STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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** 47923 Based on interview and record review, the facility failed to: 1. Ensure an informed consent was obtained from resident representative for the use of psychotropic drug (any drug that affects brain activities associated with mental process and behavior) for one of one sampled resident (Resident 2). This deficient practice had the potential for the resident representative to have a lack of knowledge to make an informed consent and not knowing in advance the potential risk and benefits of the psychotropic drug. Findings: 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 hypertensive heart disease (heart condition caused by high blood pressure), acute kidney failure (a condition in which the kidneys can't filter waste from the blood), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). A review of Resident 2's History and Physical (H&P), dated 3/12/2024, indicated, Resident 2 did not have the capacity to understand and make decisions. A review of Resident 2's Minimum Data SET ([MDS] resident assessment and care screening tool) under Section GG (Functional Abilities and Goals), dated 3/15/2024, the MDS indicated Resident 2 was totally dependent (Resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, and personal hygiene. A review of Resident 2's Order Summary Report, dated 5/24/2024, indicated, Resident 2's physician prescribed lorazepam (medication used to relieve anxiety) oral solution to give 0.25 milliliter (ml, unit of fluid volume) twice a day for anxiety and agitation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/2024 at 9:22 a.m. with Registered Nurse (RN 3), Resident 2's clinical records were reviewed. RN 3 stated the facility had no documentation to indicate informed consent for the use of lorazepam was obtained and risks and benefits were explained by Resident 2's physician from resident representative regarding the use of lorazepam. RN 3 stated the facility staff can't initiate any psychotropic drug until the physician obtained an informed consent from the resident or resident representative. During an interview on 5/23/2024 at 12:32 p.m. with the Director of Nursing (DON), the DON stated it was an oversight by the facility staff for not verifying with the physician of Resident 2's if he called resident representative and obtained an informed consent for the use of lorazepam. The DON stated whoever was listed in the Admission Record was the recognized resident representative. The DON stated psychotropic drugs have adverse reaction (an unintended effect of a medication that is harmful or unpleasant) that has negative outcome to the resident. A review of facility's policy and procedure (P&P) titled, Psychotherapeutic Medications, undated, the P&P indicated, Informed consent will be obtained by physician prior to administering psychotherapeutic drugs. A review of facility's policy and procedure (P&P) titled, Informing Residents of Health, Medical Condition and Treatment Options, revised 2/2021, the P&P indicated, Each resident is informed of his/her total health status and medical condition, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also informed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042 Based on observation, interview, and record review the facility failed to: 1. Ensure the low loss air mattress was in functioning condition for one of one sampled resident (Resident 177). This deficient practice resulted in Resident 177 sleeping in a bed that was not functioning and uncomfortable, which had the potential not to meet the resident's needs. Findings: A review of Resident 177's Admission Record, the Admission Record indicated, Resident 177 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 177's diagnoses included type 2 diabetes mellitus (abnormal blood sugar), acute respiratory failure (a serious condition that makes it difficult to breathe on your own), and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of Resident 177's History and Physical (H&P), dated 4/2/2024, indicated Resident 177 had the capacity to understand and make decisions. A review of Resident 177's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 4/14/2024, indicated Resident 177 was assessed to have a clear cognition in daily decision making. The MDS indicated Resident 177 required supervision or touching assistance from staff for activities of daily living (ADLs) such as sit to lying, sit to stand, toilet transfer, lying to sitting on side of bed. And roll left and right. During a concurrent observation and interview on 5/22/2024 at 10:00 a.m. with Resident 177 in Resident 177's room, the bed mattress was observed to be sunken in at the middle of the bed. Resident 177 stated the bed has been like this for a few weeks. Resident 177 stated the staff did try to fix it when first observed, the staff was unable to fix it, so it has been like this since. Resident 177 stated that my back does hurt after lying in the bed for too long, I try to get my butt in the hole so my back would not hurt so much. During a concurrent observation and interview on 5/23/2024 at 12:41 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 177's room, observed the mattress sunken in on the middle of the bed. CNA 4 stated yes, the bed mattress is sunken in, it has been like this for about a week. CNA 4 stated maintenance did attempt to fix it but not sure what happened. CNA 4 stated, this could affect the resident by potentially hurting the back, not comfortable, and it is just not right for the resident's bed to look like that. During a concurrent observation and interview on 5/23/2024 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 5, in Resident 177's room, observed the mattress sunken in on the middle of the bed. LVN 5 stated yes, the bed is sunken in the middle. LVN 5 stated that if the bed is not functioning properly, it would affect the resident. LVN 5 stated it would be very uncomfortable for the resident to lay in a bed not functioning. