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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician was promptly notified and appropriate follow-up occurred for one out of three sampled residents (Resident 1) when licensed nursing staff was made aware of Resident 1's report of new onset pain and noted limited range of motion in Resident 1's left knee on 10/12/2025 (three days after Resident 1 exhibited a fall) but did not confirm receipt of physician notification on 1/24/2026 after Resident 1 complained of pain accompanied by a popping noise in her left knee.These failures had the potential to result in delayed diagnosis, delayed treatment, missed opportunity for diagnostic testing and specialty consultation, and delayed care planning.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. The admission Record indicated Resident 1's diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), anxiety (a feeling of uneasiness), chondrocostal junction syndrome (a rare, benign, inflammatory condition causing pain), and other abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering and dressing and supervision or touching assistance for walking. During a review of Resident 1's care plan titled Arthritis, initiated 4/1/2025, the care plan interventions indicated to monitor, document and report to physician if there signs and symptoms or complications such as: joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement), and pain after exercise or weight bearing. During a review of Resident 1's Change of Condition Note, dated 10/9/2025, the note indicated on 10/9/2025, Resident 1 was found sitting on the floor by the bed. The note indicated Resident 1 stated she lost her balance and fell on the way back to her bed from the restroom. During an interview on 1/26/2026 at 2:35 p.m. with Resident 1, Resident 1 stated she underwent two knee surgeries on both left and right knees a long time ago. Resident 1 stated she felt that metal hardware was moving in her knee. Resident 1 stated her pain was not effectively managed for three months and caused so much stress that it caused her hair to fall out. During a concurrent observation and interview on 1/27/2026 at 2:06 p.m. with the Director of Rehabilitation (DOR), in Resident 1's room, Resident 1's knee was observed. Resident 1 flexed and straightened her leg while the DOR examined the knee. The DOR stated she felt a clicking, like crepitus, but could not identify if there was hardware. Resident 1 stated the popping noise had gotten worse since her fall on 10/9/2025. Resident 1 stated she had always reported the popping noise and pain to the nursing and rehabilitation staff since (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/9/2025. During a concurrent interview and record review on 1/27/2026 at 3:10 p.m. with Registered Nurse (RN) 2, Resident 1's OBRA, Interim Nursing Progress Note, dated 10/12/2025, and all of Resident 1's Change of Condition Notes, dated 10/2025 through 1/27/2026, were reviewed. The Interim Nursing Progress Note indicated Resident 1 had an impairment affecting one lower extremity. There were no Change of Condition Notes dated in 10/2025 indicating the physician was made aware of Resident 1's left knee impairment. RN 2 stated he wrote Resident 1's OBRA, Interim Nursing Progress Note and recalled on 10/12/2025, Resident 1 complained of left knee pain with limited range of motion. RN 2 stated Resident 1 had a history of bilateral knee surgery. RN 2 stated based on those findings, he instructed the assigned Licensed Vocational Nurse (LVN) to notify the physician and document a Change of Condition especially because Resident 1 recently fell on [DATE]. RN 2 stated he did not follow up to confirm the physician was informed and confirmed that a Change of Condition Note was not completed. RN 2 stated not notifying the physician and not initiating a Change of Condition Note had the potential to result in delayed treatment, missed opportunity for orthopedic consultation (a branch of medicine focused on the diagnosis, treatment, rehabilitation, and prevention of injuries and diseases of the musculoskeletal system), failure to evaluate for a possible post-fall related injury, and a delay in appropriate care planning. During a concurrent interview and record review on 1/27/2026 at 3:45 p.m. with LVN 1, Resident 1's Change of Condition Note, dated 1/24/2026, was reviewed. The note indicated Resident 1 complained of 6/10 left knee pain accompanied by popping sounds. The note indicated there was no visible swelling or bruising noted, and the physician recommended to continue to monitor Resident 1 and administer pain medication as needed. LVN 1 stated she wrote the Change of Condition note but did not know if the physician received the Change of Condition notification since she only left a voicemail and did not follow up. LVN 1 stated she endorsed the change of condition to the oncoming nurse but did not ensure the physician received the message. LVN 1 stated the documentation in the Change of Condition Note was inaccurate since it reflected physician recommendations when the physician had not been reached. LVN 1 stated because she was unable to speak directly to the physician, she documented her own recommendation for monitoring and pain management for Resident 1. LVN 1 stated the failure to follow up if the physician had received the Change of Condition notification had the potential to result in delayed medical evaluation and treatment. During a review of the facility's Policy and Procedure (P&P) titled, Change of Condition Notification, dated 8/25/2022, the P&P indicated the Licensed Nurse would promptly inform the resident, consult with the resident's Physician and when the resident endures a significant change in their condition caused by, but not limited to 1) a significant change in the resident's physical, mental or psychosocial status; and/or 2) a significant change in treatment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an At Risk for Fall Care Plan for one out of three sampled residents (Resident 1) when the facility failed to ensure Resident 1 was wearing appropriate footwear before Resident 1 fell on [DATE].This failure placed Resident 1 at an increased risk for fall and injury.