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	07/16/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 implement a care plan intervention to document wandering behavior (a person wandering moving from one place to place without a clear or immediate purpose) for one of seven sampled residents (Resident 1). This deficient practice resulted in Resident 1 leaving the facility unnoticed.Findings: During a review of Resident 1's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), type 2 diabetes mellitus without complications ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's History and Physical (H&P), dated 3/5/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 6/9/2025, the MDS indicated, Resident 1 was able to understand and be understood by others. The MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required supervision (helper provides verbal cues) from staff for activities of daily living such as toileting hygiene, upper body dressing and personal hygiene. The MDS indicated, Resident 1 had not exhibited wandering behavior. During a concurrent interview and record review on 7/16/2025 at 10:42 a.m., with Registered Nurse 1 (RN 1), Resident 1's care plan, titled The resident is an elopement risk related to disoriented to place) dated 3/5/2025, was reviewed. RN 1 stated one of the interventions indicated to document wandering behavior and attempt diversional interventions in behavior log. RN 1 stated the facility staff did not monitor and document Resident 1's wandering behavior since he did not attempt or exhibited that kind of behavior. RN 1 stated Resident 1's wandering behavior should be monitored by putting the number of episodes and documented on the Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). RN 1 stated it is important to document Resident 1's wandering behavior so they could prevent and developed a plan for resident not to leave unattended and implement interventions to mitigate the risks. RN 1 stated care plan interventions should be followed and implemented for continuity of care. During an interview on 7/16/2025 at 12:31 p.m., with the Assistant Director of Nursing (ADON), the ADON stated there was no documented evidence of the number of episodes of Resident 1's wandering behavior. The ADON stated care plan is a communication tool among Interdisciplinary Team ([IDT] - a group of healthcare professionals working together to plan the care needed for each resident) to provide standard of care to residents. The ADON stated the facility did not follow the care plan intervention. The ADON stated it is important to implement each intervention in the care plan so they can manage and meet the needs of the resident. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 9/7/2023, the P&P indicated, The facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.

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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 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. (continued on next page)

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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 0689 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 ensure one of seven sampled residents (Resident 1) did not elope (leave the facility unsupervised) by failing to:1. Conduct regular inspection of the facility's exterior gate. 2. Document Resident 1's wandering behavior episode as indicated in the care plan.This deficient practice resulted in Resident 1 leaving the facility unnoticed on 7/14/2025. Findings: During a review of Resident 1's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), type 2 diabetes mellitus without complications ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's History and Physical (H&P), dated 3/5/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 6/9/2025, the MDS indicated, Resident 1 was able to understand and be understood by others. The MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required supervision (helper provides verbal cues) from staff for activities of daily living such as toileting hygiene, upper body dressing and personal hygiene. The MDS indicated, Resident 1 had not exhibited wandering behavior. During a review of Resident 1's Elopement Evaluation, dated 3/4/2025, 6/6/2025, and 6/12/2025 indicated Resident 1 was not at risk for elopement. During a review of Resident 1's Progress Notes, dated 7/14/2025, the Progress Notes indicated, Resident 1 was last seen at around 4:15 a.m. and noted missing around 5:00 a.m. during medication pass administration. During an interview on 7/15/2025 at 3:28 p.m. with the Director of Maintenance (DOM), The DOM stated he had no documented record log of the exterior gate including the padlock and chain were routinely inspected. The DOM stated the padlock and the chain on the exterior gate was old. The DOM stated the padlock and chain on the exterior gates are primarily for safety and security reasons to prevent residents from leaving unattended. The DOM stated Resident 1 probably pushed the exterior gate so hard and was able to disengage the padlock from the chain. The DOM stated it was important to conduct regular inspection of the exterior gates to create a safe and secured environment. During a concurrent interview and record review on 7/16/2025 at 10:42 a.m., with Registered Nurse 1 (RN 1), Resident 1's care plan, titled The resident is an elopement risk related to disoriented to place) dated 3/5/2025, was reviewed. RN 1 stated one of the interventions indicated to document wandering behavior and attempt diversional interventions in behavior log. RN 1 stated the facility staff did not monitor and document Resident 1's wandering behavior since he did not attempt or exhibited that kind of behavior. RN 1 stated Resident 1's wandering behavior should be monitored by putting the number of episodes and documented on the Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). RN 1 stated it is important to document Resident 1's wandering behavior so they could prevent and developed a plan for resident not to leave unattended and implement interventions to mitigate the risks. RN 1 stated care plan interventions should be followed and implemented for continuity of care. During an interview on 7/16/2025 at 12:31 p.m., with the Assistant Director of Nursing (ADON), the ADON stated there was no documented evidence of the number of episodes of Resident 1's wandering behavior. The ADON stated it was important to keep tract of Resident 1's wandering behavior so they could notify the physician. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated 1/1/2012, the P&P indicated, To protect the health and safety of the residents, visitors, and facility staff. The P&P indicated the Director of Maintenance is responsible for maintaining the inspection record report of the building. During a review of the facility's P&P titled, Wandering and Elopement, dated 2/10/2023 indicated the resident's risk for elopement and preventative interventions will be documented in the resident's medical record. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 9/7/2023, indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.