

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  08/28/2025
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 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the licensed nurse failed to document the monitoring of signs and symptoms of infection and the amount of urine output, for one of three residents (Resident 1), on the Medication Administration Record on two different shifts in the month of February 2025. This deficient practice had the potential to result in lack of communication between staff and delay and interrupt the provision of care needed to maintain the residents' highest practicable, physical, mental, and psychosocial well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), acute kidney failure (when the kidneys suddenly stop working properly), and malignant neoplasm (cancer) of the prostate (a small gland in men that helped make some of the fluid in semen). During a review of Resident 1's History and Physical (H&amp;P), dated 2/26/2025, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 1 was dependent (helper did all the effort) on staff with self-care and mobility. During a review of Resident 1's care plan for Foley catheter (a hollow tube inserted into the bladder to drain or collect urine), initiated on 1/17/2025, the care plan goals indicated Resident 1 would show no signs or symptoms of infection (when harmful germs entered the body and caused illness) and remain free from catheter-related trauma. The care plan interventions indicated to check tubing for kinks each shift, monitor and document output, monitor for signs and symptoms of infection. During a review of Resident 1's Order Summary Report, dated 8/28/2025, the report indicated to assess the urinary drainage from the Foley catheter bag for signs and symptoms of infection, cloudiness, color, sediment (solid particles that settle at the bottom of a liquid), blood, odor, and amount of urine output every shift. During an interview on 8/28/2025 at 12:29 p.m. with Treatment Nurse (TN) 1, TN 1 stated Foley catheter care included checking the catheter and drainage bag every shift and as needed (PRN) for patency, drainage, urine output, color, sediment, cloudiness, bleeding, and any trauma to the genital area. TN 1 stated the licensed vocational nurse (LVN) performed these checks and were required to document their findings on the resident's Medication Administration Record (MAR). TN 1 stated documentation was important to confirm the urine output, ensure the bladder was emptying properly, and monitor the resident's overall health. TN 1 stated if sediment or blood was observed, the physician should be notified to determine the appropriate intervention. TN 1 stated this monitoring helped ensure there were no signs or symptoms of infection. TN 1 stated the risk of infection increased if the area was not kept clean or if assessments were missed, which could lead to an urinary tract infection (UTI- an infection in the bladder/urinary tract). TN 1 stated urine not draining or the presence of sediment could indicate infection. TN 1 stated no documentation meant the care was not provided, which could negatively affect the residents' quality of care. During a concurrent interview and record review on 8/28/2025 at 1:25 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 1's MAR for 2/2025 was reviewed. The MAR indicated that nurses were to assess the urinary drainage from the Foley catheter bag for signs and symptoms of infection and the amount of urine output every shift, starting on 2/7/2025 at 3 p.m. RNS 1 stated there was no documentation of the urinary drainage assessment or accurate urine output on the MAR for the evening shift on 2/7/2025 and the night shift on 2/8/2025. RNS 1 stated it was unclear if Resident 1 had any signs or symptoms of infection. RNS 1 stated the LVN should document on the MAR every shift. RNS 1 stated it was standard of care and important to follow the physician's order. RNS 1 stated the lack of assessment and documentation increased the risk of quality of care. RNS 1 stated the Foley catheter care included monitoring urine output, observing color, monitoring for pain, and following up with a urologist (a medical specialist who diagnoses and treats disorders of the urinary system [kidneys, ureters, bladder, urethra]) if needed. RNS 1 stated dark or concentrated urine might mean the resident needed more fluids. RNS 1 stated sediment in the urine may mean there was a blockage. During a review of the facility's LVN Job Description, undated, the Job Description indicated, LVN's responsibilities included providing nursing care as ordered by the physician and recording care information accurately, timely and concisely. The Job Description further indicated LVNs should complete all required documentation, including resident assessments and interventions, in the medical record. During a review of the facility's policy and procedure</p>		