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	03/26/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to review and act on the Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) conducted for all facility residents on 12/10/2025. This deficient practice resulted in delays to adjustments to multiple residents' medications and/or plans of care due to lack of physician notification of the facility's consultant pharmacist's recommendationsFindings: During a review of the facility's Medication Regimen Review (MRR), dated 12/20/2025, the MRR indicated the facility's consultant pharmacist made recommendations for 24 of the 44 residents reviewed. During an interview on 3/26/2026 at 9:00 a.m., with the Director of Nursing (DON), the DON stated there was no evidence available to demonstrate that the MRR recommendations dated 12/10/2025 were reviewed and acted upon. The DON stated timely review and intervention was important to ensure the residents' physicians were notified of the pharmacist's recommendations, and to ensure modifications to the plan of care were made timely. The DON stated this ensured the safety of the facility's residents. During a review of the facility's policy and procedure (P&P) titled Drug Regimen Review, dated 10/1/2023, the P&P indicated the facility was to maintain the residents' highest practicable level of well-being, and prevent or minimize adverse consequences related to medication therapy, by providing oversight by a licensed pharmacist, attending physician, medical director, and the DON. The P&P indicated the DON was responsible for following up with the attending physician as indicated, and the attending physician was to respond to any irregularities reported by the pharmacist. The P&P indicated this documentation was to occur within 30 days of issuance of the MRR.

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

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	03/26/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the privacy curtain and window closed during medication administration for one of six sampled residents (Resident 14). This deficient practice had the potential to compromise Resident 14's dignity, privacy, and emotional well-being during the provision of care. Findings: During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2026, the MDS indicated Resident 14's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 14 was dependent (helper does all the effort) 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 review of Resident 14's History and Physical (H&P), dated 3/16/2026, the H&P indicated Resident 14 did not have the capacity to understand and make decisions. During an observation on 3/24/2026 at 8:30 a.m., at Resident 14's bedside, Licensed Vocational Nurse (LVN) 2 was observed administering medications to Resident 14 via g-tube. LVN 2 opened the window curtain exposing Resident 14 to outside view. LVN 2 failed to close the privacy curtain to protect Resident 14's privacy. Resident 14 was visibly exposed during the medication administration process. During an interview on 3/24/2026 at 2:50 p.m., with LVN 2, LVN 2 stated the window and privacy curtains should not have been opened during medication administration as it exposed Resident 14 to the outside and others. LVN 2 stated it was important to ensure Resident 14's privacy, dignity, and confidentiality during g-tube medication administration and provision of care. During an interview on 3/26/2026 at 9:30 a.m., with the Director of Nursing (DON), the DON stated staff were expected to protect resident privacy and dignity during all care and treatment, including g-tube medication administration. The DON stated staff were responsible for ensuring the privacy curtain was closed and the window curtain remain closed to protect the resident's privacy and dignity during care. During a review of the facility's policy and procedure (P&P) titled Resident Rights- Quality of Life, dated 10/1/2023, the P&P indicated the facility will ensure that all residents are treated with the level of dignity while residing at the facility. The P&P indicated each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality.

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	03/26/2026

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 ensure informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the administration of Depakote ([psychotropic medication] -a medication that affect the mind, emotions, and behavior) was completed for one of three sampled residents (Resident 2). This deficient practice resulted in the violation of Resident 2's right to make an informed decision regarding the use of psychotropic medication and had the potential for increased risk of adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) leading to impairment or decline in Resident 2's mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/11/2026, the MDS indicated Resident 2's cognitive skills for daily decision making (ability to think and process information) was moderately impaired. The MDS indicated Resident 2 required maximum (helper does more 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 2 received antipsychotic medication. During a review of Resident 2's physician order, dated 1/6/2026, the physician order indicated to administer Depakote 750 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth, twice a day for bipolar disorder. The physician order indicated informed consent was obtained. During a review of Resident 2's Medication Administration Records (MAR), dated 1/1/2026 through 3/24/2026, the MARs indicated Resident 2 received Depakote 750 mg a total of 153 doses. During a concurrent interview and record review on 3/24/2026 at 2:15 p.m., with the Director of Nursing (DON), Resident 2's informed consent for psychotropic medication (Depakote) dated 1/6/2026, was reviewed. The informed consent did not indicate Resident 2's and/or Resident 2's representative's (RR) signature. The informed consent did not indicate licensed nursing staff verified with the resident and/or RR that the physician obtained informed consent prior to the initiation of Depakote. The DON stated Resident 2's informed consent indicated the name of the RR; however, the date and signature were missing. The DON stated Resident 2's informed consent was incomplete. The DON stated licensed staff should have ensured Resident 2's informed consent was fully completed prior to administration. The DON stated this violated Resident 2's and Resident 2's RR right to make informed decision about the treatment and could result in the resident receiving medication without understanding the reason for the use, risks and alternatives. During a review of the facility's policy and procedure (P&P) titled Informed Consent, revised 4/1/2024, the P&P indicated residents have the right to make informed decision prior to undergo medical therapies and procedures. The P&P indicated:1. The attending physician prior to prescribing a psychotherapeutic drug shall personally examine and obtain the informed written consent of the resident or the resident's representative.2. The facility verifies that informed consent was obtained prior to the administration of a medical intervention.3. The informed consent must be signed by the resident or the resident's representative and the physician who provided the information.4. If the signature of the resident or resident's representative cannot be obtained, a licensed nurse shall sign and date the informed consent.