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 1:08 p.m. with the Director of Nursing (DON), the DON stated the mattress should not be sunken in the middle of the bed. The DON stated the after the staff unsuccessfully tried to fix the mattress, they should have reported the issue to me. The DON stated, a resident should never have to sleep in a bed that is in that condition. The DON stated it could potentially affect the resident by being uncomfortable, possible hurting the resident's back. The DON stated it is the resident's right to have a comfortable and functioning mattress to sleep on. During a review of the policy and procedure (P&P) titled, Accommodation of Needs, dated March 2021, the P&P indicated the facility's environment are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. in order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Such adaptations may include: providing a variety of types , sizes , and firmness of furniture in rooms and common areas so that residents with varying degrees of strength and mobility can independently arise to a standing position.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46257 b. A review of Resident 71's Admission Record (Face Sheet), dated 4/17/2024, the Face Sheet indicate Resident 71's was admitted to the facility on [DATE], and was readmitted on [DATE], with a diagnosis including heart failure (a chronic condition in which the hear doesn't pump blood as well as it should), type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart), polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body). A review of Resident 71's History and Physical (H&P), dated 5/23/2024, the H&P indicated Resident 71 has the capacity to understand and make decisions. A review of Resident 71's Minimum Data Set ([MDS]a standardized assessment and care screening tool), dated 5/15/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decision-making resident was not completed. Resident 71's functional abilities and goals were between helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort, and helper does all the effort. A review of Resident 31's Admission Record (Face Sheet), dated 5/23/2024, the Face Sheet indicated Resident 31 was admitted to the facility on [DATE], and was readmitted on [DATE], with a diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety (an intense, excessive, and persistent worry and fear about everyday situations), chronic obstructive pulmonary disease with exacerbation ([COPD- a group of lung diseases that block airflow and make it difficult to breathe), hypertension (when the pressure in your blood vessels is too high), gastro-esophageal reflux disease ([GERD]- a digestive disease in which stomach acid or bile irritates the food pipe lining). A review of Resident 31's History and Physical (H&P), dated 11/17/2023, the H&P indicated, Resident 3` does not have the capacity to understand and make decisions. A review of Resident 31's Minimum Data Set ([MDS]a standardized assessment and care screening tool), dated 3/15/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decisions making was scored at 99 indicating the Resident 31 could not make decision. Resident 31's functional abilities and goals were dependent (helper does all the effort. Resident does none of the effort to complete the activity. During an interview on 5/24/2024 at 1:10 p.m., with Director of Nursing (DON), the DON stated, if the advance directive information is not given and not discussed with resident and/or representative there was potential to give medical interventions when a resident may not have wanted certain interventions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the policy and procedure (P&P) titled, Health, Medical Condition and Treatment Options, Informing Residents of, dated February 2021, the P&P indicated, every resident is informed of their total health status, medical condition, and options for treatment and/or care. The facility is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the resident's right to formulate an advance directive. 47042 Based on interview and record review, the facility failed to: 1. Ensure medical records were updated to show documentation that advance directive's (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and/or responsible parties for five of 36 sampled residents (Residents 55, 71, 74, 113, 124, 71 and 31). This deficient practice had the potential for the residents not to receive necessary information, treatments and care regarding the end-of-life issues according to their wishes. Findings: a. A review of Resident 74's Admission record, the Admission Record indicated, Resident 74 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 74's diagnoses included diabetes mellitus type 2 ([DM] a chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease ([COPD] progressive lung disease that affects your ability to breathe), and epilepsy (a disorder of the brain characterized by repeated seizure). A review of Resident 74's History and Physical (H&P), dated 7/10/2023, indicated, Resident 74 had the capacity for medical decision making. A review of Resident 55's Admission Record, the Admission Record indicated, Resident 55 was initially admitted to the facility on /4/2014 and last readmitted on [DATE]. Resident 55's diagnoses included chronic obstructive pulmonary disease (COPD, lung disease that causes blocked airflow from the lungs), encephalopathy (damage or disease that affects the brain), and schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly). A review of Resident 55's H&P, dated 3/29/2024, indicated Resident 55 did not have the capacity to understand and make decisions. A review of Resident 113's Admission Record, the Admission Record indicated, Resident 113 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 113's diagnoses included type 2 diabetes mellitus (abnormal blood sugar), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), and schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 113's H&P, dated 8/24/2023, indicated Resident 113 did not have the capacity to understand and make decisions. A review of Resident 124's Admission Record, the Admission Record indicated, Resident 124 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 124's diagnoses included cognitive communication deficit (difficulty with thinking and language use), encephalopathy (damage or disease that affects the brain), and altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain). A review of Resident 124's H&P, dated 7/20/2023, indicated Resident 124 had the capacity to understand and make decisions. During