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	12/31/2025

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 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)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 follow its policy and procedure (P&P) titled Ambulation (walking) which indicated to stand on the weakest side and a little behind during ambulation for one of two sampled residents (Resident 6).This deficient practice resulted in Resident 6 losing her balance and falling to the floor while ambulating to the restroom resulting in a laceration (cut) above the right eyebrow. Resident 6 was transferred to the general acute care hospital (GACH) and required sutures (thread used to sew up wounds to hold the tissue together for healing).Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included abnormalities of gait and mobility (any unusual or irregular change in a person's walking pattern or their ability to move around easily), age-related osteoporosis (loss of bone density making the bones weak over time), and history of falling. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 12/9/2025, the MDS indicated Resident 6's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 6 required moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing, and walking ten feet. During a review of Resident 6's History and Physical (H&P), dated 8/19/2025, the H&P indicated Resident 6 could make needs known but could not make medical decisions. During a review of Resident 6's Fall Risk Evaluation, dated 12/9/2025, the Fall Risk Evaluation indicated Resident 6 was at risk for falls.During a review of Resident 6's Change in Condition Evaluation (COC), dated 12/22/2025, the COC indicated on 12/22/2025, Resident 6 got out of bed because she needed to use the restroom. The COC indicated Certified Nursing Assistant (CNA) 4 was also in the room. Resident 6 tripped after getting out of bed and fell to the floor. The COC indicated Resident 6 had a laceration above her right eyebrow. The COC indicated there was a physician's order to transfer Resident 6 to the general acute care hospital (GACH) for evaluation. During a review of Resident 6's Skin Check, dated 12/22/2025, the Skin Check indicated Resident 6 had a laceration measuring 4 centimeter (cm, unit of measurement) in length by 0.3 cm in width above her right eyebrow.During a review of Resident 6's Progress Notes, dated 12/22/2025, the Progress Notes indicated, on 12/22/2025 at 4:46 p.m., Resident 6 was transported by Emergency Medical Services (EMS- includes Emergency Medical Responders to transfer an individual to the hospital) to the GACH. During a review of the GACH Emergency Department (ED) Notes, dated 12/22/2025, the GACH ED Notes indicated Resident 6 had a 3 cm laceration on her right forehead repaired with seven sutures. The GACH ED Notes indicated lidocaine with epinephrine (medication injected to numb the area) was used during the procedure. The Notes indicated Resident 6 had a repeat Computed Tomography (CT- detailed computer image) of the head, on 12/22/2025 at 11:51 p.m., which resulted in no intracranial hemorrhage (a brain bleed). The Notes indicated Resident 6 could discharge back to the facility. During a review of Resident 6's Progress Notes, dated 12/23/2025, the Progress Notes indicated on 12/23/2025 at 6:10 a.m., Resident 6 was readmitted to the facility. The Progress Notes indicated Resident 6 had a laceration on her right forehead with intact sutures and without bleeding or swelling. During a review of Resident 6's Skin Check, dated 12/23/2025, the Skin Check indicated Resident 6 had seven sutures .During an interview on 12/30/2025 at 1:29 p.m., with CNA 4, CNA 4 stated, on 12/22/2025, Resident 6 was very restless and tried to get up out of bed. CNA 4 stated she placed her chair outside of Resident 6's room to monitor and assist the resident if she tried to get out of bed. CNA 4 stated when she saw Resident 6 get out of bed, she approached the resident and asked her if she needed to use the restroom. CNA 4 stated Resident 6 did not like to be touched or held. CNA 4 stated she walked in front of Resident 6 while leading the way to the restroom. CNA 4 stated she reached for the door to the restroom and when she turned around Resident 6 lost her balance and was unable to catch her. CNA 4 stated because she was walking in front of Resident 6, she was unsure how the resident lost her balance and fell. During a concurrent interview on 12/31/2025 at 10:14 a.m., with the Director of Rehab (DOR), Resident 6's Physical Therapy (PT) Treatment Note, dated 12/17/2025, was reviewed. The PT Treatment Note indicated Resident 6 exhibited self-limiting behavior and required encouragement to participate and exhibited anxiety (feeling of unease, fear, or dread) with activity. The PT Treatment Note indicated supervision or touching assistance was required when Resident 6 walked ten feet. The DOR stated Resident 6 required supervision or touching assistance when ambulating (walking) which meant Resident 6 required physical or verbal cues for safety. The DOR stated optimal safety precautions required the staff member to