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	03/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the wall next to a residents' bed was maintained in good repair for one of six sampled residents (Resident 10). This deficient practice had the potential to negatively impact Resident 10's comfort and well-being and contributed to an environment that was not consistent with a clean, safe, and home-like setting. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2026, the MDS indicated Resident 10's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 10 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 an observation on 3/23/2026 at 11:45 a.m., in Resident 10's room, an area on the wall adjacent to the right side of Resident 10's bed, between the bed and bedside cabinet, was observed with chipped and peeling paint, and cracked and missing plaster exposing the underlying material beneath the painted surface. The area was unrepaired. During a concurrent observation and interview on 3/25/2026 at 9:15 a.m., with Maintenance Supervisor (MS) 1, in Resident 10's room, observed the wall between the right side of Resident 10's bed and the bedside cabinet. MS 1 measured the area of the wall. The area measured 22 inches in length and six (6) inches in width. MS 1 stated the wall was damaged and should have been repaired to maintain the room in good condition. MS 1 stated resident rooms should be maintained in a manner that supports a clean, safe, and home-like environment. During a review of the facility's policy and procedure (P&P) titled Maintenance Services, dated 10/1/2023, the P&P indicated the maintenance department was responsible to maintain all areas of the building and grounds in a safe and operable manner at all times.