a concurrent interview and record review on 5/23/2024 at 8:48 a.m. with Social Service Director (SSD), Residents 55, 74, 113, and 124's advance directives were reviewed. The SSD stated, Residents 55 and 74 advance directive acknowledgements were not filled out, so it was not completed. The SSD stated, Residents 113 and 124 did not have an advance directive form in the chart. The SSD stated advance directive acknowledgements are to be done within 5 days of admission. The SSD stated, written information was given to the resident and/or family and everything on the document was explained. The SSD stated, an advance directive was to know the wishes of the resident when they are not able to voice their opinions anymore. The SSD stated, the residents have the right to be informed and make informed decisions. During an interview on 5/24/2024 at 1:10 p.m., with Director of Nursing (DON), the DON stated, if the advance directive information is not given and not discussed with resident and/or representative there was potential to give medical interventions when a resident may not have wanted certain interventions. A review of the policy and procedure (P&P) titled, Health, Medical Condition and Treatment Options, Informing Residents of, dated February 2021, the P&P indicated, every resident is informed of their total health status, medical condition, and options for treatment and/or care. The facility is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the resident's right to formulate an advance directive.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46257 b. During observations, on 5/30/24 at 9:15 a.m., disclosed a large red excoriated area on Resident 117 upper buttocks area. A review of Resident 117's admission record (face sheet) indicated Resident 117 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses that include metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), urinary tract infection (an infection in any part of the urinary tract system) and hemiplegia (muscle weakness or partial paralysis on one side of the body). A review of Resident 117's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 5/2/2024, indicated Resident 117 was severely cognitively impaired, unable to make needs known, and required extensive assistance from staff in ADLs (activities of daily living- an individual's daily self-care activities) with toileting, showering, and upper/lower dressing. A record review of Resident 117's skin progress report, dated 5/7/2024, indicated Resident 117 had a Stage 1 pressure ulcer (a intact skin wound on a bony area of the body that does not lose color fast when pressing and removing a finger) on his lower left leg. A review of the facility's policy and procedures, titled Change in a Resident's Condition or Status, dated on 2001 and revised in [DATE], indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 46832 Based on interview and record review, the facility failed to: 1. Ensure a change of condition was completed for two of seven sampled residents (Resident 117 and 7) skin assessments. This deficient practice has the potential to negatively affect the provision of necessary care and services. Findings: a. A review of Resident 7's Admission Record (Face Sheet), dated 5/23/2024, the face sheet indicated Resident 7 was admitted to the facility on [DATE], and was readmitted on [DATE], with a diagnosis including type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy), muscle weakness (can have causes that aren't due to underlying disease), major depression (persistently depressed mood or loss of interest in activities), urinary tract infection (an illness in any part of the urinary tract, they system of organs that makes urine), thrombocytopenia (a disorder causes bleeding into the tissues, bruising). (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's History and Physical (H&P), dated 2/8/2024, the H&P indicated Resident 7 can make decisions for activities of daily living. A review of Resident 7's Minimum Data Set ([MDS]a standardized assessment and care screening tool), dated 2/27/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decision-making resident is rarely/never understood. Resident 7's functional abilities and goals were impaired on both sides. During a concurrent interview and record review, on 5/23/24, at 2:17 p.m., with Treatment Nurse 2 (TN 2), TN 2 stated Resident 117 had redness on his left calf. TN 2 stated Resident 117 was contracted at both legs. TN 2 stated charge nurses were responsible for a resident's change of condition (COC- also known as a SBAR (Situation Background and Reassessment) is a sudden change from a patient's baseline in physical, cognitive, behavioral, or functional domains). TN 2 stated a COC form should had been completed for Resident 117. TN 2 stated she did not see a COC for Resident 117 left leg redness. TN 2 stated the risk of not documenting a change of condition in a resident could result in staff not knowing what was going on with a resident. During a concurrent interview and record review, on 5/24/24 at 9:45 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated charge nurses were responsible for documenting any COC in a resident. LVN 4 stated she was not informed of nor had seen Resident 117's left leg redness. LVN 4 stated there wasn't a COC regarding Resident 117's left leg redness although there should had been completed. LVN 4 stated the risk of not documenting a change of condition in a resident could result in neglecting a resident's treatment, not knowing if a resident's physician or family was informed, staff not being informed of what was going on with a resident, and possibly progress wound/skin breakdown. During an interview, on 5/24/24 at 1:10 p.m., with the Director of Nursing (DON), the DON stated a COC for a resident should had been reported to the charge nurse. DON stated whichever staff member that witnessed the COC was responsible for initiating the form. DON stated when completing a COC, a charge nurse should've had evaluated the resident, notified the resident's doctor and document. DON stated the risk of not documenting a COC on a resident could result in not knowing if the resident's family or doctor was notified. DON stated COC's are critical as they are the licensed staff members guide to care for the resident.

