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	07/08/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify one of seven sampled residents' (Resident 6) Responsible Party (RP) 1 of Resident 6's abuse allegation with another resident.This deficient practice resulted in RP 1 being unaware of Resident 6's wellbeing and of the facility's interventions to keep Resident 6 safe.Findings:During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including 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), and anxiety disorder (persistent and excessive worry that interferes with daily activities). The Face Sheet indicated Resident 6 was self-responsible and RP 1 was Resident 6's first emergency contact.During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/10/2025, the MDS indicated Resident 6 was able to understand and be understood by others and Resident 6's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 6 required maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. During a review of Resident 6's History and Physical (H&P), dated 8/28/2024, the H&P indicated Resident 6 could make needs known but could not make medical decisions.During a review of Resident 6's Change in Condition Evaluation (COC), dated 7/2/2025, the COC indicated on 7/2/2025, Resident 6 reported to the activity aide that another resident grabbed onto his neck and was hit on the head. During an interview on 7/8/2025 at 1:11 p.m., with RP 1, RP 1 stated he was the point of contact for Resident 6, which meant anything that happened to Resident 6, he was supposed to be notified. RP 1 stated he did not receive a phone call from the facility on 7/2/2025 and was not informed about Resident 6's abuse allegation. RP 1 stated he wanted to be informed of Resident 6's well-being to ensure Resident 6 was safe in the facility.During an interview on 7/8/2025 at 1:52 p.m., with Registered Nurse (RN) 2, RN 2 stated when an abuse allegation was made, the licensed nurse was responsible for notifying the resident's RP. RN 2 stated the purpose of notifying the RP was to ensure the RP was aware of the resident's well-being and to allow the RP to make any necessary decisions. RN 2 stated the resident's RP was listed on their Face Sheet.During a concurrent interview and record review on 7/8/2025 at 1:55 p.m., with RN 2, Resident 6's H&P dated 8/28/2024 was reviewed. RN 2 stated Resident 6 could not make medical decisions, therefore should have a designated RP to be notified of any changes and to make any necessary medical decisions. During a concurrent interview and record review on 7/8/2025 at 1:57 p.m., with RN 2, Resident 6's Face Sheet was reviewed. RN 2 stated Resident 6 was listed as his own RP and RP 1 was listed as Resident 6's emergency contact. RN 2 stated Resident 6's Face Sheet was incorrect, and Resident 6 should not be listed as his own RP. During a concurrent interview and record review on 7/8/2025 at 1:59 p.m., with RN 2, Resident 6's COC, dated 7/2/2025, was reviewed. RN 2 stated on 7/2/2025, she was under the impression that Resident 6 was his own RP based on Resident 6's Face Sheet RN 2 stated she did not notify RP 1 of Resident 6's abuse allegation. RN 2 stated notifying RP 1 was important to allow RP 1 to make any medical decisions that were best for Resident 6 related to the allegation such as sending Resident 6 to the hospital for evaluation. During an interview on 7/8/2025 at 2:13 p.m. with the Director of Nursing (DON), the DON stated RP 1 should have been notified of Resident 6's abuse allegation. The DON stated RP 1 was part of the healthcare team and RP 1 was the person to agree or disagree with Resident 6's plan of care. The DON stated notifying RP 1 was necessary to allow RP 1 to make any medical decisions related to Resident 6's care. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated once an abuse allegation was made, the licensed nurse was responsible for notifying the responsible party of the incident and the results of assessment findings.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of three sampled resident's (Resident 6) right to be free from physical abuse by another resident (Resident 7). This deficient practice had the potential for Resident 6 experiencing further abuse from Resident 7.Findings:a. During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included 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), and anxiety disorder (persistent and excessive worry that interferes with daily activities).During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/10/2025, the MDS indicated Resident 6's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 6 required maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. During a review of Resident 6's History and Physical (H&P), dated 8/28/2024, the H&P indicated Resident 6 could make needs known but could not make medical decisions.During a review of Resident 6's Change in Condition Evaluation (COC), dated 3/14/2025, the COC indicated on 3/14/2025, the Licensed Vocational Nurse (LVN) reported Resident 6 was hit in the face, for no reason, by another resident.During a review of Resident 6's COC, dated 7/2/2025, the COC indicated on 7/2/2025, Resident 6 reported to the activity aide that another resident grabbed onto his neck and was hit on the head.b. During a review of Resident 7's admission Record (Face Sheet), the Face Sheet indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder, and encephalopathy (any damage or disease that affects the brain). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognition was moderately impaired. The MDS indicated Resident 7 had delusions. The MDS indicated Resident 7 required supervision with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 7's H&P, dated 5/3/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's COC, dated 3/14/2025, the COC indicated on 3/14/2025, Resident 7 claimed another resident spat on him, then Resident 7 hit the other resident in the face.During a review of Resident 7's COC, dated 7/2/2025, the COC indicated another resident reported to the activity aide that Resident 7 grabbed his neck and hit him on his head for no reason. During a review of Resident 7's Care Plan titled, Behavioral Issues, revised 5/5/2025, the Care Plan indicated Resident 7 had behavioral issues related to schizophrenia manifested by auditory hallucinations (sounds or voices that are no there) telling him to hurt others, schizophrenia manifested by paranoid delusions that someone will hurt him, and schizoaffective disorder manifested by sudden change in mood from pleasant to extreme anger. The Care Plan's interventions indicated to intervene as necessary to protect the rights and safety of others, divert attention, and remove from the situation and take to an alternate location.During an interview on 7/8/2025 at 11:44 a.m. , with Resident 6, Resident 6 stated on 7/2/2025, Resident 7 grabbed him from behind, held onto the front of his neck, and hit the back of his head.During an interview on 7/8/2025 at 12 p.m., with Activities Assistant (AA) 1, AA 1 stated on 7/2/2025 at approximately 9:30 a.m., Resident 6 approached him and informed him Resident 7 tried to choke and hit Resident 6 on the back of the head. AA 1 stated, [Resident 7]'s behavior is usually up and down.During an interview on 7/8/2025 at 12:11 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated he observed Resident 7 place his hand onto the back of Resident 6's neck. CNA 5 stated after observing the incident, he brought Resident 6 to his room to ensure Resident 6 was okay. During an interview on 7/8/2025 at 12:36 p.m., with the Director of Nursing (DON), the DON stated upon investigation of Resident 6's allegation, he confirmed Resident 7 approached Resident 6 and tapped Resident 6's neck. During an interview on 7/8/2025 at 12:51 p.m., with Social Services (SS) 1, SS 1 stated Resident 6 continued to claim Resident 7 came from behind and grabbed his (Resident 6) neck. SS 1 stated upon speaking to the nursing staff, Resident 7 walked behind Resident 6 and touched Resident 6's neck. SS 1 stated Resident 7's behavior has been up and down, in and out of the hospital. [Resident 7] has issues with intrusiveness, can get aggressive for no reason, and annoying other [residents].During an interview on 7/10/2025 at 2:11 p.m., with the Administrator (ADM), the ADM stated Resident 7, like many residents in the unit, was impulsive and aggressive depending on his triggers. The ADM stated Resident 6 and Resident 7 had a prior physical