for his diagnosis of schizophrenia, or the manifesting behaviors of aggression and striking at others. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 10/2023, the P&P indicated a comprehensive care plan was to be developed for each resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a low-air-loss-mattress (LALM, a mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) as ordered to one of four sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for the development of pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence).Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/21/2025, the MDS indicated Resident 1 had severe cognitive impairment (significant trouble with thinking, memory, learning, concentrating, or decision-making). The MDS indicated Resident 1 required supervision or touch assistance for rolling left and right in bed. The MDS indicated Resident 1 was at risk for developing pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 1's physician order, dated 8/22/2025, the order indicated staff were to provide Resident 1 with a low-air-loss-mattress (LALM, a mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) due to his high risk for wound decline around his tailbone. During an observation on 12/11/2025 at 10:53 a.m., in Resident 1's room, observed Resident 1 did not have a LALM. During an observation on 12/11/2025 at 11:00 a.m., in Room B, Bed A (Resident 1's previous room), a LALM was observed on the bed. Bed A was unoccupied and not assigned to a resident. During an interview on 12/11/2025 at 2:20 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the purpose of the LALM was to decrease pressure on the skin. LVN 2 stated LALMs were used for residents who were at risk for developing pressure ulcers. LVN 2 stated that Resident 1's physician order for a LALM was an active order, and Resident 1 should have the LALM as ordered. During an interview, on 12/11/2025 at 2:22 p.m., with LVN 2, at Resident 1's bedside, LVN 2 stated Resident 1 did not currently have a LALM. LVN 2 stated the LALM in Room B, Bed A was Resident 1's, and stated that when Resident 1 was moved to Room A, Bed A, the LALM was forgotten. LVN 2 stated the LALM should have been provided to Resident 1 as ordered. During a review of the facility's job description titled Licensed Vocational Nurse, dated 5/2017, the job description indicated staff were to provide treatment in a proficient manner per direction from the physician and follow through on resident care services needed to meet the individualize needs of the resident.