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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** 46832 Based on interview and record review the facility failed to: 1. 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) assessment screening was resubmitted to determine the facility's ability to provide special care and needs for one of 7 residents (Resident 38). This deficient practice has the potential to negatively affect the provision of necessary care and services. Findings: A review of Resident 38's admission record (face sheet) indicated Resident 38 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses that include metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), anxiety (a feeling of worry, nervousness or unease about everyday situations) and paranoid schizophrenia (a mental health condition where a person feels distrustful and suspicious of other people and acts accordingly). A review of Resident 38's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 5/6/2024, indicated Resident 38 was severely cognitively impaired, unable to make needs known, and required extensive assistance from staff in ADLs (activities of daily living- an individual's daily self-care activities) with toileting, showering, and upper/lower dressing. During a concurrent interview and record review, on 5/24/2024 at 10:31 a.m., with the MDS Coordinator, the MDS Coordinator stated PASRRs were to be completed while a resident was in the hospital. MDS Coordinator stated the facility could also do PASRR if not completed in the hospital. MDS Coordinator stated PASRRs were completed when a resident had a change in mental health behavior or change in a mental health medication. MDS Coordinator stated Resident 38 was in isolation (a precaution used to minimize spread of infection associated with health care) when the Level 2 PASRR was to be completed. MDS Coordinator stated once isolation was lifted, a new PASRR was to be resubmitted for Resident 38. MDS Coordinator stated the risk of not resubmitting a new PASRR could result in residents not receiving the care and services needed. MDS Coordinator stated, We will make corrections to have a system set in place to avoid missing things like this. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/24/24 at 1:10 p.m., with the DON, the DON stated PASRRs were completed by a hospital prior to a resident's admission. The DON stated if a hospital did not complete a resident's PASRR, the facility was responsible for doing so. The DON stated if a resident's level 1 PASRR was positive (meaning a resident had been diagnosed with a mental illness or was developmentally delayed), the facility was required to contact the California Department of Health Care Services to conduct a Level 2 screening. The DON stated a PASRR was not resubmitted for Resident 38 due to being on isolation precautions. The DON stated once the isolation period for the resident was complete, the facility was to resubmit a PASRR screening for Resident 38. The DON stated the risk of not resubmitting a PASRR screening could result in a resident not receiving the required services and/or resources for their mental illness. The DON stated, We are looking into a system to track residents who may need a PASRR completed if they are in isolation. A resident would still need to be re-evaluated whether in isolation or not. A review of the facility's policy and procedures, titled Preadmission Screening and Resident Review (PASRR), dated 2001 and revised 3/2023, indicated, The Preadmission Screening and Resident Review (PASRR) policy is a federal requirement to help ensure that individuals arc not inappropriately placed in nursing homes for long term care. PASRR requires that: The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.

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Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Correctly fill out the Preadmission Screening and Resident Review ([PASRR], a tool to determine if the person had, or was suspected of having, a mental illness, intellectual disability, or related condition) level one screening and refer one of seven sampled residents (Resident 147) who had a diagnoses of schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior) and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread and uneasiness) to the appropriate state-designated authority for PASRR level two evaluation and determination. This deficient practice had the potential to result in Resident 147 not receiving appropriate treatment recommendations for schizoaffective and anxiety disorder. Findings: A review of Resident 147's Admission record, the Admission Record indicated, Resident 147 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 147's diagnoses included schizoaffective disorder and anxiety disorder. A review of Resident 147's History and Physical (H&P), dated 12/20/2023, indicated, Resident 147 did not have the capacity to understand and make decisions. A review of Order Summary Report, dated 5/1/2024, indicated, Resident 147's physician prescribed quetiapine fumarate (a antipsychotic medication that is used to improve mood, thoughts, and behavior for people with schizoaffective disorder) 50 milligrams (mg, unit of measurement) twice a day for schizophrenia manifested by paranoid (feeling of extreme fear and distrust of others) delusions (something that is believed to be true or real but that is actually false or unreal) causing extreme fear. During a concurrent interview and record review on 5/23/2024 at 11:26 a.m., with the Minimum Data Set (MDS) coordinator, Resident 147's PASRR Level 1 Screening, dated 12/21/2023, was reviewed. The MDS coordinator stated the PASRR Level 1 Screening did not indicate Resident 147 had a diagnosed mental disorder such as schizoaffective disorder and anxiety disorder. The PASRR Level 1 Screening also did not indicate Resident 147 on antipsychotic medication. The MDS coordinator stated Resident 147's case was closed due to no serious mental illness and a PASRR level two evaluation and determination were not required. The MDS coordinator stated Resident 147's PASRR Level 1 Screening was completed inaccurately. The MDS coordinator stated Resident 147's PASRR Level 1 Screening should had been marked as an individual with a diagnosed mental disorder of schizoaffective disorder and anxiety disorder to trigger PASRR Level 2 evaluation and redetermination so Resident 147 could be evaluated and possibly receive appropriate treatment recommendations for schizoaffective and anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), revised 3/2023, the P&P indicated, If level 1 is positive for suspected mental illness/developmentally delayed in this case it needs to be advanced to a level II evaluation. The P&P also indicated All individuals seeking admission to Medicaid-certified nursing facility must be evaluated for mental illness and/or intellectual disability.