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	03/26/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of six sampled residents (Resident 14, Resident 1, and Resident 52) were free from chemical restraints when staff failed to: 1. Ensure Resident 1 and Resident 52's as needed (PRN) psychotropic medications (drugs that affects mental processes) were limited to an administration period of 14 days. 2. Document attempted gradual dose reductions (GDR, the stepwise tapering of a medication dose to determine if symptoms can be managed by a lower dose or if the medication can be discontinued) for Resident 14's fluoxetine (medication to treat depression) and olanzapine (antipsychotic medication). 3. Develop and document non-pharmacological interventions provided to Resident 14 for her behavioral manifestations, from 2/2/2025 to 11/24/2025, for which staff administered fluoxetine and olanzapine. These deficient practices placed Residents 14, 1, and 52 at risk of receiving psychotropic medications without clinical indication.Findings:1a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) 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 review of Resident 1's physician order, dated 2/18/2026, the physician order indicated Resident 1 was to receive Olanzapine (a psychotropic medication) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), one (1) tablet by mouth every eight (8) hours as needed for psychosis (a mental health symptom involving loss of contact with reality). The order did not indicate a stop date. 1b. During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), hypertension (HTN- high blood pressure), and muscle weakness (loss of muscle strength). During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 cognition was intact. The MDS indicated Resident 52 required moderate assistance from staff for ADLs. During a review of Resident 52's physician order, dated 2/19/2026, the physician order indicated Resident 52 was to receive Restoril (a psychotropic medication) 15 mg, 1 capsule by mouth every 24 hours as needed for inability to sleep. The order did not indicate a stop date. During a concurrent interview and record review on 3/25/2026 at 10:25 a.m., with the Director of Nursing (DON), Resident 1's physician order for Olanzapine 10 mg, dated 2/18/2026, Resident 52's physician order for Restoril 15 mg, dated 2/19/2026, and the facility's policy and procedure (P&P) titled Psychotherapeutic Drug Management, revised 1/6/2026, were reviewed. The physician orders did not indicate a stop date for the administration of Olanzapine and Restoril. The P&P indicated the PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician evaluates the resident in person for the appropriateness of that medication. The DON stated the purpose of the 14-day limit was to ensure the continued need for the psychotropic medication was clinically justified to prevent unnecessary use of such medications. 2a. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] and re-admitted [DATE]. Resident 14's diagnoses included major depressive disorder, schizophrenia, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 14's MDS, dated (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	03/26/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], the MDS indicated Resident 14 had severely impaired cognition. The MDS indicated Resident 14 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 14 required substantial to maximal assistance from staff to roll left and right in bed and was dependent on staff for all other mobility. During a review of Resident 14's discontinued physician orders, dated 1/28/2025, the order indicated to administer Olanzapine from 1/28/2025 to 9/17/2025, for bipolar disorder. During a review of Resident 14's discontinued physician orders, dated 1/28/2025, the order indicated to administer Fluoxetine from 1/28/2025 to 11/24/2025, for depression. During a review of Resident 14's discontinued physician orders, dated 9/18/2025, the order indicated Resident 14 received Olanzapine from 9/18/2025 to 11/24/2025, for auditory hallucinations (hearing things). During an interview on 3/25/2026 at 1:59 p.m., with the DON, the DON stated that non-pharmacologic interventions were to be implemented for residents receiving psychotropics. The DON stated non-pharmacological interventions of less restrictive measures should be implemented for managing behaviors and to assist in identifying causes of the behaviors. During an interview on 3/25/2026 at 2:06 p.m., with the DON, the DON stated Resident 14 did not have non-pharmacological interventions ordered, or documented as provided, from 2/2/2025 to 11/24/2025. During a review of the facility's P&P titled Psychotherapeutic Drug Management, revised 1/6/2026, the P&P indicated the use of non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications. 2b. During a review of Resident 14's discontinued physician orders, dated 11/25/2025 to 3/5/2026, the orders indicated Resident 14 received:1. Fluoxetine 10 mg, once daily, for uncontrollable crying.2. Olanzapine 10 mg, once daily, for yelling and screaming without cause during care. During a review of Resident 14's Medication Administration Record (MAR), dated 1/1/2026 to 1/31/2026, the MAR indicated that on 1/7/2026, Resident 14 exhibited one episode of uncontrollable crying, yelling, and screaming without cause during care. There were no other behaviors documented for 1/2026. During a review of Resident 14's MAR, dated 2/1/2026 to 2/28/2026, the MAR indicated Resident 14 did not exhibit behaviors for which staff administered fluoxetine or olanzapine. During a review of Resident 14's MAR, dated 1/1/2026 to 1/31/2026, the MAR indicated Resident 14 did not exhibit the behaviors for which staff administered fluoxetine or olanzapine. During an interview on 3/25/2026 at 2:03 p.m., with the DON, the DON stated staff were to conduct behavior monitoring on residents receiving psychotropic medications to monitor for effectiveness and identify if there was a continued need for the medication. The DON stated that if the resident was not displaying the behavior the psychotropic was indicated for, the expectation was that a gradual dose reduction (GDR) would be attempted. The DON stated the GDR attempts were to be documented and care planned. During an interview on 3/25/2026 at 2:06 p.m., with the DON, the DON stated there was no documented evidence of a GDR being conducted for Resident 14's administration of fluoxetine and olanzapine since 6/2025. The DON stated that continued use of psychotropic medication, without documented indication of the target behaviors, placed Resident 14 at risk for sustaining adverse effects (undesired, harmful, and unexpected reactions occurring from medical treatment) from the medications. During a review of the facility's P&P titled Psychotherapeutic Drug Management, revised 1/6/2026, the P&P indicated nursing staff were to review the use of psychotropic medication with the Attending Physician/Licensed Healthcare Professional (LHP) and Interdisciplinary Team at least quarterly to determine the continued presence of target behaviors. The P&P indicated that unless clinically contraindicated, the Attending Physician/Licensed Healthcare Professional was to attempt a Gradual Dose Reduction (GDR).

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	03/26/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code Section N of the Minimum Data Set (MDS, a resident assessment tool) for one of 12 sampled residents (Resident 14). This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS, the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace) regarding Resident 14's health status and increased the potential for Resident 14 to not receive the care and services to address the medications she was receiving.Findings: During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] and re-admitted [DATE]. Resident 14's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (MDD, a serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and convulsions (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 14's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 14 had severely impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 14 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 14 was not receiving antipsychotics (prescription medications used to treat psychosis and severe mood disorders, including schizophrenia), antidepressants (medication used to treat depression), anticonvulsants (medication used to prevent or reduce the severity of convulsions), or hypoglycemic agents (medications that lower blood sugar levels). During a review of Resident 14's Medication Administration Record (MAR), dated 3/1/2026 to 3/31/2026, the MAR indicated Resident 14 received antipsychotics, antidepressants, anticonvulsants, and hypoglycemic agents within the MDS reference date (the dates of the MAR reviewed when the MDS is completed). During an interview on 3/25/2026 at 12:16 p.m., with the MDS Coordinator (MDSC), the MDSC stated Resident 14's MDS dated [DATE] did not accurately identify the medications Resident 14 was receiving. The MDSC stated it was important to identify and record Resident 14's medications accurately because the MDS guided the plan of care. The MDSC stated this would ensure Resident 14's medications were routinely reviewed for effectiveness, and that there was an indication for their continued use. During a review of the facility's policy and procedure (P&P) titled RAI Process, revised 5/19/2025, the P&P indicated that all information recorded within the MDS assessment must reflect the resident's status at the time of the Assessment Reference Date.

