

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 06/13/2025
NAME OF PROVIDER OR SUPPLIER Lakewood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the physician's orders for one of six sampled residents (Resident 9), who had orders to administer Hydrocortisone cream (a medication used to reduce pain, itching, and swelling because of the body's immune response) for dermatitis (skin inflammation, causing redness, itching, blistering or scaling) and for a Dermatologist (physician who specializes in treating the skin) consultation.</p> <p>This failure had the potential to lead to worsening of Resident 9's skin condition and placed the resident at risk for discomfort and hospitalization.</p> <p>Findings:</p> <p>During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 9's diagnoses included encephalopathy (damage or disease that affects the brain) and cellulitis (a skin infection that causes swelling and redness) of the left and right lower limbs (arm and leg).</p> <p>During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool) dated, 4/29/2025, the MDS indicated Resident 9 had moderate cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). The MDS indicated Resident 9 required partial/moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADLs) such as showering/bathing self and performing personal hygiene.</p> <p>During a review of Resident 9's Progress Notes dated 6/7/2025, the Progress notes indicated Resident 9 had generalized (widespread) body rash. The Progress notes indicated, the physician was aware of the resident's condition and ordered to apply hydrocortisone 1% cream daily x 30 days for dermatitis.</p> <p>During a review of Resident 9's Treatment Administration Record (TAR) dated 6/2025, the TAR did not indicate hydrocortisone 1% cream was administered to Resident 9 on 6/7/2025-6/11/2025.</p> <p>During a review of Resident 9's Change of Condition (COC) dated 6/12/2025, the COC indicated Resident 9 had redness to the bilateral (both) lower legs. The COC indicated the physician was notified and ordered to refer Resident 9 for dermatologist consult.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 9's Order Summary Report dated 6/13/2025, the Order Summary Report did not indicate Resident 9's hydrocortisone was entered as ordered on 6/7/2025. The Order Summary Report did not indicate Resident 9's Dermatology consult was entered as ordered on 6/12/2025.</p> <p>During a concurrent interview and record review on 6/13/2025 at 1:44 p.m. with Licensed Vocational Nurse (LVN) 7, Resident 9's Progress Note dated 6/7/2025, physician's orders dated 6/2025, and COC dated 6/12/2025 were reviewed. LVN 7 stated Resident 9 had orders for hydrocortisone and dermatology consult, however she did not see the orders entered to be implemented. LVN 7 stated, resident 9 had not been seen by the dermatologist.</p> <p>During an interview on 6/13/2025 at 3:05 p.m. with the Director of Nursing (DON), the DON stated nurses should implement all orders from the physician, on the day the orders were received. The DON stated nurses should follow the physician's orders timely to ensure the plan of care was implemented to assist with the resident's condition and needs.</p> <p>During a review of facility's policy and procedure (P&P) titled, Medical Records Manual - Procedures, dated 12/28/2022, the P&P indicated, the licensed nurse receiving the telephone/verbal order will transcribe the order in the resident medical record at the time the order is taken.</p> <p>During a review of the facility's undated LVN Staff Nurse Job Description, the Job Description indicated general duties for the licensed nurse included to provide nursing care as prescribed by the physician in accordance with established standards of care, to administer professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental and emotional well-being. The licensed nurse receives, transcribes orders accurately from the physician and completes medical treatments as indicated and ordered by the physician.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/11/2025, ADM and IDT retained a Private Investigator (a person hired by individuals or groups to undertake investigatory law services) to assist with attempting to locate the resident.</p> <p>&nbsp;</p> <p>On 6/11/2025, the ADM contacted the Property Manager (a professional or company that oversees and manages the building on behalf of the owner, handling tasks like tenant relations, maintenance, and financial management) to conduct another inspection of all windows in the facility to ensure the windows were secured with a screw. The Property Manager was scheduled to come to the facility on 6/13/25.