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46257 b. During observations and interviews, on 5/22/2024 at 1:11 p.m., with Resident 150 in his room, Resident 150 stated he had difficulty in reading the newspaper and he had been asking the nursing staff to schedule him for eye surgery. Resident 150 further stated that he was anxious and afraid of losing his sight. A review of Resident 150's Admission Record, the Admission Record indicated, Resident 150 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 150's diagnoses included left eye visual loss and type 2 diabetes mellitus ([DM] a chronic condition that affects the way the body processes blood sugar). A review of Resident 150's History and Physical (H&P), dated 7/19/2023, indicated, Resident 150 had the capacity to understand and make decisions. A review of Resident 150's Minimum Data Set ([MDS]) resident assessment and care screening tool) under Section B (Hearing, Speech, and Vision), dated 5/3/2024, the MDS indicated Resident 150's vision was moderately impaired. A review of Resident 150's Order Summary Report, dated 5/1/2024, the Order Summary Report indicated for eye health vision consult with follow up treatment. A review of Resident 150's care plan, titled Impaired vision, dated 4/28/2023, the care plan indicated, Resident 150 had impaired vision and not able to see small and large prints but can identify objects in his environment. During an interview and record review on 5/22/2024 at 1:45 p.m., with the Social Service Assistant (SSA), Resident 150's Best Vision Care Report, dated 11/8/2023 and 2/26/2024 were reviewed. The Best Vision Care Report indicated, Resident 150 had a diagnosis of diabetic retinopathy and needs to be referred to ophthalmology eye clinic for surgery evaluation. The SSA stated he did not refer or scheduled an ophthalmology clinic appointment as recommended for Resident 150. During an interview on 5/22/2024 at 2:03 p.m., with the Assistant Director of Nursing (ADON), the ADON stated SSA was responsible in scheduling Resident 150's ophthalmology clinic appointment. The ADON stated there was no documentation in Resident 150's clinical records indicating he was referred to eye retina specialist (an ophthalmologist who has undergone additional training to become an expert in the diagnosis, management and treatment of disease and surgery of the vitreous body of the eye (watery gel between the lens and the retina) and the retina (back of the eye). The ADON stated progressive vision loss would cause permanent blindness. A review of facility's policy and procedure (P&P) titled, Accommodation of Needs, undated, the P&P indicated, The staff will assist the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's P&P titled, Social Services Referrals, dated 12/2008, the P&P indicated, Social service will collaborate with the nursing staff or other pertinent disciplines to arrange for services and will document the referral in the resident's medical record. 47923 Based on interview and record review, the facility failed to provide vision care services to two of two sampled residents (Resident 119 and 150) by failing to: 1. Arrange an ophthalmology (branch of medical science dealing with the anatomy, functions, and diseases of the eye) office visit for glaucoma (group of eye conditions that can cause blindness, gradual loss of sight) surgery evaluation for two of two sampled residents (Resident 119 and 150). These deficient practices had the potential for Resident 119 and 150's vision to continue to get worse, lose vision and negatively affect Resident 119 and 150's quality of life. Findings: a. A review of Resident 119's Admission Record, the Admission Record indicated, Resident 119 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 119's diagnoses included type 2 diabetes mellitus ([DM] a chronic condition that affects the way the body processes blood sugar) and blindness in one eye (loss of vision in one eye as a result of reduced blood flow to the eye from the heart). A review of Resident 119's History and Physical (H&P), dated 8/13/2023, indicated, Resident 119 was able to make decision for activities of daily living. A review of Resident 119's Best Vision Care Report, dated 2/26/2024, indicated, to refer Resident 119 to ophthalmology eye clinic for glaucoma surgery evaluation. During an interview on 5/23/2024 at 10:02 a.m., with Registered Nurse (RN 1), RN 1 stated Resident 119's pre-approval authorization for referral to ophthalmology eye clinic for glaucoma surgery evaluation was denied by the insurance and that was the reason why no appointment was made. During an interview on 5/23/20243 at 11:26 a.m., with the Social Service Director (SSD), the SSD stated Resident 119's referral to ophthalmology eye clinic for glaucoma surgery evaluation was not made because she was not aware of the referral. The SSD stated the facility failed to provide Resident 119's vision care needs. During an interview on 5/24/2024 at 1:32 p.m., with the Director of Nursing (DON), the DON stated it was the facility's responsibility to schedule residents appointment regardless of medical insurance.