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	06/08/2026

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 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 develop a person-centered care plan to address one of three sampled residents' (Resident 1) behavior of ambulating (walking) unassisted.This deficient practice resulted in Resident 1 ambulating 127 feet (ft, a unit of measurement) and sustaining a right humeral head fracture (a break in the bone near the shoulder) and had the potential to result in Resident 1 sustaining additional injuries and falls.Cross Reference F689.Findings:During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of the upper end of the right humerus (a break in the bone near the shoulder), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal instructions or touch assistance to steady) when walking 150 feet (ft, a unit of measurement).During a review of Resident 1's History and Physical (H&P), dated 5/28/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Fall Risk Evaluation, dated 2/20/2026, the Fall Risk Evaluation indicated Resident 1 was at a high risk for falls. During a review of Resident 1's Physician's Order, dated 2/26/2026, the Physician's Order indicated for restorative nursing assistance (RNA) to perform ambulation (walking) with a front wheel walker (FWW- a lightweight metal frame aid with two wheels on the front legs and rubber tips on the back) or hand held assist (HHA- holding the resident's hand to provide physical support) five times a week or as tolerated.During a review of Resident 1's Physical Therapy (PT) Discharge summary, dated [DATE], the PT Discharge Summary indicated, on 2/26/2026, Resident 1 met her goal of safely ambulating 100 ft using a FWW on level surfaces with supervision or touching assistance, and contact guard assist (CGA, helper keeps one or two hands on the resident's body to steady and provide balanace) with a FWW. The PT Discharge Summary indicated for Resident 1 to be added to the Restorative Ambulation Program to ambulate with FWW or HAA, as tolerated, to maintain Resident 1's current gait (the way an individual walks) level and reduce the risks for functional decline.During a review of Resident 1's Change in Condition Evaluation (COC), dated 5/17/2026, the COC indicated, on 5/17/2026 at approximately 10 a.m., Resident 1 fell in the hallway. The COC indicated when Resident 1 was asked what happened, Resident 1 stated, I tried to get up and just fell. The COC indicated Resident 1 complained of four out of ten pain to the right knee and right elbow. The COC indicated Resident 1's physician ordered a STAT X-ray (an urgent or immediate type of imaging of the bones) of the right shoulder, right knee, right elbow, and right hip.During a review of Resident 1's Radiology Results Report, dated 5/17/2026, the Radiology Results Report indicated a fracture of Resident 1's right humeral head (a break at the top of your right arm bone near the shoulder (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	joint).During a review of Resident 1's COC, dated 5/17/2026, the COC indicated the facility received Resident 1's X-ray results of a fracture of the right humeral head. The COC indicated Resident 1 complained of four out of ten pain to her right upper extremity (right arm). The COC indicated Resident 1's physician ordered to transfer Resident 1 to the general acute care hospital (GACH) for further medical evaluation and treatment. During a review of the GACH Emergency Department (ED) Note, dated 5/18/2026, the ED Note indicated Resident 1 arrived to the ED with her right shoulder in a sling (supportive device used to immobilize and protect an injured arm) with complaints of right elbow and right shoulder trauma following a fall. The ED Note indicated an X-ray was done which resulted with a nondisplaced fracture (when the bone is cracked or broken, but the fragments remain in their proper alignment) of the right humeral head. The ED Note indicated to admit Resident 1 to the GACH. During a review of the GACH Orthopedic (branch of medicine focused on the diagnosis, treatment, prevention, and rehabilitation of the musculoskeletal system) Surgery Note, dated 5/19/2026, the GACH Orthopedic Surgery Note indicated Resident 1's humeral head fracture could be treated nonoperatively and immobilization (limiting the movement of an injured body part to stabilize the area, reduce pain, and promote proper tissue healing) in a sling was appropriate. During an interview on 6/5/2026 at 10:44 a.m., with Resident 1, Resident 1 stated her right arm hurt but could not recall how she fell or hurt her right arm.During an interview on 6/5/2026 at 11:43 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated she provided the ordered therapy to Resident 1. RNA 1 stated Resident 1 had to ambulate with a one person assist and either with a FWW or HHA. RNA 1 stated Resident 1 usually sat and propelled herself in the wheelchair, however, Resident 1 would often