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	03/26/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sampled resident's (Resident 6) Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder are placed in facilities that can provide the appropriate care) was filled out to indicate an existing psychiatric condition.This deficient practice had the potential to result in improper placement and unidentified specialized services for Resident 6. Findings:During a review of Resident 6's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 6 on 7/08/2021 and was re-admitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 6's cognition (ability to think and make decisions) was cognitively intact. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves)During an interview and record review on 3/24/2026 at 1:51 p.m. with Social Worker (SW) 1 Resident 6's admission Record and PASARR and Resident Review Level I Screening, dated 11/12/2025 was reviewed. SW 1 stated Resident 6 had a diagnosis of schizophrenia. The SW 1 stated Resident 6's PASARR Level I Screening diagnosis of schizophrenia should have been checked (as yes). The SW 1 stated completing the PASARR Level 1 screening correctly was important to be able to meet the needs of the resident and identify if the Resident needed a PASSAR II.During an interview on 3/25/2026 at 12:31 p.m. with the Director of Nursing (DON), the DON stated PASARR should be accurate for proper recommendation and appropriate resident placement.During a record review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review, revised 10/01/2023, the P&P indicated the facility conducts Level I PASARR screen for all admissions and readmissions. The P&P indicated All individuals, regardless of payor source, seeking admission to a Medi-Cal-certified Skilled Nursing Facility (SNF) must have a PASRR Determination by the Department of Health Care services (DHCS) or Department of Development Services (DDS) prior to the facility accepting the admission.

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	03/26/2026

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 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 a Preadmission Screening and Resident Review ([PASRR] - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) screening was completed for one of six sampled residents (Resident 1), who had diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), upon admission. This deficient practice had the potential to result in Resident 1 not receiving a required evaluation and identification of the resident's need for specialized mental health services. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and paranoid 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 2/25/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (the ability to think and process information) 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 had major depression major depressive disorder and paranoid schizophrenia as active diagnoses. During a concurrent interview and record review on 3/26/2026 at 9:30 a.m., with the Director of Nursing (DON), Resident 1's medical records were reviewed. The medical records did not indicate a PASRR Level I screening had been completed upon admission to determine whether Resident 1 had a mental illness requiring PASRR review. The DON stated a PASRR Level I screening should have been completed for Resident 1 for his diagnoses of depression and schizophrenia. The DON stated the facility failed to ensure a PASRR screening was completed for Resident 1 upon admission due to the resident's mental health diagnoses. The DON stated this failure had the potential to result in the resident's mental health needs and services not being identified and addressed. During a review of the facility's policy and procedure (P&P), titled Pre-admission Screening and Resident Review (PASRR), dated 10/1/2023, the P&P indicated: 1. All residents are screened for mental illness or intellectual disability with state agency coordination. 2. PASRR must be completed prior to admission. 3. The facility performs PASRR Level I screenings for all residents, including those currently residing with mental illness or intellectual disability.

