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	06/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) was treated with dignity and respect by Certified Nursing Assistant (CNA) 1 during care. This deficient practice resulted in Resident 3 feeling unvalued or respected and had the potential to negatively affect the resident's sense of self-esteem and self-worth. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension ([HTN]- high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 3's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 3's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 3 was dependent on staff for sitting and lying on the bed. During a review of Resident 3's situation, background, assessment, recommendation ([SBAR]- a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 6/19/2025, timed 2:45 p.m., the SBAR indicated on 6/19/2025 around 2:45 p.m., Resident was hit on her head and pushed back by CNA. The SBAR indicated Resident 3 complained of a headache following the incident. During an interview on 6/23/2025 at 2:05 p.m., with Resident 3, Resident 3 stated on the afternoon of 6/19/2025, after CNA 1 completed personal hygiene care, the resident requested to be placed back in bed. Resident 3 stated at that time, CNA 1 was rough, assisted her in a forceful and abrupt manner, and spoke in a disrespectful tone while helping her get back in bed. Resident 3 stated she felt like she did not matter and that she was not valued or respected as a person. Resident 3 stated the care provided by CNA 1 left her feeling upset and uncomfortable, and that she developed a headache following the incident. Resident 3 stated after the incident, she informed the facility's social services (SS) staff that CNA 1 had been rough and disrespectful while providing care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/23/2025 at 2:50 p.m., with CNA 1, the CNA 1 stated on 6/19/2025 approximately 2:00 p.m., she provided personal hygiene care for Resident 3. CNA 1 stated while assisting Resident 3 back in bed. CNA 1 stated while she was adjusting Resident 3's head of the bed, Resident 3 reported that her head was hurting and requested that the head of the bed to be raised more slowly. CNA 1 stated she was trying to finish care quickly to complete her tasks before the end of her shift. CNA 1 stated that in doing so, she may have been abrupt in her actions and tone and did not provide care as gently or respectfully as she should have. CNA 1 stated she did not offer further assistance or reassurance after Resident 3 voiced discomfort, nor did she notify the nurse of Resident 3 complaints of head pain at that time. During an interview on 6/24/2025 at 9:22 a.m., with SS 1, SS 1 stated on 6/19/2025 at approximately 2:30 p. m., Resident 3 informed her that CNA 1 was rough and disrespectful during care. SS 1 stated Resident 3 was worried and concerned that it could happen again and expressed fear about receiving care from CNA 1 in the future. SS 1 stated she reassured Resident 3 that CNA 1 would not provide care for her again and immediately reported the incident to the change nurse. SS 1 stated the resident should been treated with dignity and should feel safe and respected during care. During an interview on 6/24/2025 at 9:35 a.m., with Registered Nurse (RN) 1, RN 1 stated on 6/19/2025 at 2:45 p.m., she was made aware by SS 1 that Resident 3 reported that CNA 1 was disrespectful while providing care to the resident. RN 1 stated she immediately assessed Resident 3 and was informed by the resident that CNA 1 was rough while providing care. RN 1 stated following CNA 1's care, the resident complained of a headache. RN 1 stated that staff were expected to treat residents with respect and dignity, and to report resident's complaints of pain or distress immediately so that appropriate assessment and interventions would be provided. During a review of the facility's policies and procedures (P&P) titled Resident Rights, revised 1/1/2012, the P&P indicated the facility's employees were to treat all residents with kindness, respect and dignity and honor the exercise of residents' rights. During a review of the facility's P&P titled Resident Rights-Quality of Life, revised 3/2017, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. The P&P indicated facility staff would treat residents with dignity and sensitivity.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise one of three sampled residents (Resident 2) comprehensive care plan and interventions after a new order from the neurologist (a medical doctor who specializes in the diagnoses, treatment of disorders affecting the brain, and nervous system) which indicated the resident should avoid smoking due to medical risks. This deficient practice had the potential to result in Resident 2's ineffective care, treatment and services which could lead to increased risk in the resident's medical condition due to continued smoking. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (worry, or unease). During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 2's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's History and Physical (H&P), dated 3/30/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During an interview on 6/24/2025 at 7:25 a.m., with Resident 2, Resident 2 stated she was a smoker. During a telephone interview on 6/24/2025 at 10:11 a.m., with Resident 2's Responsible Party ([RP]- an individual who is designated as the primary point of contact, including making healthcare decisions) 1, RP 1stated he visited the resident regularly and spoke with her daily by phone. RP 1 stated he was concerned about Resident 2's health because the resident continues to smoke at the facility despite the neurologist's order dated 5/22/2025 instructing Resident 2 to avoid smoking. RP 1 stated he felt the facility was not following the neurologists' order and was not providing the necessary care or support to help the resident comply with the neurologists' instructions. RP 1 stated he was upset and frustrated that no interventions or education had been put in place to discourage Resident 2's smoking or monitor her behavior. RP 1 stated this placed Resident 2 at risk for worsening her medical conditions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/2025 at 11:35 a.m., with Registered Nurse (RN) 2, Resident 2's neurologist written order, dated 5/22/2025, and Care Plan titled The resident was a smoker, dated 3/28/2025, were reviewed. RN 2 stated the order indicated Resident 2 should avoid smoking due to medical risks. RN 2 stated Resident 2 continued to smoke despite the order. RN 2 stated an Interdisciplinary Team ([IDT]- a coordinated group of experts from several different fields) conference should have been conducted after the order was received on 5/22/2025, to determine additional interventions to address the resident's smoking. RN 2 stated there was no documented evidence the IDT was conducted on 5/22/2025. RN 2 stated Resident 2's care plan was not revised to reflect the smoking restrictions, and no new interventions were implemented to address the order, such as smoking cessation education or behavioral support. RN 2 stated she should have revised the care plan and taken more steps to follow the order and protect the resident's health. During an interview on 6/24/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated he was aware that Resident 2 had an order on 5/22/2025 instructing the resident to avoid smoking due to health risks. The DON stated the order was not added to or reflected in Resident 2's care plan and no interventions such as education or smoking cessation and support had been implemented. The DON stated Resident 2's care plan should have been revised after receiving the order and new interventions in place to support the resident and how to address the resident's care needs. During a review of the facility job description titled RN Staff Nurse, undated, the job description indicated the RN would receive and transcribe orders from the attending/alternate physician and would initiate, review, revise and update the resident care plan as indicated in the orders. During a review of the facility's policies and procedures (P&P) titled Comprehensive Person- Centered Care Planning, dated 9/7/2023, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives, and timeframes to meet a resident's medical, nursing and mental and psychosocial well-being. The P&P indicated the comprehensive care plan must be reviewed and revised by the interdisciplinary team after each assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services in accordance with professional standards of practice for one of three sampled residents (Resident 2) by failing to: 1. Ensure implementation of physician's orders for dental and podiatry services for Resident 2. 2. Clarify a neurologists' (a medical doctor who specializes in the diagnoses, treatment of disorders affecting the brain, and nervous system) order for drug testing for Resident 2. This deficient practice resulted in Resident 2 not receiving services and treatments as ordered by the physician and had the potential to place the resident at risk for unmanaged health concerns. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (worry, or unease). During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 2's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's History and Physical (H&P), dated 3/30/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's Order Summary Report, dated 6/24/2025, the order summary report indicated Resident 2's attending physician ordered dental consultation with treatment and podiatry service. This order started on 3/27/2025. During a review of Resident 2's care plan titled The resident had Diabetes Mellitus, date initiated 3/28/2025, the care plan interventions indicated the facility would refer the resident to podiatrist for foot care and to cut long nails. During a review of Resident 2's care plan titled The resident had oral/dental health problems ., date initiated 3/31/2025, the care plan interventions indicated the facility would coordinate arrangements for dental care as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/24/2025 at 7:25 a.m., in Resident 2's room, with Resident 2, the resident was observed lying in bed. Resident 2's toenails were visibly long, irregular in shape, and had dark brown debris underneath. Resident 2 stated she did not want the facility staff to touch or trim her toenails, but that she needed to be seen by a podiatrist to have the toenails cut and cleaned. Resident 2 stated she had tooth discomfort and needed to be seen by a dentist. During a telephone interview on 6/24/2025 at 10:11 a.m., with Resident 2's Responsible Party ([RP]- an individual who is designated as the primary point of contact, including making healthcare decisions) 1, RP 1 stated he visited the resident regularly and spoke with her daily by phone. RP 1 stated Resident 2 informed him that she had tooth discomfort and needed a dental evaluation. RP 1 stated the resident had previously expressed the need to be seen by a podiatrist for toenails care. RP 1 stated the facility had not arranged appointments with either a podiatrist or dentist since the resident's readmitted to the facility on 3/2025. RP 1 stated he was concerned about Resident 2's health because on 5/2025, there was an order from the neurologist which indicated the resident should have drug test at least once a week. RP 1 stated he was upset and frustrated that the facility was not following the neurologists' order and did not perform the drug testing for the resident as indicated in the order. RP 1 stated he expected the facility to follow through with neurologists' order and coordinate the necessary testing to ensure the resident's well-being. During a concurrent interview and record review on 6/24/2025 at 11:02 am., with Social Services (SS) 2, Resident 2's available SS progress notes dated 3/2025 to 6/2025, and clinical records, were reviewed. SS 2 stated the facility's SS staff were responsible for coordinating and arranging ancillary services such as podiatry and dental services which were provided by the outside agencies for the residents at the facility. SS 2 stated there was no documented evidence that Resident 2 received any podiatry and/or dental services since she was readmitted to the facility on 3/2025. SS 2 stated by failing to provide podiatry services placed the resident at risk for foot discomfort, infection, and decreased mobility. SS 2 stated by failing to arrange dental evaluation placed the resident at risk for worsening dental pain, oral infection, and difficulty eating. During a concurrent interview and record review on 6/24/2025 at 11:35 a.m., with Registered Nurse (RN) 2, Resident 2's neurologists' written order, dated 5/22/2025, and progress note, dated 5/22/2025, were reviewed. RN 2 stated the neurologists' order indicated Resident 2 should have drug test at least once a week. RN 2 stated the progress note, dated 5/22/2025, timed at 2:36 p.m., indicated Resident 2 had a new order from the neurologist which indicated the resident should have drug tested at least one a week. RN 2 stated she needed to clarify with the neurologist what drug test the resident needed to be tested for. RN 2 stated on 5/22/2025, she called the neurologists' office to get order clarification, however she was not able to speak with the neurology and left a message and documented that she will follow up. RN 2 stated she did not follow up after 5/22/2025 and no additional documentation was found to indicate that clarification was obtained or that the neurologist returned the call. RN 2 stated no drug testing was completed for Resident 2 since the order was written on 5/22/2025. RN 2 stated she should have ensured follow-up to clarify the order and implement the testing as directed. RN 2 stated by failing to follow up on the neurologists' order and complete the necessary drug testing placed Resident 2 at risk for potential medication interactions and the resident not receiving appropriate care and services as required. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Physician Orders, dated 12/28/2022, the P&P indicated the licensed nurse would review, transcribe and implement physician orders. The P&P indicated unclear orders must be clarified with the ordering physician and documented accordingly. During a review of the facility's P&P titled Referrals to Outside Services, revised 12/1/2023, the P&P indicated the facility would provide residents with outside services as required by physician order. The P&P indicated the facility's Social Services would coordinate the referral of residents to outside agencies to fulfill resident needs for services not offered by the facility.