

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 02/03/2026
NAME OF PROVIDER OR SUPPLIER Manchester Healthcare Center		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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and records review, the facility failed to create an individualized care plan and implement interventions to prevent, one of three sampled residents, Resident 1, who was identified on admission with a significant actual risks for wandering (traveling/ walking from place to place, especially without any clear aim or purpose) and elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision), from leaving the facility unsupervised. This deficient practice without an individualized intervention resulted in Resident 1 leaving the facility on 1/30/2026, between 8:30 pm and 8:45 pm, undetected and was later found at a recovering unit in a general acute care hospital (GACH) after 2 days (2/2/2026). Findings: During a review of Resident 1 admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including encephalopathy (any disease or malfunction of the brain that alters the structure or function resulting in impaired mental state), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), altered mental status, and high blood pressure. During a review of Resident's 1 Minimum Data Set ([MDS] a resident assessment and care-screening tool) dated 1/6/2026, the MDS indicated Resident 1 can make his needs known, and the ability to understand others. The MDS indicated Resident 1 required supervision (Helper provides verbal cues and/or touching assistance/ steadying/ and/or contact guard assist as resident completes activity) with sit to stand, chair/bed-to chair-transfer, toilet transfer and walking 50 feet with 2 turns. Resident 1 required partial/ moderate assistance (Helper does less than half the effort) walking 10 feet. The MDS indicated Resident 1 did not use a wheelchair. During a review of Resident 1's Nursing admission assessment dated [DATE], done by Registered Nurse (RN 2), the Wandering and Elopement Assessment section indicated that Resident 1 had recent history of wandering and had a significant Actual Risk for wandering and elopement. During a review of Resident 1's eInteract Change in Condition (COC) Evaluation, dated 1/30/2026 at 3:30 p.m., the COC indicated on 1/30/2026, between 8:30 pm and 8:45 pm, the Director of Nursing (DON) noted during rounds Resident 1 was not in his room. During a review of Resident 1's progress notes dated 1/31/2026 at 8:46 a.m., the progress notes indicated on 1/30/2026 at approximately 8:30 pm and 8:45 pm, staff reported that Resident 1 was not in his room. Staff searched for Resident 1 in rooms, common areas, closets, and restrooms, but could not find him in the facility. Other staff drove along the street and called nearby hospitals but couldn't locate Resident 1. The progress notes indicated on 2/2/2026 at approximately 2:54 pm, Resident 1 was found at a Recovering Unit in a GACH. The Administrator picked up Resident 1 from the GACH and brought back to the facility. During interview on 2/3/2026 at 9:30 a.m., with the DON, the DON stated Resident 1 was not at risk for elopement before this incident. The DON stated it was believed that Resident 1 left the building through the exit door near the rehab room. During a concurrent observation and interview on 2/3/26 at 11:30 a.m., with Resident 1, Resident 1 was awake on his bed</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555273
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>awake; he responded to greetings. Resident 1 was asked how he left the facility on Friday (1/30/2026). Resident 1 stated that he did not understand and could not answer the question. During interview on 2/3/2026 at 1:40 p.m., with License Vocational Nurse (LVN1), LVN 1 stated that no staff sits and monitors the exit door but will look at the exit door during her rounds and if any resident is getting close to the exit door, that resident will be redirected. During an interview on 2/3/26 at 3:05 p.m., with the RN Supervisor (RN 1), RN 1 stated he saw Resident 1 in his room around 7:30 to 7:45 p.m. during his rounds. Then around 8:00 pm, while he was taking care of a newly admitted resident, he heard the door alarm beside the rehab room went off, he and other staff responded to the alarm. He looked outside the door and into the parking lot and did not see anyone, At the same time a Certified Nurse Assistant (CNA) told him that Resident 1 was not in his room. RN 1 stated staff searched for Resident 1, both inside the facility and outside, but they did not see him. It was dark outside. He then notified the Administrator and the law enforcement about Resident 1 missing. During the interview, the RN 1 confirmed that all the exit doors in the facility were not locked, all doors have alarms, and the alarm would go off if someone tried to leave, but no one can access the doors from outside. RN 1 stated that the exit doors are being monitored by the nursing staff whose assignments are close to the exit doors, they will monitor the doors during their rounds. During an interview on 2/3/2026 at 3:50 p.m., with the Administrator, the Administrator confirmed the doors were not locked because the facility is not a locked facility, the doors can easily be assessed from inside in case of emergency. The Administrator stated that the nurses monitor the exit door near their assigned area. During a concurrent interview and record review on 2/4/2026 at 1:45 p.m., with RN 2, RN 2 stated according to the admission assessment on Resident 1 on 12/30/2025, Resident 1 was identified with significant risks for wandering and elopement, but there was no care plan developed, to prevent Resident 1 from getting out of the facility. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 10/1/2023, the P&P indicated that the purpose of the policy was to ensure that a comprehensive person-centered Care Plan is develop for each resident based on their individual assessed needs. The P&P indicated the facility's Interdisciplinary Team (IDT) should develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with Omnibus Budget Reconciliation Act of 1987, (OBRA, a federal law that established foundational quality of care standards and rights for nursing home residents) and MDS guidelines. During a review of the facility's P&P titled, Wandering and Elopement, dated 10/1/2023, the P&P indicated to enhance the safety of residents of the facility, the facility will identify residents at risk for elopement and minimize any possible injury because of elopement. The P&P indicated the Licensed Nurse will assess residents upon admission and readmission and determine their risk of wandering/elopement. Residents at risk of wandering/elopement, preventative interventions will be documented in the resident's medical record and will be reviewed and re-evaluated by the IDT upon admission.</p>		