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. The admission Record indicated Resident 1's diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), anxiety (a feeling of uneasiness), chondrocostal junction syndrome (a rare, benign, inflammatory condition causing pain), and other abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering and dressing and supervision for walking. During a review of Resident 1's care plan At Risk for Fall, initiated 4/10/2025, the care plan interventions included ensuring Resident 1 wore appropriate footwear when ambulating. During a review of Resident 1's Fall Risk Evaluation, dated 10/6/2025, the Fall Risk Evaluation indicated Resident 1 was at risk for a fall. During a review of Resident 1's Change of Condition Note, dated 10/9/2025, the note indicated, on 10/9/2025, Resident 1 was found sitting on the floor by the bed. The note indicated Resident 1 stated she lost her balance and fell on the way back to her bed from the restroom. During a review of Resident 1's Post Fall Evaluation, dated 10/9/2025, the Post Fall Evaluation indicated Resident 1 was bare footed during the time of the fall on 10/9/2025. During a concurrent interview and record review on 1/27/2026 at 11:50 a.m. with Registered Nurse (RN) 1, Resident 1's Progress Notes, dated 10/2025, and Resident 1's At Risk for Fall Care Plan, initiated 4/10/2025, were reviewed. The Progress Notes lacked documentation to indicate Resident 1's footwear was monitored. RN 1 stated because there was no documented monitoring of Resident 1's footwear, the intervention could not be verified as implemented. RN 1 stated the lack of effectively implementing the care plan placed Resident 1 at increased risk for a fall. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that included measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of three sampled resident's (Resident 1) pain was effectively assessed, reassessed, and managed when facility staff failed to ensure:Resident 1's complaint of pain and subsequent refusal of a therapy session were communicated to nursing staff for further assessment and intervention on 1/27/2026.A numerical pain reassessment was documented following the administration of pain medication to evaluate effectiveness throughout the month of January 2026.Resident 1's pain was reassessed and addressed after physical therapy sessions on 10/21/2025 and 10/22/2025, despite continued reports of pain that affected the resident's participation.Resident 1's complaint of new-onset of 10/10 pain was treated with ordered pain medication, including Tramadol (pain medication), on 10/28/2025.Resident 1's new-onset report of 10/10 pain on 10/28/2025 triggered timely interdisciplinary evaluation and adjustment of pain management interventions. These failures had the potential for Resident 1 to experience ongoing unrelieved pain, decreased participation in physical therapy, delayed intervention, and increased risk for functional decline.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), anxiety (a feeling of uneasiness), chondrocostal junction syndrome (a rare, benign, inflammatory condition causing pain), and other abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering and dressing and supervision or touching assistance for walking. During a review of Resident 1's care plan titled Arthritis, initiated 4/1/2025, the interventions indicated to monitor, document and report to physician if there signs and symptoms or complications such as: joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care ability, contracture (permanent shortening of muscle tissue) formation, joint shape changes, crepitus (creaking or clicking with joint movement), and pain after exercise or weight bearing. During a review of Resident 1's Change of Condition Note, dated 10/9/2025, the note indicated, on 10/9/2025, Resident 1 was found sitting on the floor by the bed. The note indicated Resident 1 stated she lost her balance and fell on the way back to her bed from the restroom. The note indicated Resident 1 was sent to the General Acute Care Hospital (GACH) for further evaluation. During a review of Resident 1's Physical Therapy Note, dated 10/15/2025, the note indicated Resident 1 refused to ambulate during the therapy session. The note did not document a reason for the resident's refusal to walk. During a review of Resident 1's Physical Therapy Note, dated 10/22/2025, the note indicated Resident 1 reported joint pain and discomfort and refused to ambulate during the therapy session. During a review of Resident 1's MAR, dated 10/15/2025 and 10/22/2025, the MAR indicated Resident 1 did not receive any pain medications on those dates. During a review of Resident 1's care plan titled Chronic Pain, revised 10/28/2025, the interventions indicated to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. The interventions indicated to observe and report changes in sleep patterns, decrease in functional abilities and range of motion, and resistance to care. During an interview on 1/26/2026 at 2:35 p.m. with Resident 1, Resident 1 stated she had previously undergone