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview and record review, the facility failed to: 1. Ensure the low air loss mattress ([LALM] a mattress designed to prevent and treat pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) was set and maintained at correct setting for one of three sampled residents (Resident 82). This deficient practice placed Resident 82 at risk for further skin breakdown. Findings: A review of Resident 82's Admission record, the Admission Record indicated, Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 82's diagnoses included dysphagia (difficulty of swallowing), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and muscle weakness (lack of strength in the muscles). A review of Resident 82's History and Physical (H&P), dated 5/17/2024, indicated, Resident 82 was able to make decisions for activities of daily living. A review of Resident 82's Minimum Data Set ([MDS] resident assessment and care screening tool) under Section GG (Functional Abilities and Goals), dated 4/13/2024, the MDS indicated Resident 82 was totally dependent (Resident does none of the effort to complete the activity) in oral hygiene, personal hygiene, upper and lower body dressing and mobility. The MDS under Section M (Skin Conditions) also indicated, Resident 82 was high risk for developing pressure ulcer. A review of Resident 82's Order Summary Report, dated 5/20/2024, indicated, Resident 82's physician prescribed LALM for wound care and management. A review of Resident 82's Wound Risk Assessment (used to assess the risk of tissue damage due to pressure ulcer or shear forces), dated 5/17/2024, indicated total score of 14 (score of 8 or greater considered as high risk). A review of Resident 82's Skin Progress Report, dated 5/17/2024, the Skin Progress Report, indicated, Resident 82 had unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by necrotic or eschar (dead tissue) on Sacro-coccyx (tail bone), right heel, right lateral malleolus (bone on the outer side of the ankle), and stage 1 (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on left knee. A review of Resident 82's Weights and Vitals Summary indicated, Resident 82 weighed 103 pounds (lbs.) on 5/18/2024. During an observation on 5/21/2024 at 11:00 a.m., Resident 82 was observed laying in bed on a LALM. The LALM was observed on and functioning with settings at 340 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/22/2024 at 11:34 a.m., with Treatment Nurse (TN 1), Resident 82 was observed laying in bed. TN 1 stated Resident 82 was laying on LALM with settings at 340 lbs. TN 1 stated Resident 82 was not 340 lbs. and the setting should be based on the resident's weight. TN 1 stated Resident 82's current weight was 103 pounds. TN 1 stated incorrect or improper setting of the LALM would result in resident's delayed wound healing or possibly worsening of pressure ulcer. During an interview on 5/22/2024 at 1:59 p.m., with the Assistant Director of Nursing (ADON), the ADON stated it was important to follow the settings of the LALM which is based on resident's weight for the airflow and circulation. The ADON stated if the weight was set a lot higher than what the resident's weighs then it could cause extra pressure on the bony prominence of the resident. A review of facility's policy and procedure (P&P) titled, Pressure-Reducing Mattresses, undated, the P&P indicated, To provide mattresses that will prevent and/or minimize pressure on the skin. Adjust air mattresses to a desired firmness according to patient's weight.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042 Based on observation, interview and record review, the facility failed to: 1. Provide a complete Restorative Nursing Assistant (RNA) treatment per physician's order by failing to provide hand rolls and splints seven days a week for three of 14 sampled residents (Residents 115, 124, and 145). This deficient practice had the potential to promote the worsening development of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to the residents' extremities. Findings: a. A review of Resident 115's Admission Record indicated Resident 115 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses that include respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), dysphagia (difficulty swallowing foods or liquids), fibromyalgia (a long-term condition that involves widespread body pain and tiredness) and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). A review of Resident 115's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 4/7/2024, indicated Resident 115 was severely cognitively impaired, unable to make needs known, and required extensive assistance from staff in ADLs (activities of daily living) with toileting, showering, and upper/lower dressing. During an interview on 5/22/2024 at 2:43 p.m. with RNA 2, RNA 2 stated, Resident 115 had a hand roll, hand splint and right knee splint 7 days a week. RNA 2 stated not providing services as ordered could cause the resident to get worse. RNA 2 stated when I am not at the facility no one covers my resdients, the resdients are not getting services those days. 46832 b. During a concurrent observation, interview and record review on 5/23/2024 at 2:55 p.m. with RNA 3, Resident 124 Document Survey Report (POC), dated May 2024 was reviewed. The POC indicated, RNA to apply bilateral hand rolls for 4-6 hours every day 7 days a week. The POC indicated Resident 124 did not receive this service on 5/7/2024, 5/8/2024, 5/16/2024, 5/17/2024, 5/18/2024, 5/20/2024, and 5/21/2024. RNA 3 no it was not documented that the hand rolls were placed on the resident those days. RNA 3 stated if the order is for 7 days a week the hand roll should be placed on the resident or documented why it was not placed. RNA 3 stated the hand roll was to prevent further contractures, if the hand roll is not placed on the resident the contractures could potentially get tighter, increased pain. RNA 3 stated on the days I am not in the facility there was no RNA coverage for the resdients to receive services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 124's Admission Record, the Admission Record indicated, Resident 124 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 124's diagnoses included cognitive communication deficit (difficulty with thinking and language use), encephalopathy (damage or disease that affects the brain), and altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain). A review of Resident 124's H&P, dated 7/20/2023, indicated Resident 124 had the capacity to understand and make decisions. A review of Resident 124's MDS, dated [DATE], indicated Resident 124 was dependent on staff for ADLs such as eating, oral hygiene, upper and lower body dressing, toileting, and showering. A review of Resident 124's Order Summary Report (physician orders), dated 