</p> <p>&nbsp;</p> <p>An ad hoc committee (a committee for the situation) meeting was conducted on 6/11/2025 to discuss current concerns regarding the elopement incident. Elopement Quality Assurance and Performance Improvement (QAPI, the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance [QA] and Performance Improvement [PI]) was updated to reflect current procedures to minimize the recurrence of elopement incidences.</p> <p>Findings:</p> <p>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 paranoid schizophrenia, COPD, anxiety, hypertension, and type 2 diabetes mellitus.</p> <p>During a review of Resident 1 ' s order summary report, dated 6/4/2025, the order summary report indicated Resident 1 ' s medications included amlodipine besylate (medication used to treat high blood pressure) 5 milligram (mg, a unit of measurement) one tablet one time a day for hypertension, aripiprazole (medication used to treat schizophrenia) 15 mg, one tablet two times a day for schizophrenia, divalproex sodium (medication used to treat seizures, a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) 250 mg, three tablets two times a day for schizophrenia, glimepiride (medication used to treat high blood sugar) 2 mg, one tablet one time a day for diabetes mellitus type 2, lorazepam (medication used to relieve anxiety) 1 mg, one tablet every six hours as needed for anxiety, Novolin R Injection (medication used to treat high blood sugar) sliding scale (a varied dose of insulin based on blood glucose level) before meals and at bedtime for diabetes mellitus type 2, and quetiapine fumarate (medication used to treat schizophrenia) one tablet at bedtime for schizophrenia.</p> <p>During a review of Resident 1 ' s elopement evaluation, dated 6/4/2025, the evaluation indicated Resident 1 was not at risk for elopement and did not have a history of elopement or an attempted elopement while at home.</p> <p>During a review of Resident 1 ' s care plan, titled, The resident is an elopement risk/wanderer related to impaired safety awareness, schizophrenia, episode of eloping the facility, dated 6/5/2025, the care plan interventions indicated to identify patterns of wandering and intervene as appropriate. The interventions indicated the resident ' s triggers (cause) for wandering/eloping were confusion and agitation and the resident ' s behaviors de-escalated by redirection (divert).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s history and physical (H&P) dated 6/5/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 6/8/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, and partial assistance (Helper does less than half the effort) from staff for oral hygiene, toileting hygiene, showering, dressing, and putting on and taking off footwear. The MDS indicated, Resident 1 required supervision from staff for rolling left and right, sitting to lying, lying to sitting on side of bed, chair to bed transfer, toilet transfer, and walking.</p> <p>During a review of Resident 1 ' s change in condition (COC), dated 6/8/2025 at 11:40 p.m., the COC indicated Resident 1 who resided in Room A, was observed entering the bathroom while the Licensed Vocational Nurse 1 (LVN) was making rounds. The COC indicated on 6/9/2025 at 12:20 a.m., Resident 1 ' s roommate left Room A and alerted staff members that Resident 1 was missing. The COC indicated the LVN 1 went to Room A and found the window opened and the window screen torn. The COC indicated LVN 1 searched for Resident 1 inside and outside the facility but was unable to locate the resident.</p> <p>During an observation on 6/10/2025 at 11:34 a.m., in Room A, the window with the screen bent outwards and partially removed, where Resident 1 eloped from, was on a ground level with a view to the parking lot leading to a street and stores.</p> <p>During an interview on 6/10/2025 at 12:34 p.m., with the Maintenance Supervisor (MS), the MS stated the windows in the rooms facing the street were secured with locks to prevent the windows from sliding open. The MS stated the top window sliding track (a component within a sliding window system that allows the window sash [the part holding the glass] to glide horizontally [sideways]) of the window frame had a screw to prevent the window from opening when lifted. The MS stated prior to Resident 1 ' s elopement on 6/8/2025, the window did not have a screw on the top to prevent Resident 1 and other residents from opening the window. The MS stated Resident 1 might have lifted the window open to elope.