bilateral knee surgeries. Resident 1 stated she felt that metal hardware was moving in her knee. Resident 1 stated she went 11 days without pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication after making numerous complaints to the Rehabilitation Department and nursing staff. Resident 1 stated her pain had not been effectively managed for several months. Resident 1 described her pain as severe and throbbing. During a concurrent observation and interview on 1/27/2026 at 2:06 p.m. with the Director of Rehabilitation (DOR), in Resident 1's room, Resident 1's knee was observed while the resident flexed and extended her knee. The DOR stated she felt clicking like crepitus (crackling, popping, or grindings in the joint or soft tissues) but could not determine the presence of hardware in Resident 1's knee. Resident 1 stated the popping sensation and pain had worsened since her fall on 10/9/2025 and reported that she had repeatedly informed nursing and rehabilitation staff on the popping sensation and pain since that date. 1. During an observation and interview on 1/27/2026 at 10:52 a.m. with Resident 1, in Resident 1's room, Resident 1's was sitting on her bed and holding her knee. Resident 1 appeared uncomfortable. Resident 1 stated the facility staff did not address her pain and reported her pain was10/10 and she felt like her body was on fire. Resident 1 stated her knee pain worsened with movement and reported she informed the occupational therapy staff (OT 1) of her pain. During an interview on 1/27/2026 at 10:55 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was Resident 1's assigned nurse and was not notified of any reports of pain for Resident 1. During an interview on 1/27/2026 at 2:28 p.m. with OT 1, OT 1 stated she offered Resident 1 an occupational therapy session at approximately 8:00 a.m. or 9:00 a.m., which the resident declined due to pain. OT 1 stated she did not notify LVN 2 of Resident 1's pain complaint or therapy refusal. OT 1 stated she should have notified nursing so the resident's pain could have been assessed and addressed timely. 2. During a concurrent interview and record review on 1/27/2026 at 11:28 a.m. with Registered Nurse (RN) 1, Resident 1's Medication Administration Progress Notes, dated 12/2025 through 1/2026, were reviewed. The Progress Notes indicated numerical pain ratings were not documented to evaluate the effectiveness of Resident 1's pain medication on 12/31/2025, 1/13/2026, 1/17/2026, 1/23/2026, and 1/24/2026. RN 1 stated the licensed nurses did not document a numerical pain rating upon reassessment of Resident 1's pain, resulting in the facility's failure to accurately assess and track the effectiveness of Resident 1's pain medication. 3. During a concurrent interview and record review on 1/27/2026 at 2:45 p.m. with Physical Therapy Assistant (PTA) 1, Resident 1's Physical Therapy Note, dated 10/15/2025 and 10/22/2025, were reviewed. PTA 1 stated he authored the Physical Therapy Notes and recalled Resident 1 complained of pain on both dates. PTA 1 stated he did not notify nursing staff of the resident's pain complaint on 10/15/2025. PTA 1 stated on 10/22/2025, Resident 1 continued to complain of left knee pain, and he should have notified the charge nurse to ensure the resident's pain was reassessed and addressed. PTA 1 stated the failure to notify nursing had the potential to result in continue unrelieved pain for Resident 1. 4. During concurrent interview and record review on 1/28/2026 at 11:06 a.m. with the Director of Nursing (DON), Resident 1's Change of Condition Note, dated 10/28/2025, and Resident 1's MAR, dated 10/2025 through 11/2025, were reviewed. The Change of Condition Note indicated, on 10/28/2025, Resident 1 complained of new onset 10/10 pain affecting both arms, both legs and the coccyx (tail bone). The note indicated Resident 1 refused Tylenol and Ibuprofen (pain medications) and was prescribed Tramadol (a pain medication) Oral Tablet 50 milligrams (mg - a unit of measurement) by mouth every eight hours as needed for severe pain (8-10 pain scale). The MAR lacked documentation that Tramadol or any other pain medication was administered following Resident 1's report of 10/10 pain on 10/28/2025. The DON stated Resident 1's pain was not treated as ordered following the reported pain, which had the potential for Resident 1 to experience unrelieved pain. 5. During a concurrent interview and record review on 1/28/2026 at 12:08 p.m. with the DON, all of Resident 1's Interdisciplinary Team (IDT) Notes, dated in 2025, were reviewed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no IDT Notes indicating an interdisciplinary evaluation or modification of pain management interventions following Resident 1's report of new-onset 10/10 pain on 10/28/2025. The DON stated a lack of interdisciplinary evaluation resulted in a missed opportunity to address Resident 1's pain management needs. During a review of the facility's Policy and Procedure (P&P) titled, Pain Management, dated 5/26/2023, indicated the following:The facility's Interdisciplinary Team would review the pain assessment and develop resident centered care plan for pain management. The goal for pain management would be resident centered and determined by the resident's acceptable level of pain.The Licensed Nurse would administer pain medication as ordered and document medication administered the MAR.After medications were administered, the licensed nurse would re-evaluate the resident's level of pain within one hour.If there is a new onset of pain, if the pain has changed in nature, or the pain has not been relieved with current medication, the licensed nurse would notify the physician.