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	03/26/2026

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 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 observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for three of 18 sampled residents (Residents 1, 32, and 5), by failing to:Develop and implement care plan interventions for Resident 1's diagnoses of major depression major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety (a feeling of fear, dread, and uneasiness). Develop and implement care plan interventions for Resident 1's use of Buspirone (an antianxiety medication).Develop and implement care plan interventions for Resident 32's risk for falls and convulsions. Develop and implement care plan interventions for Resident 5's history of post traumatic stress disorder (PTSD - a mental health condition that is triggered by experiencing or witnessing terrifying life-threatening events). These deficient practices had the potential to result in Residents 1, 32, and 5's unmet mental health, psychosocial, safety, and trauma informed care needs, and placed the residents at risk for ineffective care planning, and avoidable harm. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included major depressive disorder, paranoid schizophrenia, and anxiety. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 required moderate (helper does less than half the effort) assistance 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 did not indicate major depression, paranoid schizophrenia, and anxiety as active diagnoses. During a concurrent interview and record review on 3/26/2026 at 9:02 a.m., with the Director of Nursing (DON), Resident 1's medical records were reviewed. The medical records did not indicate a care plan related to Resident 1's diagnoses of major depression, paranoid schizophrenia, and anxiety. The medical records did not indicate a care plan related to Resident 1's use of Buspirone. The DON stated a care plan should have been developed to address Resident 1's identified mental health diagnoses and medication use, including specific interventions to guide staff with direction for the resident's care and services. The DON stated without a comprehensive person-centered care plan, there was a potential for unmet psychosocial and mental health needs, and ineffective symptom management. 2. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE]. Resident 32's diagnoses included epilepsy (a brain condition that causes recurring seizures [convulsions, sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), generalized muscle weakness, and difficulty walking. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 32 required (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	03/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantial to maximal assistance from staff for personal hygiene and mobility while in and out of bed. During a review of Resident 32's Physician's Progress Notes, dated 2/6/2026, 2/9/2026, and 2/23/2026, the progress notes indicated Resident 32 lacked coordination and was at high risk for repeat falls requiring hospitalization. During an interview on 3/23/2026 at 1:04 p.m., with Resident 32, Resident 32 stated he had a fall a few months ago but could not provide details about how the fall occurred or why. During an interview on 3/24/2026 at 12:29 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 32 was at risk of falls and had a history of convulsions. LVN 2 stated both conditions required a care plan. LVN 2 stated Resident 32 did not have a care plan addressing his risk of falls or history of convulsions. LVN 2 stated the purpose of care planning these conditions was to ensure the resident's safety, and to provide a plan of care that outlined what services and interventions were to be provided. 3. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 2/13/2026 with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and post traumatic stress disorder (PTSD - a mental health condition that is triggered by experiencing or witnessing terrifying life-threatening events). During a review of Resident 5's MDS dated [DATE], the MDS indicated the resident had intact cognition. During a review of Resident 5's H &P dated 2/14/2026, the H&P indicated Resident 5 had the capacity to make medical decisions. During a review of Resident 5's Care Clan, the care plan indicated the resident had a worsening case of depression as evidence by history PTSD. Resident 5's care plans did not address assessments or interventions relating to the resident's history of PTSD. During a concurrent observation and interview on 3/26/2026, at 8:45 a.m. with Resident 5, Resident 5 was observed lying in bed under the blanket. Resident 5 stated that she has PTSD but does not want it in her medical record. Resident 5 stated she has had PTSD for many years. During a interview on 3/26/2026, at 11:43 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 5 sometimes seems depressed. During a concurrent interview and record review on 3/26/2026 at 2:45 p.m. with Social Worker (SW) 1, Resident 5's care plans were reviewed. SW 1 stated there was no documentation indicating the resident had a comprehensive care plan for PTSD. During a concurrent interview and record review on 3/26/2026, at 4:03 p.m. with the DON, the DON stated the importance of having a care plan for residents with PTSD was to have treatment for the resident to be taken care of properly. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 1/2023, the (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	03/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated the facility will develop a comprehensive person-centered for each resident based on their individual assessment needs. The P&P indicated the care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. The P&P indicated The facility's Interdisciplinary Team, in coordination with the resident and family or representative must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, physical, mental, and psychosocial needs that are identified. The P&P indicated assessments of residents are ongoing, care plans are reviewed and revised.

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	03/26/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain fingernails clean and neat for one of six sampled residents (Resident 18). This deficient practice had the potential to result in a negative impact on Resident 18's quality of life and self-esteem and had the potential for development of infection.Findings: During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE]. Resident 18's diagnoses included legal blindness (vision loss), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness (loss of muscle strength), and dysphagia (difficulty swallowing). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 18's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 18 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 review of Resident 18's care plan titled The resident has impaired skin integrity, dated 3/12/2026, the care plan indicated to keep Resident 18's fingernails short. During an observation on 3/23/2026 at 11:04 a.m., at Resident 18's bedside, Resident 18's fingernails were observed long and untrimmed with dark brown debris underneath the nail bed. During a concurrent observation and interview on 3/25/2026 at 12:35 p.m., with Resident 18, at Resident 18's bedside, Resident 18 was observed eating lunch using his hands. Resident 18's fingernails were observed long with black substance underneath the nails. Resident 18 stated he was blind and unable to see his fingernails, but could feel they were long. Resident 18 stated he would like staff to cut them. During an interview with the Infection Preventionist (IP) on 3/24/2026 at 1:41 p.m., the IP stated nail care should be assessed daily. The IP stated residents who required assistance with cleaning or trimming their nails should be assisted by the certified nursing assistants (CNAs) or licensed nurses. The IP stated fingernails were a source of bacteria, and that dirty or untrimmed nails could contribute to the spread of infection, especially among residents who may not be able to maintain their own hygiene. The IP stated routine nail care was an essential part of both personal hygiene and infection control. During a review of the facility's policy and procedure (P&P), titled Nail Care and revised on 2/24/2026, the P&P indicated that residents' nails are to be maintained in a clean, trimmed, and hygienic condition.

