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	01/09/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff did not use a blanket to tie one of three residents (Resident 1) to the bed, to prevent from falling. This failure had the potential to restrain the resident without a physician's order.This failure placed Resident 1 at risk of injury.This failure had the potential to negatively affect the resident's psychosocial and physical well-being when the resident could not move freely.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and hyperlipidemia ([high cholesterol], excess of lipids or fats in your blood).During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated, 10/15/2025, the MDS indicated Resident 1 had severe (extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADLs) such as showering/bathing self and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to perform movements such as rolling left to right and changing from sitting to lying.During a review of facility's five-day investigation report, dated 1/5/2026, the report indicated, The Certified Nursing Assistant (CNA) acknowledged placing linen to the bed of Resident 1 to protect and ensure that Resident 1 did not sustain a fall while attending to another resident.During an interview on 1/9/2026 at 1:21 p.m., with CNA 1, CNA 1 stated staff should not use an object to put across a resident's lap to keep them in bed because it takes away the resident's right to move, stand, and walk.During an interview on 1/9/2026 at 1:49 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated staff should not use linen across a resident because it restricted the resident's movement, even if the resident is considered a fall risk.During an interview on 1/9/2026 at 2:05 p.m., with Physical Therapist (PT) 1, PT 1 stated tying Resident 1 to the bed using linen across their lap (on 12/28/2025) was a type of restraint (use of physical force or a device to limit a person's movement or access to their body, typically as a last resort to prevent immediate harm to themselves or others). PT 1 stated a restraint required a doctors' order. PT 1 stated the facility does not use blanket as a restraint towards a resident.During an interview on 1/9/2026 at 2:38 p.m., with CNA 2, CNA 2 stated they had tied linen across Resident 1's breast and ankles to the bed because they had wanted to ensure Resident 1 was not going to fall, while they had to attend to another resident on 12/28/2025. CNA 2 stated tying Resident 1 to the bed using should not have been done because it was form of restraint. CNA 2 stated tying Resident 1 to the bed could have affected the resident's dignity. CNA 2 stated they should have called other staff to help while attending to both Resident 1 and another resident.During a concurrent interview and record review on 1/9/2026 at 4:53 p.m., with Director of Nursing (DON), the (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy and procedure (P&P) titled, Restraints, dated 1/25/2024, was reviewed. The DON stated CNA 2 was not following the facility's P&P by not honoring Resident 1's right from moving freely even if CNA 2's intention was to prevent Resident 1 from falling.During a review of facility's P&P titled, Restraints, dated 1/25/2024, the P&P indicated, the facility should honor the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms.During a review of facility's P&P titled, Resident Rights, dated 1/2012, the P&P indicated residents have the freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. Employees should treat all residents with kindness, respect, and dignity and honor the residents' rights.