

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 08/27/2025
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)
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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed or implemented for one out of three sampled residents (Resident 1) for oxygen administration (medical treatment that delivers oxygen at a concentration higher than room air). This deficient practice resulted in no care plan being created for Resident 1's oxygen administration, which could potentially cause a delay in care and negatively affect the delivery of care. Findings: During a review of Resident 1's admission Record, dated 8/26/2025, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's History and Physical (H&P) dated 5/6/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 6/26/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 1 required supervision for eating, personal hygiene and putting off and on footwear. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathing and dressing. During a review of Resident 1's Order Summary Report, dated 8/25/2025, the order summary report indicated Resident 1 had an order for oxygen at two (2) liters per minute via nasal cannula (a small plastic tube, which fits into residents' nostrils for providing supplemental oxygen) to keep oxygen saturation at or above 92% for interstitial lung disease (a group of disorders that cause swelling and scarring in the lungs). During a review of Resident 1's electronic record, a care plan for Resident 1's oxygen administration was not found. During an interview on 8/27/2025 at 12:06 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated a care plan had goals and interventions for residents to maintain a good quality of life. LVN 1 stated Resident 1's oxygen therapy (medical treatment that delivers oxygen at a concentration higher than room air) should be part of Resident 1's care plan. LVN 1 stated a care plan must be developed for oxygen therapy to provide information to licensed nurses on how to monitor residents, what signs and symptoms to look out for and how many liters of oxygen to deliver to the residents. LVN 1 stated if there was no care plan, there would be no guidance for oxygen therapy. During an interview on 8/27/2025 at 1:31 p.m. with the Director of Nursing (DON), the DON stated a care plan was a focus on a resident's problem and was based on doctor orders and nursing interventions. The DON stated there should be a care plan for Resident 1's oxygen therapy. The DON stated if something did not get care planned, the facility might not provide what was needed for the residents. The DON stated it was important for things to get care planned to develop accurate interventions and to provide instructions on residents' care. During a review of facility's Policy and Procedures (P&P) titled Comprehensive Person - Centered Care Planning, dated 9/7/2023, the P&P indicated the facility would provide person - centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of the residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. During a review of facility's P&P titled Person - Centered Care Planning, dated 5/22/2025, the P&P indicated the comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well - being.</p>		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer oxygen safely for one out of three sampled residents (Resident 1) by failing to ensure: 1. Resident 1's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was dated with an open date; and 2. Resident 1 received oxygen according to doctor's order. These deficient practices had the potential to cause Resident 1 to have lung damage and increased the risk for Resident 1 to develop a respiratory infection. Findings: During an observation on 8/26/2025 at 12:00 p.m. in Resident 1's room, Resident 1 received oxygen at five (5) liters per minute ([LPM] a unit that expresses flow rate). During an observation on 8/27/2025 at 10:09 a.m. in Resident 1's room, Resident 1 received oxygen at three (3) LPM. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's History and Physical (H&P) dated 5/6/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 6/26/2025, the MDS indicated Resident 1's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 1 required supervision for eating, personal hygiene and putting off and on footwear. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathing and dressing. During a review of Resident 8's Order Summary Report, dated 8/25/2025, the order summary report indicated Resident 1 had an order for oxygen at two (2) liters per minute via nasal cannula (a small plastic tube, which fits into residents' nostrils for providing supplemental oxygen) to keep oxygen saturation (the amount of oxygen you have circulating in your blood) at or above 92% for interstitial lung disease (a group of conditions that cause inflammation and scarring in the lungs' interstitial tissue). During an interview on 8/27/2025 at 12:06 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was on continuous oxygen at 2 LPM. LVN 1 stated licensed nurses set the oxygen setting based on doctors' orders and all licensed nurses must follow doctors' orders. LVN 1 stated if a licensed nurse delivered more oxygen than ordered, it would potentially compromise Resident 1's air exchange. LVN 1 stated for a resident with a diagnosis of COPD, a high oxygen flow rate could damage their lungs. LVN 1 stated he checked Resident 1's nasal cannula and it was dated with an open date. LVN 1 stated nasal cannulas must get changed once a week and dated when a new one is opened. LVN 1 stated nasal cannulas get changed for infection control. During a concurrent observation and interview on 8/27/2025 at 12:42 p.m. with LVN 1 in Resident 1's room, Resident 1 received oxygen at 3 LPM and the nasal cannula did not have a label with an open date. LVN 1 stated oxygen should be set to deliver 2 LPM and he did not know it was set to 3 LPM. LVN 1 stated delivering 3 LPM to Resident 1 was not following the doctor's orders because the doctor's order indicated to deliver oxygen at 2 LPM. LVN 1 stated licensed nurses put Resident 1's health at risk because they did not follow doctors' orders. LVN 1 stated the nasal cannula was not labeled with an open date and should be dated so they would know when to change the cannula to prevent infections. During an interview on 8/27/2025 at 1:31 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was on oxygen therapy because he had episodes of fluctuating oxygen saturation. The DON stated licensed nurses must set oxygen according to doctor's orders because that was the doctor's recommendation. The DON stated if a resident received more oxygen than ordered it would potentially hyper oxygenate (to administer a higher-than-normal concentration of oxygen) the resident. The DON stated it was important to deliver the correct amount of oxygen to the residents to maintain residents at the indicated level. During a review of facility's Policy & Procedure (P&P) titled Oxygen therapy, dated 11/2017, the P&P indicated oxygen would be administered under safe and sanitary conditions to meet resident needs. The P&P indicated licensed nurses' staff would administer oxygen as prescribed. The P&P indicated nasal tubing should be changed no more than every 7 days and labeled with the date of change.</p>		