STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555099	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to effectively notify both designated emergency contacts listed on a resident ' s Admission Record for one out of three sampled residents (Resident 1) when the following occurred: 1) The licensed nurses did not attempt to contact Family Member (FM) 2 listed on Resident 1 ' s Admission Record when Resident 1 exhibited a change of condition on 10/17/2024. 2) The licensed nurses did not contact Resident 1 ' s Responsible Party (RP- Family Member [FM] 1) on 10/17/2024 to obtain informed consent for a newly prescribed medication (hydroxyzine hydrochloride - a medication used to help control anxiety and tension caused by nervous and emotional conditions) for the management of Resident 1 ' s anxiety and aggressive behavior. 3) The licensed nurses did not ensure FM 1 or FM 2 were notified when Resident 1 was sent to the General Acute Care Hospital (GACH) on 10/18/2024. These deficient practices caused FM 1 to become upset when she arrived at the facility to visit Resident 1 on 10/19/2024 only to find out that the resident was sent to the GACH on a 5150 (allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization). 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], with a diagnosis of paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 1 ' s Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 9/12/2024, the MDS indicated that Resident 1 ' s cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 needed supervision for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s History and Physical (H&P), dated 3/7/2024, the H&P indicated Resident 1 had the ability to make his needs known, but could not make medical decisions. During an interview on 11/5/2024 at 2:05 p.m. with Family Member (FM) 1, FM 1 stated that she came to visit Resident 1 on 10/19/2024 and was told that Resident 1 went to the GACH on 10/18/2024 because the resident exhibited aggression and behavioral changes on 10/17/2024. FM 1 stated that she nor FM 2 was made aware that Resident 1 exhibited a change of condition, was prescribed a new medication, nor that Resident 1 was sent to the GACH for a 5150 hold. During a review of Resident 1 ' s Change of Condition note, dated 10/17/2024, the note indicated Resident 1 grabbed Licensed Vocational Nurse (LVN) 1 ' s arms without provocation, continued to exhibit angry outbursts, and was eventually redirected and monitored. The note also indicated FM 1 was made aware of the change of condition. There was no documentation provided to indicate a voicemail was left, multiple attempts were made, or an attempt was made to notify FM 2 listed on the Admission Sheet. During a review of Resident 1 ' s Transfer Form, dated 10/18/2024, the form indicated FM 1 was notified of Resident 1 ' s transfer and was made aware of Resident 1 ' s clinical situation. During an interview on 11/6/2024, at 12:42 p.m., with LVN 1, LVN 1 stated she was assigned to care for Resident 1 on 10/17/2024. LVN 1 stated that Resident 1 exhibited an episode of physical aggression while LVN 1 was helping another resident in the hallway. LVN 1 stated Resident 1 grabbed her arm and LVN 1 attempted to guide Resident 1's arm away from her and attempted to redirect the resident. LVN 1 stated that when a resident exhibited a change of condition, it was the responsibility of the licensed nurses to notify the resident ' s family or RP, which were listed on the Admission Record. LVN 1 stated that she attempted to call the RP of Resident 1 once and left a voicemail. LVN 1 stated that she did not attempt to call FM 2 because she believed that FM 1 had to approve to have FM 2 be notified of any changes. During an interview, on 11/6/2024, at 1:47 p.m., with Registered Nurse (RN) 1, RN 1 stated that if there was a change of condition exhibited by a resident, then the resident ' s first emergency contact listed on the Admission Record was to be notified. RN 1 stated that if the first emergency contact was not able to be reached, then the second emergency contact would have to be notified. RN 1 stated that she signed and reviewed the Transfer Form and assumed LVN 1 had successfully notified Resident 1's RP or family but did not verify that they were made aware. RN 1 stated that Resident 1 ' s RP had the right to be made aware of Resident 1 ' s transfer to the GACH. During an interview, on 11/6/2024, at 2:34 p.m., with LVN 2, LVN 2 stated that she was scheduled to work on 10/17/2024, and helped LVN 1 complete documentation when Resident 1 exhibited a change of condition. LVN 2 stated that he completed and signed Resident 1 ' s Change of Condition Note, but did not verify if the resident's family or the RP was notified. LVN 2 stated that he told LVN 1 to call the family while he notified the physician, and he was under the assumption that LVN 1 was able to make FM 1 aware of Resident 1 ' s change of condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 11/6/2024, at 2:34 p.m., with LVN 2, Resident 1 ' s Consent Form for Hydroxyzine, dated 10/17/2024, was reviewed. The Consent Form indicated FM 1 received informed consent for Resident 1 ' s new order for Hydroxyzine Hydrochloride 25 milligrams (MG - a unit of measurement) and that LVN 1 and LVN 2 both verified consent. LVN 2 confirmed that LVN 1 and LVN 2 signed the consent form. LVN 2 stated that he did not follow the normal process to obtain informed consent over the telephone and provided his signature on the form without verbal consent from FM 1. LVN 2 stated he assumed LVN 2 notified FM 1 of the new order. LVN 2 stated that it was the right of the resident ' s RP to be fully aware of the changes of condition and newly prescribed medications of their loved ones as soon as possible. During a review of the facility ' s Policy and Procedure (P&P) titled, Change of Condition, revised 4/1/2015, the P&P indicated the Licensed Nurse would promptly notify the legal representative or an appropriate family member when there was an incident involving the resident; a significant change in the resident ' s physical mental or psychosocial occurs; and when a decision to transfer the resident from the facility was made .

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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 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** 47679 Based on observation, interview, and record review, the facility failed to ensure a resident slept on a pillow with a pillowcase for one out three sampled residents (Resident 1). This deficient practice had the potential to make Resident 1 feel less dignified and feel uncomfortable sleeping or resting in his own bed. 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 paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of dread or uneasiness). During a review of Resident 1 ' s Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 9/12/2024, the MDS indicated Resident 1 ' s cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 required supervision 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 interview, on 11/5/2024, at 2:05 p.m., with Resident 1's Family Member (FM) 1, FM 1 stated that there were no pillowcases provided to Resident 1 on any of his pillows. During an observation, on 11/6/2024, at 11:30 a.m., in Resident 1 ' s room, Resident 1 ' s pillow was observed on his bed without a pillowcase. During an interview, on 11/6/2024, at 11:30 a.m., Resident 1 stated that he had to make his own bed that morning (11/6/2024) and had to sleep on the pillow without a pillowcase the entire night. Resident 1 stated that he let the nurses know that he wanted a pillowcase, but the staff did not do anything. During a concurrent observation and interview, on 11/6/2024, at 11:33 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 1 ' s room, there was no pillowcase observed on Resident 1 ' s pillow. CNA 1 stated that all residents were supposed to have a pillowcase on his or her pillow because it was to keep the resident comfortable. CNA 1 stated that having Resident 1 go without a pillowcase throughout the night was not honoring Resident 1 ' s rights or dignity. During a review of the facility ' s Policy and Procedure (P&P) titled, Resident Rights - Accommodation of Needs, revised 1/1/2012, the P&P indicated the residents' individual needs are accounted for in the facility's provision of a clean comfortable bed with an adequate mattress, sheets, pillow, pillow case and blankets, all of which are in good repair, and consistent with individual resident needs.