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	02/20/2025

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 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** 36331 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from accident hazards by failing to consult with the Psychiatrist (a medical doctor who specializes in mental health) prior to going out on pass (OOP, temporary leave from the facility), according to its Policy and Procedure (P&P). This failure had the potential to negatively affect Resident 1 psychosocial well-being and cause harm or danger for the resident and others while OOP. 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 schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior), anxiety disorder (mental health condition that causes excessive fear, worry, or dread) and presence of cardiac pacemaker (small electronic device is implanted in the chest to regulate the heart's rhythm and rate). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 11/27/2024 indicated Resident 1 had clear speech, the ability to express ideas and wants, and clear comprehension. The MDS indicated Resident 1 required partial/moderate assistance (staff does less than half the effort) with Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene and putting on/taking off footwear. During a review of Resident 1's Release of Responsibility for Leave of Absence indicated Resident 1 went OOP on 1/10/2025, 1/18/2025, 1/25/2025, 2/08/2025, and 2/15/2025. During a review of Resident 1 Physician's order dated 1/10/2025, the Physician's order indicated Resident 1 may go out on pass for 4-6 hours for therapeutic purposes with RP if not medically contraindicated. During a review of Resident 1's Physician's order dated 1/18/2025, the Physician's order indicated Resident 1 may go out on pass independently with supervision/RP for 4-6 hours maximum one time only until 2/14/2025 11:59 p.m. (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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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 02/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Psychiatric Follow-up Note dated 1/28/2025, the Note indicated Resident 1 had fair to poor judgment, insight, and impulse. During a review of Resident 1's Physician's order dated 2/15/2025, The Physician's order indicated Resident 1 may go out on pass independently with supervision/RP for 4-6 hours maximum. During an interview on 02/20/2025 at 11:30 a.m. with the Registered Nurse Supervisor (RNS) stated she reviewed Resident 1's clinical record and did not find documentation to indicate the psychiatrist was consulted prior to Resident 1 going OOP. RNS stated the Psychiatrist should have been consulted and staff should have documented the Psychiatric consult. RNS stated failing to get clearance from the Psychiatrist could be dangerous for Resident 1 because he may harm himself or others. During an interview on 02/20/2025 at 1:35 p.m., the Psychiatric Nurse Practitioner stated he was not consulted and did not give his approval for Resident 1 to go OOP. During a review of the facility's P&P titled, Out on Pass , dated 1/11/2016, the P&P indicated the purpose of the policy was to provide residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning. The P&P indicated, if the Attending Physician and Psychiatrist determine that the resident may participate in activities outside the facility, the Attending Physician will write/give an order for a resident to go out on pass on the physician order sheet.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received medications as ordered by the physician by failing to: 1.Provide Resident 1's medications to the resident's Responsible Party (RP) to be given while the resident was Out on Pass (OOP, temporary leave from the facility), according to its Policy and Procedure (P&P). 2.Accurately document medication administration in Resident 1's Medical Records. These failures had the potential to result in worsening of Resident 1's symptoms or condition and lead to medication errors. 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 schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior), anxiety disorder (mental health condition that causes excessive fear, worry, or dread) and presence of cardiac pacemaker (small electronic device is implanted in the chest to regulate the heart's rhythm and rate). During a review of Resident 1's Order Summary Report , the Summary Report indicated on 11/21/2024, the physician ordered to administer the following medications to Resident 1: Divalproex Sodium (anti-seizure medication also used to treat manic episodes [periods of abnormally elevated, extreme changes in mood, behavior]) 250 milligrams (mg) by mouth three times a day for schizoaffective disorder m/b sudden mood swings from happy to depressed. Gabapentin (anti-seizure medication also used as mood stabilizer) 300 mg. three times a day for schizoaffective disorder m/b agitation and paranoia when in groups and meetings. During a review of Resident 1's care plan, dated 11/22/2024, the care plan indicated Resident 1 had a behavior problem related to schizoaffective disorder manifested by (m/b) sudden mood swings from happy to depressed and auditory hallucinations (a false perception of objects or events involving your senses: sight, sound, smell, touch and taste) hearing voices of unseen others. The care plan goal indicated Resident 1 will have no evidence of behavior problems by review date. The care plan nursing interventions included to administer medications as ordered. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 11/27/2024 indicated Resident 1 had clear speech, the ability to express ideas and wants, and clear comprehension. The MDS indicated Resident 1 required partial/moderate assistance (staff does less than half the effort) with Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene and putting on/taking off footwear. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Release of Responsibility for Leave of Absence (OOP log), indicated the following OOP dates, time out, expected time of return and time of return: 1/10/2025 time out 10:40 a.m., expected time in 5:00 p.m., time of return 3:40 p.m. 1/18/2025 time out 9:52 a.m., expected time in 5:00 p.m., time of return 3:30 p.m. 1/25/2025 time out 10:07 a.m., expected time in 5:00 p.m., time of return 3:44 p.m. 2/1/2025 time out 10:50 a.m., expected time in 5:00 p.m., time of return 4:20 p.m. 2/15/2025 time out 10:20 a.m., expected time in 3:00 p.m., no time of return to the facility. During a review of Resident 1's Medication Administration Record (MAR) dated 1/2025 and 2/2025, the MAR indicated Divalproex Sodium 250 mg. and Gabapentin 300 mg. were to be given three times a day at 9:00 a. m., 1:00 p.m. and 5:00 p.m. The MAR indicated there was a check mark (indicating medication was administered) for Divalproex Sodium 250 mg and Gabapentin 300 mg. at 1:00 p.m. for the following dates 1/10/2025, 1/18/2025, 1/25/2025, and 2/1/2025 (while Resident 1 was OOP and was not present at the facility). The MAR also indicated there was a 9 and no check mark documented on 2/15/2025 at 1:00 p.m. During a review of Resident 1's MAR and Progress notes dated 1/2025 and 2/2025, the MAR and Progress notes did not indicate Resident 1's medications were provided to the resident's RP to be given at 1:00 p.m. while resident was OOP on 1/10/2025, 1/18/2025, 1/25/2025, 2/1/2025 and 2/15/2025. During an interview on 02/20/2025 at 11:30 a.m. with the Registered Nurse Supervisor (RNS) stated she reviewed Resident 1's clinical record and found one progress note, dated 12/25/2024 indicating (12 p.m.) medications and instructions were provided to the responsible party. RNS stated there were no other documentation to indicate Resident 1's medications were provided to the RP when the resident went OOP (on 1/10/2025, 1/18/2025, 1/25/2025, 2/1/2025 and 2/15/2025). RNS also stated Resident 1 went out on pass before December 25, 2024, and several times after, and medications were documented as given with no explanation. RNS acknowledged staff should have documented accurately to reflect Resident 1 was out on pass and medications may have been given to the responsible party to give to Resident 1 or given when he returned to the facility. During interviews on 2/25/2025 at 5:05 p.m. and 3/3/2025 at 2:02 p.m., Resident 1's RP stated, the facility gave her the resident's afternoon medication due one time (date unknown) to be given while OOP. RP stated, she did not receive the medications aside from the one time and assumed they would be given when the resident returned to the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 3/3/2025 at 2:40 p.m. with the Director of Nursing (DON), Resident 1's MAR and OOP log dated 1/2025 and 2/2025 were reviewed. The DON stated, Resident 1's 1:00 p.m. doses of Divalproex sodium and Gabapentin should have been given to Resident 1's RP on 1/10/2025, 1/18/2025, 1/25/2025, 2/1/2025 and 2/15/2025 because the resident was expected to be out of the facility when the medications were due (at 1 p.m.). The DON stated, there were no supporting documentation to indicate the medications were provided to the resident RP. The DON stated it was important to ensure nurses provided the resident's medication to the RP to ensure the resident received the needed medication as ordered. The DON stated Resident 1's MAR had check marks documented for the 1:00 p.m. doses of Divalproex sodium and Gabapentin on 1/10/2025, 1/18/2025, 1/25/2025 and 2/1/2025 which indicated the resident's medications were administered by the licensed nurse at the facility, however this was inaccurately documented because the resident was OOP and not in the facility during these times. The DON also stated, it was important for nurses to accurately document medication administration. The DON stated, inaccurate documentation could lead to miscommunication for nurses and doctors whether the medication was administered and could lead to issues like double dosing or missed dosing. During a review of the facility's P&P titled Medication-Administration, dated 1/1/2012, the P&P indicated the purpose of this policy is to ensure the accurate administration of medications for residents in the Facility. The P&P indicated medications will be administered by a licensed nurse and upon the order of the physician. or licensed independent practitioner. The P&P indicated medications may be administered one hour before or after the scheduled medication administration time and the time and dose of the drug administered to the resident will be recorded in the residents medication record including the date, time and dosage of the medication. During a review of the facility's P&P titled, Out on Pass , dated 1/11/2016, the P&P indicated prior to the resident leaving OOP, a Licensed Nurse will assess the resident's physical and mental status and ensure that the resident and RP (if applicable) has been instructed of any special needs of the resident during the pass as applicable (e.g. special diet, needs, medications), there is a physician order for medications to be given while OOP and only the medication that must be administered while OOP will be given to the resident or RP. The P&P indicated the Licensed nurse will document the provision of the medication to the resident for use while OOP.