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	02/04/2025

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 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** 46505 Based on interview and record review, the facility failed to notify, one of eight sampled residents (Resident 1) doctor, when the resident refused to receive dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so) on 12/13/2024 and missed scheduled dialysis on 12/16/2024 and 12/20/2024. This failure resulted in the doctor not aware and not providing further orders for Resident 1 ' s treatment. This failure placed Resident 1 ' s health and safety at risk for medical complications and hospitalization . Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, a condition where the kidneys can no longer support your body ' s needs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dependency on renal dialysis. During a review of Resident 1 ' s History and Physical (H&P), dated 11/2/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/7/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 had moderate cognitively impairment. The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on footwear, and personal hygiene. The MDS indicated Resident 1 required partial assistance from staff for sitting to standing, chair to bed transfer, toilet transfer, shower transfer, and walking, and Resident 1 required supervision from staff for rolling left and right, siting to lying, and lying to sitting on side of bed. During a review of Resident 1 ' s order summary report (MD orders), dated 11/20/2024, the MD orders indicated hemodialysis (a type of treatment that removes waste and extra fluids from the blood and regulates blood pressure) every Mondays and Fridays. During a review of Resident 1 ' s post dialysis evaluation, dated 12/13/2024, the evaluation indicated Resident 1 did not have treatment because Resident 1 refused to have hemodialysis. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Lakewood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12023 Lakewood Blvd. Downey, CA 90242	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s progress note, dated 12/13/2024, the progress note indicated Resident 1 came back from the dialysis center and refused to be dialyzed while at the dialysis center. During a review of Resident 1 ' s skilled COVID evaluation, dated 12/16/2024, the evaluation indicated Resident 1 refused dialysis and there ' s no indication the doctor was notified. During a review of Resident 1 ' s skilled COVID evaluation, dated 12/20/2024, the evaluation indicated Resident 1 refused dialysis and there ' s no indication the doctor was notified. During a review of Resident 1 ' s long term care evaluation, dated 12/21/2024, the evaluation indicated Resident 1 last received dialysis on 12/13/2024 and the next treatment date was scheduled on 12/23/2024. During a review of Resident 1 ' s SBAR (Situation, Background, Assessment, and Recommendation, a structured way to communicate to the care team about a resident ' s change in condition) Summary Situation, Background, Assessment, and Recommendation ([SBAR] a structured way to communicate to the care team about a resident ' s change in condition). dated 12/23/2024 at 10:31 p.m., the SBAR indicated Resident 1 had shortness of breath and was transferred to a general acute hospital for further evaluation and treatment. During a concurrent interview and record review on 2/4/2025 at 2:20 p.m. with Registered Nurse 1 (RN 1), Resident 1 ' s long term care evaluation, dated 12/21/2024, and progress notes were reviewed. RN 1 stated the long-term care evaluation indicated the last time Resident 1 received dialysis was on 12/13/2024 and the next treatment date was 12/23/2024. RN 1 stated it was not safe for Resident 1 toreceive dialysis treatment ten days after the last one which was on 12/13/2024. RN 1 stated Resident 1 ' s progress notes did not indicate documentation Resident 1 refused dialysis on 12/13/2024. RN 1 stated Resident 1 ' s progress notes did not indicate documentation Resident 1 missed dialysis on 12/16/2024 and 12/20/2024. RN 1 stated there was no documentation the doctor was notified when Resident 1 refuseddialysis on 12/13/2024 and when Resident 1 misseddialysis on 12/16/2024 and 12/20/2024. During an interview on 2/10/2025 at 8:55 a.m. with the Director of Nursing (DON), the DON stated there was no documentation the doctor was notified when Resident 1 refused to go to dialysis. The DON stated if there was no documentation, it was not done. During a review of the facility ' s policy and procedure (P&P), titled Refusal of Treatment, dated 1/1/2012, the P&P indicated the facility would honor a resident ' s request to not received medical treatment as prescribed by their attending physician and the charge nurse would document information relating to the refusal in the resident ' s medical record. The P&P indicated the documentation should include the date and time the attending physician was notified and his or her response.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to complete and send pre (before)-dialysis (a treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to) evaluation to the dialysis center, for one of eight sampled residents (Resident 1). This failure had the potential to cause lack of communication between the facility and the dialysis provider. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, a condition where the kidneys can no longer support your body ' s needs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dependency on renal dialysis. During a review of Resident 1 ' s History and Physical (H&P), dated 11/2/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on footwear, and personal hygiene. The MDS indicated Resident 1 required partial assistance from staff for sitting to standing, chair to bed transfer, toilet transfer, shower transfer, and walking, and Resident 1 required supervision from staff for rolling left and right, siting to lying, and lying to sitting on side of bed. During a review of Resident 1 ' s order summary report (MD orders), dated 1/31/2025, the MD orders indicated on 11/20/2024 to decrease hemodialysis (a type of treatment that removes waste and extra fluids from the blood and regulates blood pressure) to two times a week and Resident prefers Mondays and Fridays. During a review of Resident 1 ' s dialysis record on 12/9/2024, the record did not indicate a pre-dialysis information was sent to the dialysis center on 12/9/2024. The record indicated Resident 1 had post-dialysis (after) evaluation document, dated 12/9/2024, indicating Resident 1 had returned from dialysis on 12/9/2024 at 9:07 a.m. During a concurrent interview and record review on 2/4/2025 at 2:20 p.m. with Registered Nurse 1 (RN 1), Resident 1 ' s dialysis records for 12/9/2024 was reviewed. RN 1 stated the facility did not send Resident 1 ' s pre-dialysis evaluation form to the dialysis center on 12/9/2024. RN 1 stated the dialysis center sent Resident 1 ' s post-dialysis evaluation when Resident 1 returned from dialysis on 12/9/2024 at 9:07 am. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2025 at 12:54 p.m., with the Director of Nursing (DON), the DON stated before a resident goes to dialysis, the facility should check the resident ' s vital signs and fill out the pre-dialysis evaluation and send it with the resident to the dialysis center. The DON stated resident ' s pre-dialysis evaluation would serve as communication between the nursing home and the dialysis center. The DON stated, after each dialysis treatment, the dialysis center would fill out the post-dialysis portion indicating the weight, vital signs and any information the dialysis center would like communicated to the facility. The DON stated the facility did not send Resident 1 ' s pre-dialysis evaluation on 12/9/2024. The DON stated without the pre dialysis evaluation, the facility did not send any communication to the dialysis center. During a review of the facility ' s policy and procedure (P&P) titled, Dialysis Management, dated 1/25/2024, the P&P indicated a pre dialysis evaluation should be completed by facility ' s licensed nurse.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to document in the medical record, the assessment and interventions conducted to one of eight sampled residents (Resident 2), who complained of itchy scalp. This deficient practice had the potential to result in lack of communication among staff involved in the resident's care and the facility's failing to reassess the effectiveness of Resident 2 ' s scalp treatment. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel, and behave), major depressive disorder (a mood disorder that causes a constant feeling of sadness and loss of interest), and hyperlipidemia (a condition in which there are high levels of fat in the blood). During a review of Resident 2 ' s history and physical (H&P), dated 12/17/2024, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/23/2024, the MDS indicated Resident 2 was able to understand others and be understood. The MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 required supervision from staff for all activities of daily living such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 2 required supervision from staff for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair to bed transfer, toilet transfer, shower transfer, and walking. During a review of Resident 2 ' s physician order, dated 1/20/2025, the order indicated Selenium Sulfide external shampoo 2.25% to the scalp topically in the morning, every Monday, Wednesday, and Saturday, for dry itchy scalp. During an interview on 2/4/2025 at 3:20 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 had complained of itchiness on the scalp on 1/20/2025. LVN 1 stated Resident 2 ' s head was checked and did not find nits (eggs) or lice (a tiny, wingless insects that feed on human blood) but had dryness and dandruff in the scalp. LVN 1 stated, Resident 2 ' s doctor was called on 1/20/2025 and had ordered the shampoo. During a concurrent interview and record review on 2/4/2025 at 4:30 p.m. with LVN 1, Resident 2 ' s progress notes dated 1/20/2025 was reviewed. LVN 1 stated the assessment of Resident 2 ' s scalp and the doctor notification were not documented in Resident 2 ' s clinical record, and there was no change in condition made. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/4/2025 at 4:40 p.m. with the Director of Nursing (DON), the DON stated there was no documentation that LVN 1 assessed Resident 2 ' s head or when LVN 1 called the doctor. The DON stated LVN 1 should have documented when he assessed Resident 2 and when the doctor was called. The DON stated there if there was no assessment, they would not know and reassess Resident 2. During a review of the facility ' s policy and procedure (P&P), titled Alert Charting Documentation, dated 1/1/2012, the P&P indicated alert charting is required for special monitoring, signs of infection, and changes in medical condition. The P&P indicated the Licensed Nurse may initiate alert charting at their discretion as an additional measure for concerns or as a preventative measure.