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	03/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to report injury of unknown origin (injuries not observed by any person or the source of the injury could not be explained by the resident) to the California Department of Public Health (CDPH), for one of seven sampled residents (Resident 7), who had bruise on right and left lower side of face and swollen left side of cheek. This failure resulted in a delay of investigation by the CDPH and placed Resident 7 at risk for further injuries. Findings: During a review of Resident 7 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis includingunspecified dementia (a progressive state of decline in mental abilities), paroxysmal atrial fibrillation (irregular heartbeat), and other abnormal of gait and mobility (unsteady walking, and difficulty with coordination). During a review of residents 7 ' s Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2025, the MDS indicated Resident 7 had cognitive impairment. The MDS indicated Resident 7 required substantial/maximal assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side.) During a review of Resident 7 ' s Change of Condition (COC) dated 3/8/2024 timed 1:05 p.m., the COC indicated Certified Nurse Assistance (CNA) reported Resident 7 had bruise on right side of face, left lower side of face and left side swollen cheek. The COC indicated the physician recommended to send Resident 7 to a general acute care hospital (GACH). During a review of Resident 7 ' s progress notes dated 3/8/2025, the progress notes did not indicate documented evidence the bruise on right side of face, left lower side of face and left side swollen cheek were reported to CDPH. During an observation and interview on 3/13/2025 at 4:45 p.m. in Resident 7 ' s room, Resident 7 was observed with round, quart-size, purplish skin discoloration on the left side of chin. Resident 7 ' s right side cheek was swollen. Resident 7 stated he did not know what happened to his face. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/17/2025 at 3:49 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Registered Nurse (RN) 2 was informed when she observed Resident 7 had a bruised on left side of face while passing medications. During an interview on 3/17/2025 at 5:00 p.m. with the Director of Nursing (DON), the DON stated the injury (bruise on right side of face, left lower side of face and left side swollen cheek) of unknown origin should have been reported to the State agency (SA), Ombudsman (patient advocate) and police. The DON stated Resident 7 ' s bruise on right and left lower side of face and swollen left side of cheek were not reported to the SA. The DON stated the SA would do a deep investigation of the incident to know what caused Resident 7 ' s bruised right and left lower side of face and swollen left side of cheek. The DON stated when the facility reports to SA, it is for the safety of the residents. The DON stated these injuries (bruises) does not happen commonly to residents and needs to be reported to the SA. The DON stated Resident 7 ' s COC was not reported to the police, because we thought is more medical than an issue of abuse. During an interview on 3/19/2025 at 4:30 p.m. with Registered Nurses (RN) 3, RN 3 stated, Resident 7 had a one on one (1:1) staff sitter for safety and fall preventions. RN 3 stated on 3/8/2025, RN 2 told him about Resident 7 ' s swollen face. RN 3 stated I wentto Resident 7 ' s room and assessed the swollen right side of face and the light small bruise on the left side of face. RN 3 stated Resident 7 ' s swollen right side of face, bruised left side of face was an injury of unknown source, and should have been reported to the SA for investigation. RN 3 stated, the facility ' s priority was to provide safety to Resident 7 and all the residents in the facility. RN 3 stated it was the facility policy to report to the SA if there was a suspected abuse. During an interview on 3/20/2025 at 1:30 p.m. with Certified Nurse Assistant (CNA) 6, CNA 6 stated, On 3/8/2025 during the day shift, while Resident 7 was eating breakfast, I noticed his left side chin had greenish discoloration and right cheek was swollen and I thought he had tooth procedure done. CNA 6 stated she reported her observation (greenish discoloration of left side chin and swollen right cheek) to the charge nurse on 3/8/2025. During a review of the facility ' s policy and procedures (P&P) titled, Injuries of Unknown Origin- Investigation, dated 11/18/2015, the P&P indicated, an injury of unknown source are injuries not observed by any person or the source of the injury could not be explained by the resident. During a review of the facility ' s P&P titled, Abuse Reporting and Investigations, dated 12/21/2023, the P&P indicated when the Administrator or designated representative received a report of injuries of an unknown source, the Administrator or designated representative, will notify outside agencies and send a written SOC341 report to CDPH Licensing and Certification within 24 hours.