11/21/2023, indicated, RNA to apply right bilateral (both sides) hand rolls for 4-6 hours every day 7 times a week. c. During an observation on 5/21/2024 at 12:30 p.m. in Resident 145's room, Resident 145 had a right-hand contracture, resident did not have a splint or hand roll to hand. A review of Resident 145's Admission Record, the Admission Record indicated, Resident 145 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 145's diagnoses included type 2 diabetes mellitus (abnormal blood sugar), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of Resident 145's H&P, dated 5/11/2023, indicated Resident 145 had the capacity to understand and make decisions. A review of Resident 145's MDS, dated [DATE], indicated the resident was assessed to have a clear cognition in daily decision making. The MDS indicated Resident 145 required maximal assistance from staff for ADLs such as oral hygiene, upper body dressing, and dependent on staff for toileting, showering, and lower body dressing. A review of Resident 145's physician orders, dated 6/22/2023, indicated, RNA to apply right hand roll for 4-6 hours every day 7 times a week. During a concurrent interview and record review on 5/23/2024 at 2:55 p.m. with RNA 3, Resident 145's POC, dated May 2024 was reviewed. The POC indicated, RNA to apply right hand roll for 4-6 hours every day 7 days a week. The POC indicated Resident 145 did not receive this service on 5/4/2024, 5/5/2024, 5/7/2024, 5/8/2024, 5/11/20204, 5/12/2024, 5/16/2024, 5/17/2024, 5/18/2024, 5/19/2024, 5/20/2024, and 5/21/2024. RNA 3 no it was not documented that the right-hand roll was placed on the resident those days. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2024 at 8:24 a.m. with Director of Staff Development (DSD), DSD stated splints and hand rolls are to prevent contractions or further contractions. DSD stated, if splints or hand rolls not placed everyday it could affect the resident, not getting care, the resdients function could decline, and contractures to the extremities could become worse. DSD stated, the staff should be documented daily when they put on the devices and if a resident refuses or not in the facility then that should be documented. DSD stated there have been times we do not have RNA coverage and the resdients may not have gotten services that day. During an interview on 5/24/2024 at 1:10 p.m., with Director of Nursing (DON), the DON stated, we do need more RNAs, we try to cover them when they are off but there are times there just is not enough staff for coverage. The DON stated, if splints are not put on as ordered by the physician it could affect the resident by potentially causing more contractures to the resident. A review of the policy and procedure (P&P) titled, Restorative Nursing Services, dated July 2017, the P&P indicated, residents will receive restorative nursing are as needed to help promote optimal safety and independence.

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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** 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 164 did not have a cigarette lighter in his possession. This failure had the potential to result in a fire being started in the facility. Findings: During a concurrent observation and interview on 5/23/24 at 8:10 a.m. on the smoking patio with Resident 164, Resident 164 stated he keeps his own cigarettes and lighter. A lighter was observed in Resident 164's hand. During a concurrent observation and interview on 5/23/24 at 1:55 p.m. in Resident 164's room, a lighter was observed on the nightstand. Resident 164 states staff is aware he has a lighter and they didn't say anything. Resident 164 states staff did not provide education on keeping a lighter in his room. During an interview on 5/23/24 at 2:08 p.m. with AA1, AA1 stated the Activity Assistants monitor the residents when they smoke. The Activity Assistant keeps the lighter. Residents can't keep lighters because they might smoke in their room or light things on fire. During an interview on 5/24/24 at 10:20 a.m. with AD1, AD1 stated the Activity Assistant keeps the lighters. Residents who are alert and oriented get to keep their cigarettes but can't keep their lighters. Residents can't keep the lighters because it's the facility policy. The policy is in place to protect residents from lighting a cigarette in the room, they could burn something or light something on fire. A review of Resident 164's Admission Record (Face Sheet), the Face Sheet indicated Resident 164 was admitted to the facility on [DATE] with diagnoses of congestive heart failure (weak heart), hypertension (high blood pressure), and heart attack. A review of Resident 164's History and Physical (H&P) dated 2/9/2024, the H&P indicated Resident 164 has the capacity to understand and make decisions. A review of the facility's policy and procedure (P&P) titled Smoking Policy and Procedure, (no date), the P&P indicated residents may keep cigarettes but not lighters.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47923 Based on observation, interview, and record review the facility failed to: 1. Ensure accurate destruction of all medications including narcotic (drug which relieves pain and induces drowsiness, stupor, or unconsciousness) were conducted with the signature of licensed nurse, per facility's Policy and Procedure (P&P) titled, Discarding and Destroying Medications. This deficient practice increased the risk of loss or diversion of controlled medication. Findings: During a concurrent observation and interview on 5/23/2024 at 12:14 p.m., with the Director of Nursing (DON) in his office, controlled medication area inspection was conducted. The DON produced multiple Controlled and Antibiotic Drug Record sheets (a log containing the time, quantity, and nurse's signature each time a dose is administered) that had been destroyed by him and facility's pharmacy consultant. The DON stated the facility's Controlled and Antibiotic Drug Record dated 5/8/2024, there were twenty resident medications disposed without signature of licensed nurse witnessing the destruction of the medications. The disposed medications included the following: Lacosamide (medication used to treat seizure) 10 milligrams (mg, unit of measurement)/ per milliliter (ml, unit of