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	03/26/2026

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 - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to ensure care and treatment were provided with professional standards of practice for two of three sampled residents (Residents 3 and 14) by failing to ensure:1. Resident 3 and 14's tube feeding bottles were correctly labelled.2., Staff verified Resident 14's gastrostomy tube ([g-tube]- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement and patency prior to medication administration. These deficient practices had the potential to place Residents 3 and 14 at risk for unsafe care, improper treatment administration, and avoidable complications and serious medical complications requiring medical intervention and hospitalization.Findings:1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included presence of a gastrostomy tube (g-tube, a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications, or to vent gas/liquids). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 3 had moderately impaired cognitive skills for daily decision making (noticeable decline in memory, language, thinking). The MDS indicated Resident 3 required substantial to maximum assistance for toileting hygiene and was dependent on staff for personal hygiene and rolling left and right in bed. During an observation on 3/23/2026 at 10:00 a.m., at Resident 3's bedside, observed a bottle of enteral feeding (liquid nutrients administered through a g-tube) connected to Resident 3's enteral feeding pump. The enteral feeding bottle was labelled with a different resident's name (Resident 14). During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] and re-admitted [DATE]. Resident 14's diagnoses included presence of a g-tube. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 14 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 14's physician order, dated 3/11/2026, the order indicated staff were to label the enteral feeding bottle with the resident's name. During an observation on 3/23/2026 at 10:13 a.m., at Resident 14's bedside, observed a bottle of enteral feeding connected to Resident 14's enteral feeding pump. The enteral feeding bottle was labelled with Resident 3's name. During an interview on 3/24/2026 at 12:42 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated enteral feeding bottles were to be labelled with the resident's name to ensure the enteral feeding type was correct. LVN 2 stated that incorrectly labelled enteral feeding bottles created the potential for nutritional issues. During an interview on 3/24/2026 at 1:04 p.m., with the Director of Staff Development (DSD), the DSD stated staff were to document the resident's name on the enteral feeding bottle. The DSD stated the information documented on the enteral feeding label should match the order and the resident it is being administered to. The DSD stated this was to ensure the resident received the right feeding and nutrition ordered, and to prevent allergic reactions to the formula. During a review of the facility's policy and procedure (P&P) titled Care and Services, dated 2/20/2026, the P&P indicated staff were to provide residents with the necessary care and services to maintain the highest level of practicable functioning in an environment that enhances quality of life in the facility. 2. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included g-tube, paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 14's MDS, dated [DATE], the MDS indicated (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	03/26/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident 14's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 14 was dependent (helper does all the effort) from staff for ADLs. During a review of Resident 14's History and Physical (H&P), dated 3/16/2026, the H&P indicated Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's care plan titled G-tube, dated 1/26/2026, the care plan indicated to check g-tube placement before medication administration. During a review of Resident 14's physician order, dated 3/10/2026, the physician order indicated to check for g-tube placement and patency before each medication administration, every shift. During an observation on 3/24/2026 at 8:30 a.m., at Resident 14's bedside, observed LVN 2 administer eight medications to Resident 14 without first verifying g-tube placement and patency. During an interview on 3/24/2026 at 2:45 p.m., with LVN 2, LVN 2 stated she administered Resident 14's medications through the g-tube without checking for placement and patency prior to administration. LVN 2 stated it was important to check g-tube placement and patency prior to medication administration to ensure the g-tube remained properly positioned in the stomach and was free from obstruction before use. LVN 2 stated failure to verify placement and patency could result in medication being administered through a displaced or clogged tube, which could lead to ineffective medication administration, aspiration (choking), blockage, and injury. LVN 2 stated these could place Resident 14 at risk for medical complications requiring hospitalization. During an interview on 3/26/2026 at 9:20 a.m., with the Director of Nursing (DON), the DON stated nursing staff were expected to confirm g-tube placement and patency prior to administering medications through the g-tube in order to ensure safe and appropriate medication delivery. The DON stated administering medications without first verifying g-tube placement and patency was unsafe, inconsistent with facility expectations, and not in accordance with professional standards of nursing practice. The DON stated these had the potential to place Resident 14 at risk for harm. During a review of the facility's P&P titled Feeding Tube- Administration of Medication, revised 2/24/2026, the P&P indicated the facility will ensure medications are administered appropriately and safely when the resident has a feeding tube in place. The P&P indicated:Check tube placement by gently inserting 15 cubic centimeters (cc, unit of measurement) of air into the tube via the piston syringe (medical device used for irrigation, wound cleansing, and flushing feeding tubes or catheters) and auscultating (listening) the resident's abdomen about 3 inches below the sternum (breast bone) with the stethoscope (medical instrument for listening to the action of someone's heart or breathing).After establishing the tube was patent and in the correct position, clamp the enteral tube.Flush the tube with approximately 30 cc of purified water.Administer medication(s).

