

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 09/19/2025
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 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)

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
---	-------	-----------

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 09/19/2025
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)		
<p>F 0600</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 residents were free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of five sampled residents (Resident 2) when Resident 2 reported he was struck by Resident 1 when the resident entered his room. This deficient practice caused Resident 2 to feel violated and unsafe in the facility and had the potential to cause serious bodily injury to the resident. Findings: a. During a review of Resident 1's admission Record (Face Sheet - front page of the chart that contains a summary of basic information about the resident) dated 9/17/2025, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and a fracture (break in a bone) of the left radius (wrist). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/5/2025, the MDS indicated Resident 1's cognition (ability to think, remember and reason) was severely impaired. The MDS indicated Resident 1 had fluctuating behavior (easily distracted and difficulty keeping track of what is being said) and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject). The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 7/29/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's clinical record for the month of September 2025, the clinical record did not indicate any documentation regarding a resident-to-resident altercation, no updated care plans and no evidence of protective interventions implemented after the altercation occurred on 9/2/2025. During a review of Resident 1's CIC Evaluation, dated 7/31/2025, the CIC indicated Resident 1 was not sleeping, wandered along hallways and upon redirection became agitated and fought back with staff. The CIC indicated Resident 1 was provided with a calm environment but continued to bother roommates by pulling their blankets, with intrusiveness, yelling and screaming. The CIC indicated Resident 1 was placed on 1:1 supervision (a staff member provides constant, direct observation of a single resident). During a review of Resident 1's CIC Evaluation, dated 7/31/2025, the CIC indicated Resident 1 had increased agitation, aggression towards staff and delusional behavior. The CIC indicated while Resident 1 was in his room, he began to bang on the walls, then leaped over and grabbed a CNA staff by both arms, snatched his phone from his hand and ran down the hallway. The CIC indicated Resident 1 broke a window and sustained a laceration to his middle right finger. Resident 1 was transferred to the GACH for further treatment. During a review of Resident 1's Change in Condition (CIC - a communication tool used to communicate a resident's change of condition) Evaluation, dated 9/2/2025, the CIC indicated Resident 1 sustained a left wrist fracture (a break or crack in a bone that occurs when excessive force is applied to it) which was reported as an injury of unknown origin by the facility. Resident 1 was transferred to the general acute care hospital (GACH). During a review of Resident 1's Behavioral Health Progress Note, dated 9/16/2025, the progress note indicated Resident 1 had a history of and exhibited anxious mood, persistent worrying, inability to relax, and became easily annoyed and irritable. Interventions included implementing calming skills to reduce and manage anxiety symptoms and learning anger management techniques to reduce angry outbursts. b. During a review of Resident 2's admission Record, the record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired and had behaviors of delusion. The MDS indicated Resident 2 required set-up (helper assists only prior to or following the activity) with eating and supervision (helper provides verbal cues and/or touching assistance to complete task) for toileting, bathing and personal hygiene. During a review of Resident 2's H&P, dated 5/2/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's clinical record for the month of September 2025, the clinical record did not indicate any documentation of a resident-to-resident altercation that occurred on 9/2/2025. During a review of Resident 2's clinical record for the month of September 2025, the clinical record did not indicate any documentation</p>		

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 09/19/2025
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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 09/19/2025
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)		
<p>F 0609</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 report a witnessed resident-to-resident altercation involving two of five sampled residents (Resident 1 and Resident 2) to the California Department of Public Health (CDPH). This deficient practice delayed an onsite investigation by CDPH for allegations of abuse of Resident 1 and Resident 2 and had the potential for abuse to all residents in the facility. Findings: During a review of Resident 1's admission Record dated 9/17/2025, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and a fracture (break in a bone) of the left radius (wrist). During a review of Resident 1's History and Physical (H&P), dated 7/29/2025, 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 8/5/2025, the MDS indicated Resident 1's cognition (ability to think, remember and reason) was severely impaired. The MDS indicated Resident 1 had fluctuating behavior (easily distracted and difficulty keeping track of what is being said) and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject). The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing and personal hygiene. During a review of Resident 1's clinical record for the month of September 2025, the clinical record indicated there was no documentation regarding a resident-to-resident altercation that occurred on 9/2/2025. During a review of Resident 2's admission Record, the record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's H&P, dated 5/2/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired and had behaviors of delusion. The MDS indicated Resident 2 required set-up (helper assists only prior to or following the activity) with eating and supervision (helper provides verbal cues and/or touching assistance to complete task) for toileting, bathing and personal hygiene. During a review of Resident 2's clinical record for the month of September 2025, the clinical record indicated there was no documentation regarding a resident-to-resident altercation that occurred on 9/2/2025. During an interview on 9/16/2025 at 1:35 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated he witnessed Resident 1 attempting to strike Resident 2 while Resident 2 was lying in bed in his room. CNA 2 stated he could not recall the exact date of the altercation but stated the incident occurred approximately two weeks prior. CNA 2 stated while he was in the Activity Room he heard yelling, Help! Help! from Resident 2's room. CNA 2 stated he and CNA 3 immediately ran to Resident 2's room and observed Resident 1 standing over Resident 2's bed attempting to attack him. CNA 2 stated he notified the charge nurse, Licensed Vocational Nurse (LVN) 1 of the incident but did not notify the administrator (ADM) of the altercation. During an interview on 9/16/2025 at 3:33 p.m. with CNA 3, CNA 3 stated he was at the nursing station when he heard screaming and yelling from Resident 2's room. CNA 3 stated he arrived at Resident 2's room and observed Resident 1 was extremely aggressive. CNA 3 stated he asked Resident 2 what happened, and Resident 2 stated Resident 1 hit him. CNA 3 stated he reported the incident to LVN 1, and he watched LVN 1 write the incident down on paper but did not know what happened after that. During an interview on 9/16/2025 at 4:35 p.m. with LVN 1, LVN 1 denied knowledge of the resident-to-resident altercation between Resident 1 and Resident 2. LVN 1 stated she did not notify the administrator, complete documentation, or initiate a report to the CDPH. LVN 1 stated she received a report from CNA 2 that Resident 1 complained of left wrist pain which she reported as an injury of unknown origin to the Registered Nurse Supervisor (RN) 2. During a concurrent interview and record review on 9/17/2025 at 12:34 p.m. with RN 2, the clinical records for Resident 1 and Resident 2 were reviewed. The clinical records indicated there were no documents pertaining to the resident-to-resident altercation between Resident 1 and Resident 2. RN 2 confirmed that there were no clinical records documented pertaining to a resident-to-resident altercation between Resident 1 and Resident 2 on 9/2/2025. RN 2 stated she was unaware of a resident-to-resident altercation between Resident 1 and Resident 2</p>		