volume). Lorazepam (medication used to relieve anxiety) 0.5 mg tablet. Lorazepam 1mg tablet. Lorazepam 1mg tablet. Zolpidem Tartrate (a sedative-hypnotic medication to help one sleep) 5mg tablet. Lorazepam 1mg tablet. Hydrocodone-Acetaminophen (narcotic medication used to treat pain) 5-325 mg tablet. Hydromorphone (narcotic medication used to treat pain) 2mg tablet. Lorazepam 0.5 mg tablet. Lorazepam 1 mg tablet. Morphine Sulfate (narcotic medication used to treat pain) extended release 15mg tablet. Doxycycline Hyclate (antibiotic medication that fight bacterial infection) 100mg tablet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lorazepam 0.5 mg tablet. Lorazepam 1mg tablet. Lorazepam 1mg tablet. Lacosamide 200mg tablet. Lorazepam 1 mg tablet. Clonazepam (medication used for acute management of panic disorder and seizure) 1mg tablet. Hydrocodone-Acetaminophen 5-325 mg tablet. Hydrocodone-Acetaminophen 10-325 mg tablet. During an interview on 5/23/2024 at 12:30 p.m. with the DON, the DON stated the process of controlled substance destruction includes two signatures on the Controlled or Antibiotic Drug Record, one from the Registered Pharmacy (RPH) Consultant and from a Registered Nurse (RN). The DON stated, he was the only licensed nurse responsible for the controlled substance destruction. The DON stated he regret and should have signed the destruction form along with the RPH Consultant but he did not, the RPH Consultant was the only one signed the form for destruction of the medications. The DON stated he was busy with other tasks on 5/8/2024 and that was the reason why he was not able to sign the Antibiotic or Controlled Drug Record sheets. The DON stated if the narcotic/controlled substance destruction was not documented accurately, there was no validation that it was done and there was a risk for diversion and theft of the medications if the process was not completed accurately. During a phone interview with the RPH Consultant, the RPH Consultant stated by signing the Antibiotic or Controlled Drug Record, both parties agreed that the amount was matching with the record and the amount that were destroyed. The RPH stated the facility did not follow the policy for narcotic destruction. A review of facility's P&P titled, Discarding and Destroying Medications, revised 4/2019, the P&P indicated, For any unused, non-hazardous controlled substances, the destruction and disposal of the substance must include the signatures of at least two witnesses.

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	055753	A. Building B. Wing	05/24/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Remove opened expired medication of diltiazem solution (medication to treat high blood pressure and chest pain) in subacute medication refrigerator room storage for Resident 115. This deficient practice had the potential to result in prolonged use and loss of strength of the expired medication and can lead to ineffective treatment of Resident 115's hypertension ([HTN] high blood pressure) and possibly can cause severe adverse reactions (an unintended effect of a medication that is harmful or unpleasant) including hospitalization s. Findings: A review of Resident 115's Admission record, the Admission Record indicated, Resident 115 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 115's diagnoses included HTN, cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and atrial fibrillation (irregular heartbeat). A review of Resident 115's History and Physical (H&P), dated [DATE], indicated, Resident 115 did not have the capacity to understand and make decisions. A review of Order Summary Report, dated [DATE], indicated, Resident 115's physician prescribed diltiazem 90 milligram (mg, unit of measurement)/7.5 milliliter (ml, measure of volume) solution every 8 hours, to hold if systolic blood pressure ([SBP] first number in blood pressure reading) less than 110 or heart rate (the number of times the heart beats per minute) less than 60. During a concurrent observation and interview on [DATE] at 3:50 p.m. of the subacute medication refrigerator room storage with Registered Nurse 2 (RN 2), found one bottle of opened expired diltiazem solution of Resident 115. RN 2 stated the diltiazem medication for Resident 115 indicates a pharmacy fill date of [DATE] and expiration date labeled on [DATE]. RN 2 stated expired diltiazem solution of Resident 115 should had been removed in the medication refrigerator and discarded immediately. RN 2 stated giving expired medication to Resident 115 could affect her blood pressure because of the loss of potency. During an interview on [DATE] at 12:14 p.m., with the Director of Nursing (DON), the DON stated expired medication should be placed immediately in a box labeled for destruction in medication room storage. The DON stated expired medication may not be functioning in its higher effect and Resident 115's blood pressure could not be controlled because of the expired medication. A review of facility's policy and procedure (P&P) titled, Storage of Medications, revised ,d+[DATE], the P&P indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. Building B. Wing	05/24/2024

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Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure the cook was wearing a beard restraint (device used to keep hair from falling onto food) while working in the kitchen. This failure had the potential to result in food being contaminated with hair. Findings: During an observation on 5/23/24 at 11:35 a.m. in the kitchen, CK1 was standing at the steam table taking temperatures and stirring food. CK1 had a beard of approximately two inches long that was not covered with a beard restraint. During an interview on 5/23/24 at 11:40 a.m. with CK1, CK1 stated he should be wearing a beard restraint. CK1 stated since he did not have on a beard restraint he could have gotten hair in the food. During an interview on 5/23/24 at 11:45 a.m. with DM1, DM1 stated CK1 should be wearing a beard restraint or regular face mask. The beard restraint prevents cross contamination (movement of germs from one place to another). A review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness- Food Handling, dated October 2017, the P&P indicated beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.