</p> <p>During an interview on 6/10/2025 at 1:30 p.m., with Resident 2, Resident 2 stated on 6/8/2025, she went into Room A to use the restroom, and when she noticed the window was wide open with the screen removed from the window, she told LVN 1 that Resident 1 was no longer in the room. Resident 2 stated she asked Resident 3 (other roommate), what happened to the window and Resident 3 stated she saw Resident 1 leave through the window about 10 to 15 minutes (time not identified) before Resident 2 came inside the room. Resident 2 stated Resident 1 never said she wanted to leave but Resident 1 had always wandered (going from place to place without a plan or definite purpose) in and out of the room and appeared very anxious.</p> <p>During an interview on 6/11/2025 at 8:52 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated on 6/8/2025, after Resident 2 informed staff members Resident 1 eloped, CNA 1 went into the room and saw the glass was moved and the screen was no longer in the window. CNA 1 stated Resident 1 did not say she wanted to leave but she would come out of her room and walk around before going back to bed. CNA 1 stated she never checked the windows but knew the windows were supposed to be secured.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/2025 at 10:29 a.m., LVN 1, LVN 1 stated after Resident 2 had let the staff know that Resident 1 eloped, LVN 1 went into the room and saw the window's glass was tilted off the window frame sliding track and the screen was pushed and bent outwards. LVN 1 stated she saw a small screw on the bottom of the window glass that prevented the window from being pushed to the side. LVN 1 stated it appeared Resident 1 lifted the glass open, was able to open the window. LVN 1 stated she does not check the window because she was not aware the windows could be opened.</p> <p>During a concurrent observation and interview on 6/11/2025 at 12:08 p.m., with the MS in Resident 1 ' s room, the window was observed. The MS stated the screw on the top of the window prevented the window from being lifted and slid out. The MS stated Room A ' s window was last checked on 6/6/2025. The MS stated the window was difficult to slide up, so he did not look for the screws on the top of the window. The MS stated it was not until he was investigating the window in Room A on 6/9/2025, that he noticed there were no screws on the top of the window. The MS stated all the windows should be secured. The MS stated if the residents ' room windows were not secured, residents could open the window and elope.</p> <p>During an interview on 6/11/2025 at 12:50 p.m., with Resident 1 ' s responsible party (RP), theRP stated a facility staff called her on 6/9/2025 (time unspecified) to inform her that Resident 1 eloped from the facility. The RP stated Resident 1 had eloped from a couple of other facilities before. The RP stated when Resident 1 first arrived at the facility, staff members told the RP that the facility was secured, however, the staff did not ask her if Resident 1 had previously eloped. The RP stated when she spoke to Resident 1 on Saturday 6/7/2025, Resident 1 sounded confused.</p> <p>During an interview on 6/11/2025 at 4:19 p.m., with the Registered Nurse Supervisor (RN 1), RN 1 stated he did not talk to the RP at the time of admission on [DATE] and was unaware of Resident 1 ' s history of elopement. RN 1 stated Resident 1 ' s elopement assessment, dated 6/4/2025, was not accurate. RN 1 stated he asked Resident 1 who had severe cognitive impairment about any history of elopement that Resident 1 denied. RN 1 stated any history of elopement would place Resident 1 at risk of elopement.</p> <p>During an interview on 6/11/2025 at 4:38 p.m., with the Director of Nursing (DON), the DON stated the Resident 1 ' s care plan intervention, dated 6/5/2025, on the elopement triggers were just for information purposes and the behaviors were not monitored.</p> <p>During an onsite verification of IJRP implementation on 6/12/2025, Resident 1 has not been found.</p> <p>During a review of the facility ' s policy and procedures (P&P) titled, Maintenance Service, dated 1/1/2012, the P&P indicated the maintenance department should maintain the building in good repair and free from hazards.</p> <p>During a review of the facility ' s P&P titled, Wandering and Elopement, dated 1/31/2023, the P&P indicated the facility will identify residents at risk for elopement upon admission to minimize the risk of elopement.</p>		