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to ensure appropriate skin care, adequate skin reassessment as indicated in the resident's care plan, were provided to one of seven sampled residents (Resident 6), who had generalized body dermatitis (condition of the skin in which it becomes red, swollen, itchy and sore, sometimes with small blisters and rashes) since 12/13/2024. This failure resulted in the resident ' s delayed, non-healing skin condition and had the potential to affect in maintaining the resident ' s highest practicable, physical, mental and psychosocial well-being. Findings: During a review of Resident 6 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), systematic inflammatory respond syndrome (SIRS body's response to an infectious or noninfectious insult.), and dermatitis. During a review of Resident 6 ' s History and Physical (H&P) dated 12/10/2024, the H&P indicated Resident 6 did not have the mental capacity to understand and make medical decisions. During a review of Resident 6 ' s care plan titled, Generalized body dermatitis, dated 12/13/2024, one of the interventions indicated to apply triamcinolone acetonide external cream 0.1% (topical corticosteroid, to relieve inflammation, itching, and other discomforts associated with various skin conditions) to generalized body, topically at day shift, for dermatitis. The intervention indicated to monitor efficacy of medication and call the physician if symptoms worsen. During a review of Resident 6 ' s Change of Condition (COC) dated 2/24/2025, timed 12:38 p.m., the COC indicated CNA 5 had reported that Resident 6 had generalized body redness, to initiate treatment orders, monitor skin weekly progress review. During a review of residents 6 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/7/2025, the MDS indicated Resident 6 rarely/never make self-understood and rarely/never understand others. The MDS indicated Resident 6 was dependent with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side.) During a concurrent observation and interview on 3/13/2025 at 11:05 a.m. in Resident 6 ' s room, Resident 6 was provided care by Certified Nurse Assistance (CNA) 5. Resident 6 was not verbally communicative. Resident 6 ' s skin on his back was observed with a dried rash, white and black in color. Residents 6 ' s right arm had dry scabs, and the left arm had dried rash. During an interview on 3/14/2025 at 12:58 p.m. with CNA 5, CNA 5 stated Resident 6 ' s rash in his arms, back and chest area had been there since 10/2024. CNA 5 stated Resident 6 developed more rash around 2/2025. CNA 5 stated she had seen the nurses putting lotion in Resident 6 ' s body. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/17/2025 at 11:57 p.m., with Licensed Vocational Nurse (LVN) 3, the weekly skin check dated 3/4/2025 and 3/10/2025 were reviewed. LVN 3 stated the weekly skin checks dated 3/4/2025 and 3/10/2025 did not contain proper documented assessment. LVN 3 stated, the weekly skin check indicated needs review means the skin should be under monitoring. LVN 3 stated the weekly skin assessment documentation dated 3/4/2025 and 3/10/2025 did not describe if the skin condition was getting better or worse. LVN 3 stated it did not indicate to the nurses if the treatment was working or not. LVN 3 stated the consequence for failure to monitor and document proper skin reassessment placed Resident 6 ' s skin condition at risk for poor healing and had the potential to result in skin infection and sepsis (severe infection). LVN 3 stated it was important to follow the doctor ' s orders as part of Resident 6 ' s plan of care. LVN 3 stated nurses should have reassessed the skin if the treatment was effective for Resident 6 ' s skin issues. During an interview on 3/17/2025 at 3:45 p.m. with the Director of Nursing (DON), the DON stated if resident develop a rash, we notify the primary physician and family. The DON stated skin assessment should be done weekly to monitor the progress of the skin and if treatment is working or not. The DON stated after the COC was created, the skin should have been monitored for 72 hours then weekly. The DON stated the weekly skin assessment should have a narrative description of the skin appearance. The DON stated nurses need to know if the treatment was helping the skin condition or not. The DON stated it was important to do an accurate assessment and reassessment of the skin to identify if the treatment was effective. The DON stated the risk of not doing an appropriate skin reassessment and documentation in the progress note resulted in the nurses unaware of the treatment progress and can delay the healing process of the wound/ skin condition. During a review of the facility ' s policy and procedures (P&P) titled, Skin Integrity Management, dated 6/28/2024, the P&P indicated licensed nurses should document the effectiveness of current treatment for skin integrity problems in resident ' s medical records on a weekly basis.