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 09/19/2025
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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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 09/19/2025
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)		
<p>F 0610</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 implement their policy titled Abuse Reporting and Investigations, which indicated to thoroughly investigate allegations of resident abuse, involving two of five sampled residents (Resident 1 and Resident 2). This deficient practice delayed an onsite investigation by the California Department of Public Health (CDPH) for allegations of abuse of Resident 1, and Resident 2 and had the potential for abuse to all residents in the facility. Findings: a. During a review of Resident 1's admission Record (Face Sheet - front page of the chart that contains a summary of basic information about the resident) dated 9/17/2025, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and a fracture (break in a bone) of the left radius (wrist). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/5/2025, the MDS indicated Resident 1's cognition (ability to think, remember and reason) was severely impaired. The MDS indicated Resident 1 had fluctuating behavior (easily distracted and difficulty keeping track of what is being said) and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject). The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 7/29/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's clinical record for the month of September 2025, the clinical record did not indicate any documentation of a resident-to-resident altercation that occurred on 9/2/2025. b. During a review of Resident 2's admission Record, the record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired and had behaviors of delusion. The MDS indicated Resident 2 required set-up (helper assists only prior to or following the activity) with eating and supervision (helper provides verbal cues and/or touching assistance to complete task) for toileting, bathing and personal hygiene. During a review of Resident 2's H&P, dated 5/2/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's clinical record for the month of September 2025, the clinical record did not indicate any documentation of a resident-to-resident altercation that occurred on 9/2/2025. During an interview on 9/16/2025 at 1:35 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated he witnessed Resident 1 attempting to strike Resident 2 while Resident 2 was lying in bed in his room. CNA 2 stated he could not recall the exact date of the altercation but stated the incident occurred approximately two weeks prior. CNA 2 stated while he was in the Activity Room he heard yelling, Help! Help! from Resident 2's room. CNA 2 stated he and CNA 3 immediately ran to Resident 2's room. CNA 2 stated he observed Resident 1 standing over Resident 2's bed attempting to attack him. CNA 2 stated he notified the charge nurse, Licensed Vocational Nurse (LVN) 1 of the incident. During an interview on 9/16/2025 at 3:33 p.m. with CNA 3, CNA 3 stated he was at the nursing station when he heard screaming and yelling from Resident 2's room. CNA 3 stated he arrived at Resident 2's room as observed Resident 1 was extremely aggressive. CNA 3 stated he asked Resident 2 what happened, and Resident 2 stated Resident 1 hit him. CNA 3 stated he reported the incident to LVN 1, and he watched LVN 1 write the incident down on paper but didn't know what happened after that. During an interview on 9/16/2025 at 4:35 p.m. with LVN 1, LVN 1 denied knowledge of the resident-to-resident altercation between Resident 1 and Resident 2. LVN 1 stated she did not notify the administrator, complete documentation, or initiate a report to the CDPH. LVN 1 stated she received a report from CNA 2 that Resident 1 complained of left wrist pain which she reported as an injury of unknown origin to the Registered Nurse Supervisor (RN) 2. During a concurrent interview and record review on 9/17/2025 at 12:34 p.m. with RN 2, RN 2 stated there were no clinical records documented pertaining to a resident-to-resident altercation between Resident 1 and Resident 2 on 9/2/2025. RN 2 stated she was unaware of a resident-to-resident altercation between Resident 1 and Resident 2. During an interview on 9/18/2025 at 1:19 p.m. with the DON, the DON stated that resident abuse should be</p>		