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	03/26/2026

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 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 ensure the low air loss mattress (LALM, therapeutic support surfaces designed to prevent and treat pressure ulcers [PU, localized damage to the skin and/or underlying tissue usually over a bony prominence]) was set to the correct weight setting for one of two sampled residents (Resident 3). This deficient practice created the potential for Resident 3 to develop a PU.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (stroke, loss of blood flow to a part of the brain). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 3 had moderately impaired cognition (noticeable decline in memory, language, thinking). The MDS indicated Resident 3 required substantial to maximum assistance for toileting hygiene. The MDS indicated Resident 3 was dependent on staff for personal hygiene and rolling left and right in bed. The MDS indicated Resident 3 was at risk for developing pressure ulcers (PUs). During a review of Resident 3's physician order, dated 2/27/2026, the order indicated Resident 3 was to be placed on a low air loss mattress (LALM), with the setting based on his weight. During a review of Resident 3's weight measurement, dated 3/4/2026, the measurement indicated Resident 3 weighed 133 pounds (lbs., a unit of weight measurement). During an observation on 3/23/2026 at 10:00 a.m., at Resident 3's bedside, Resident 3 was observed lying on a LALM. The dial on the LALM machine indicated the setting was for a weight between 150 lbs. and 180 lbs. During an interview on 3/24/2026 at 1:23 p.m., with the Treatment Nurse (TN), the TN stated the purpose of a LALM was to prevent the development of PUs and maintain resident skin integrity. The TN stated the weight settings affected the pressure of the mattress, with lower weight settings being softer, and higher weight settings being firmer. The TN stated that if the weight setting was too high, the LALM mattress would be too firm and increase the risk for the resident to develop a PU. During a review of the facility's policy and procedure (P&P) titled Support Surface Guidelines, dated 10/1/2023, the P&P indicated the facility was to provide care and services to promote prevention of pressure ulcer development.

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	03/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accident hazards were identified and care planned for two of four sampled residents (Resident 14 and Resident 32) when: 1. Staff did not conduct quarterly fall risk evaluations for Resident 14. 2. Staff did not develop care plans for Resident 32's high fall risk and diagnosis of convulsions (sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). This deficient practice increased the potential for Resident 14 to experience falls and fall-related complications. This deficient practice also increased the likelihood that Resident 32 would not receive the care and services required to prevent falls, and to prevent convulsions and/or complications from convulsions (e.g., falls, injuries). Findings: 1. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] and re-admitted [DATE]. Resident 14's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a stroke, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and convulsions. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 3/4/2026, the MDS indicated Resident 14 had severely impaired cognitive skills for daily decision making (significant difficulties with memory, orientation, and attention). The MDS indicated Resident 14 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 14 required substantial to maximal assistance from staff to roll left and right in bed, and was dependent on staff for all other mobility. During an interview on 3/24/2026 at 1:00 p.m., with the Director of Staff Development (DSD), the DSD stated fall risk evaluations were to be conducted upon admission, quarterly, annually, and as needed. The DSD stated any licensed nurse was able to complete the evaluation. The DSD stated the purpose of the evaluation was to identify residents who were at risk for falls, and to prevent falls and possible injuries. The DSD stated Resident 14 had not had a fall risk evaluation since 1/28/2025. The DSD stated Resident 14's fall risk status could have changed since 1/8/2025, and stated she could be at an unidentified risk for falls and injury. 2. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE]. Resident 32's diagnoses included epilepsy (a brain condition that causes recurring seizures [convulsions]), generalized muscle weakness, and difficulty walking. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 had severely impaired cognition. The MDS indicated Resident 32 required substantial to maximal assistance from staff for personal hygiene and mobility while in and out of bed. During a review of Resident 32's Physician's Progress Notes, dated 2/6/2026, 2/9/2026, and 2/23/2026, the progress notes indicated Resident 32 lacked coordination and was at high risk for repeat falls requiring hospitalization. During an interview on 3/23/2026 at 1:04 p.m., with Resident 32, Resident 32 stated he had a fall a few months ago but could not provide details about how the fall occurred or why. During an interview on 3/24/2026 at 12:29 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 32 was at risk of falls and had a history of convulsions. LVN 2 stated both conditions required a care plan. LVN 2 stated Resident 32 did not have care plans for his risk of falls, or his history of convulsions. LVN 2 stated the purpose of care planning these conditions was to ensure the resident's safety, and to provide a plan of care that outlined what services and interventions were to be provided. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 10/1/2023, the P&P indicated a comprehensive care plan was to be developed, and was to include any services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. During a review of the facility's P&P titled Fall Risk Evaluation, dated 2/24/2026, the P&P indicated that fall risk evaluation was to be completed quarterly. The P&P (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	03/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the information in the fall risk evaluation was used to develop a person-centered care plan. The P&P indicated the fall risk evaluation was to be kept in the patient's record.

