

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

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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 05/13/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate when one of seven sampled residents (Resident 1) found a condom (rubber used for safety during sexual intercourse to prevent pregnancy and sexually transmitted diseases) on her bed. This failure had the potential for the facility to not identify nonconsensual (non-consented) sexual activity in the building, violate Resident 1's right to privacy and placed the resident and other residents at risk for potential non-consensual (non-consented) sexual abuse. 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 including sciatica (a pain that happens when a big nerve in lower back gets pinched or irritated) right side, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder (health condition where a person feels really worried, scared, or nervous a lot of the time, even when there is no real danger). During a review of Resident 1's History and Physical (H&P), dated 1/27/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/2/2026, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability think and process) was moderately impaired. The MDS indicated Resident 1 used a walker and required moderate assistance (helper does less than half the effort) from staff for activities of daily living and mobility. During a concurrent interview and record review on 5/12/2026 at 12:45 p.m. with the Social Service Director (SSD), Resident 1's medical record was reviewed. The SSD stated the Care Plan was not updated, a Change of Condition (COC) was not initiated and there was no documentation by the DON or herself in the progress notes regarding Resident 1 finding the condom on Resident 1's bed. During an interview on 5/12/2026 at 12:15 p.m., with Resident 1, Resident 1 stated when she returned to her room on 5/6/2026 at 8:00 a.m., she found a condom on her bed. Resident 1 stated, on 5/6/2026, she reported the condom to the Social Services Director (SSD). The SSD stated she would inform the DON about Resident 1 finding a condom on her bed. Resident 1 stated the Director of Nursing (DON) asked her to attend a meeting with the DON, SSD, Activities Director (AD), Administrator, and a Licensed Vocational Nurse (LVN). Resident 1 stated the DON asked her if the condom belonged to another resident. Resident 1 stated she felt interrogated during the meeting, left the conference room and went to the restroom. Resident 1 stated she did not return to the meeting. During an interview on 5/12/2026 at 2:18 p.m. with the SSD, the SSD stated, on 5/6/2026 between 9:00 a.m. to 10:00 a.m., Resident 1 approached her in the hallway and reported the condom she found on her (Resident 1) bed. The SSD stated Resident 1 showed her (SSD) the condom Resident 1 was holding. The SSD stated no one was in Resident's 1 room when she (Resident 1) discovered the condom. The SSD stated she then left Resident 1 and attended the Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/resident representative, working together to develop a plan of care for the residents) meeting. After the IDT meeting, the SSD (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she informed the DON about Resident 1's reported condom found on the resident's bed. The SSD stated the DON asked the SSD to escort Resident 1 to the conference room to discuss Resident 1's report. The meeting started around 11:00 a.m. with the presence of the DON, Director of Rehabilitation (DOR), Activities Director (AD), and herself (SSD). The DON informed Resident 1 she would ask staff if they saw anyone near Resident 1's bed. The SSD stated she only interviewed Resident 1 and did not conduct an investigation on why and how the condom was found on Resident 1's bed. The SSD stated she was unaware whether the DON investigated the allegation. During an interview on 5/13/2026 at 12:40 p.m. with the DON, the DON stated, on 5/6/2026, after the SSD reported that Resident 1 found a condom on her bed, she (DON) did not conduct an investigation. The DON stated she did not interview other staff or the male residents near Resident 1's room if they observed anyone left the condom on Resident 1's bed. During an interview on 5/13/2026 at 1:20 p.m., with the Registered Nurse (RN), the RN stated on 5/6/2026, between 8:00 a.m. to 8:30 a.m., Resident 1 exclaimed, Who put this (condom) here! The RN stated she approached Resident 1 and observed the resident holding the condom in a wrapper in her hand. The RN stated she reported the incident (condom on Resident 1's bed) to the DON. The RN stated that she did not investigate the condom found on Resident 1's bed and did not document in Resident 1's progress notes. During an interview on 5/13/2026 at 1:34 p.m., with the DON, the DON stated condoms are used for protection during sexual intercourse (activity). The DON stated Resident 1 did not have signed consent or any documentation in the medical record indicating consent to engage in intercourse. The DON stated if there is no signed consent or documentation for sexual activity in the resident's medical record, the situation could be considered a possible indication of sexual abuse. During a record review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 10/1/2023, the P&P indicated residents had the right to voice grievances and the facility must respond to those grievances in a prompt manner. During a record review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 5/5/2025, the P&P indicated the facility is committed to protecting residents from abuse by anyone and has zero tolerance for abuse and must not permit anyone to engage in sexual abuse. The P&P indicated covered individuals will be trained through on-going training sessions regarding abuse prevention, investigation, reporting and documentation of abuse. Supervisors shall immediately intervene, correct and report identified situations where abuse is at risk of occurring. The facility should promptly and thoroughly investigate reports of resident abuse. The investigator should review all relevant documentation, interview the person making the incident report, interview witnesses, interview facility staff members, resident roommate and prepare an investigation report documenting findings of the investigation.		