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	03/26/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview, and record review, the facility failed to ensure trauma-care evaluation was conducted for one of one sampled resident's (Resident 5) who had a history of trauma (a lasting emotional response to distressing events that overwhelm a person's ability to cope, causing fear, helplessness, and shattered safety). This failure had the potential to result in Resident 5 experiencing re-traumatization.Findings:During a review of Resident 5's admission Record (Face Sheet), the admission Record indicated the facility admitted resident on 2/13/2026 with diagnoses that included post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and aphagia (a language disorder caused by brain damage that impairs speaking, writing, reading, and understanding).During a review of Resident 5's History and Physical (H&P), dated 2/14/2026, the H&P indicated, Resident 5 was able to make decisions for activities of daily living.During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 5 was independent in showering, bed mobility, dressing, transfer, hygiene, and eating.During a interview on 3/26/2026, at 9:44 a.m. with Resident 5, Resident 5 stated she was diagnosed with PTSD as a teenager. Resident 5 stated having nightmares and difficulty sleeping and was startled by loud noises.During a concurrent interview and record review on 3/26/2026, at 10:06 a.m., with the Director of Staff Development (DSD), Resident 5's medical record was reviewed. The DSD stated there was no Trauma Care Evaluation (TCE - assessment form) record found in the resident's record. The DSD stated, he could not get much information regarding trauma and triggers (internal or external stimuli-such as sights, sounds, smells, or specific situations-that remind a survivor of a past traumatic event, triggering intense physical and emotional reactions like flashbacks, panic, or fight or flight responses) from Resident 5. The DSD stated, he should have contacted Resident 5's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) to obtain information regarding Resident 5's PTSD. The DSD stated trauma related care training for staff was combined with behavior training but does not specifically include trauma-based care strategies. The DSD stated that the resident's triggers were important to be identified to prevent recurring psychological events. During an interview on 3/26/2026, at 4:03 p.m. with the Director of Nurses (DON), the DON stated facility staff should have assessed Resident 5's PTSD. The DON stated possible re-traumatization would harm the resident's psychosocial well-being.During a review of the facility's Policy and Procedure (P&P) dated 2/20/2026 titled, Care and Services, the P&P indicated, Residents are provided with the necessary care and services to maintain the highest level of practicable functioning in an environment that enhances quality of life in the facility.

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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure signage for enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs]) and personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) were placed outside of the room for one of 12 sampled residents (Residents 3). This deficient practice increased the potential for spread of infection to Resident 3 and other residents.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included presence of a gastrostomy (a feeding tube placed through the abdominal wall directly into the stomach, providing nutrition for people unable to eat normally). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 3 had moderately impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 3 required substantial to maximum assistance for toileting hygiene and was dependent on staff for personal hygiene and rolling left and right in bed. During a review of Resident 3's physician order, dated 6/23/2025, the order indicated staff were to administer enteral feeding (a method of delivering nutrients directly into the stomach or small intestine when a person cannot eat or swallow safely) at 65 milliliters (ml) per hour every shift. During an observation on 3/23/2026 at 9:57 a.m., outside of Resident 3's room, there were no indicators or signage posted indicating EBP precautions were required. There was no PPE available outside of the room. During an interview on 3/24/2026 at 1:40 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated EBP was implemented for all residents with indwelling medical devices, including gastrostomy tubes. The IPN stated EBP protected the residents from contracting MDROs. The IPN stated signage was to be posted outside of the room to alert staff of the need for EBP, and PPE was to be made available outside of the room for use during care activities. The IPN stated that if EBP was not implemented, there was risk for spread of infection. During a review of the facility's policy and procedure (P&P) titled Standard and Enhanced Precautions, dated 4/1/2024, the P&P indicated EBP was indicated for residents with gastrostomy tubes. The P&P indicated EBP was to be implemented for the duration of the resident's stay in the facility.

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 03/26/2026
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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had 80-square feet (sq. ft., a unit of area measurement) of living space in Rooms: 101, 102, 103, 104, 105, 107, 109, 111, 112, 114, 115, 117, 201, 202, 203, 204, 205, 207, 209, 211, 212, 214, 215, and 217. This deficient practice increased the potential for facility residents to be unable to move around freely, and also increased the potential for staff to have difficulty providing high quality care due to a lack of space.Findings: During a interview on 3/23/2026 at 3:14 p.m., with the Administrator (ADM), the ADM stated the facility did not have any active room waivers. The ADM did not provide a room waiver request letter. During a review of the Client Accommodation Analysis, dated 3/23/2026, the analysis indicated the facility's rooms had the following measurements: room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 Square (sq) Feet (ft) per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 215 square feet with 3 beds (74 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) room [ROOM NUMBER] is 215 square feet with 3 beds (74 sq ft per resident) room [ROOM NUMBER] is 155 square feet with 2 beds (77.5 sq ft per resident) During a review of a document titled Room Waiver Request, dated 3/25/2026, the document indicated the facility requested a room waiver for Rooms 101, 102, 103, 104, 105, 107, 109, 111, 112, 114, 115, 117, 201, 202, 203, 204, 205, 207, 209, 211, 212, 214, 215, and 217. During observations and interviews conducted from 3/23/2026 to 3/26/2026, there were no concerns observed as a result of the facility not providing residents with at least 80 sq. ft. of living space. Quality of care was not affected, and no complaints or concerns were reported by facility staff or residents.