stand up and push the wheelchair around in the hallway. During an interview on 6/5/2026 at 2:13 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the RNAs worked with Resident 1 to safely ambulate in the hallway. LVN 2 stated many times she observed Resident 1 ambulating in the hallway on her own by pushing her wheelchair or holding onto the side rails along the wall. LVN 2 stated Resident 1 could not tolerate ambulating for an extended amount of time and had to be redirected to sit and rest. LVN 2 stated Resident 1 should always have supervision and assistance when ambulating. During a concurrent interview and record review on 6/8/2026 at 10:11 a.m., with Minimum Data Set Nurse (MDSN) 1, Resident 1's Care Plan titled, Resident has an Activities for Daily Living Self-Care Performance Deficit, revised on 5/21/2026, was reviewed. The Care Plan indicated Resident 1 was able to walk at least 50 ft and make two turns once standing with a FWW and partial one person assist. MDSN 1 stated Resident 1 required at least a one-person assist to ambulate safely. During an interview on 6/8/2026 at 10:14 a.m., with MDSN 1, MDSN 1 stated care plans could be developed by any staff member involved in Resident 1's care. MDSN 1 stated a care plan should have been developed to address Resident 1's behavior of ambulating unassisted. MDSN 1 stated care planning Resident 1's behavior would ensure everyone participating in Resident 1's care were aware and to ensure the necessary safety interventions were implemented. During an interview on 6/8/2026 at 1:15 p.m., with the Director of Nursing (DON), the DON stated Resident 1 required assistance to safely ambulate. The DON stated Resident 1 had a known behavior of ambulating in the hallway unassisted. The DON stated this was not a safe behavior because Resident 1 was at a high risk for falls. The DON stated Resident 1's behavior should have been care planned to make the staff aware. The DON stated without a care plan, Resident 1 was at risk of not having the necessary safety interventions implemented to treat the behavior and prevent falls and injuries. 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 would provide person-centered and comprehensive care that reflected the best practice standards for meeting the health, safety, psychosocial, behavioral, and environmental needs of the residents to obtain or maintain the highest practicable physical, mental, and psychosocial well-being.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to a resident in the hallway while ambulating (walking) unassisted 127 feet (ft, a unit of measurement) and conduct a Fall Risk Evaluation accurately and completely for one of three sampled residents (Resident 1).These deficient practices resulted in Resident 1 sustaining a right humeral head fracture (a break in the bone near the shoulder). This deficient practice also had the potential to result in further falls.Findings:1. During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of the upper end of the right humerus (a break in the bone near the shoulder), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal instructions or touch assistance to steady) when walking 150 feet (ft, a unit of measurement).During a review of Resident 1's History and Physical (H&P), dated 5/28/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Fall Risk Evaluation, dated 2/20/2026, the Fall Risk Evaluation indicated Resident 1 was at a high risk for falls. During a review of Resident 1's Physician Order, dated 2/26/2026, the Physician Order indicated for restorative nursing assistant (RNA) to perform ambulation (walking) with front wheel walker (FWW- a lightweight metal frame aid with two wheels on the front legs and rubber tips on the back) or hand held assist (HHA- holding the resident's hand to provide physical support) five times a week or as tolerated.During a review of Resident 1's Care Plan titled, Resident has an Activities for Daily Living Self-Care Performance Deficit, revised on 5/21/2026, the Care Plan indicated Resident 1 was able to walk at least 50 ft and make two turns once standing with a FWW and partial one person assist.During a review of Resident 1's Change in Condition Evaluation (COC), dated 5/17/2026, the COC indicated, on 5/17/2026 at approximately 10 a.m., Resident 1 fell in the hallway. The COC indicated when Resident 1 was asked what happened, Resident 1 stated, I tried to get up and just fell. The COC indicated Resident 1 complained of four out of ten pain to the right knee and right elbow. The COC indicated Resident 1's physician's order for a STAT X-ray (an urgent or immediate type of imaging of the bones) of Resident 1's right shoulder, right knee, right elbow, and right hip.During a review of Resident 1's Radiology Results Report, dated 5/17/2026, the Radiology Results Report indicated a fracture of Resident 1's right humeral head (a break in the bone near the shoulder).During a review of Resident 1's COC, dated 5/17/2026, the COC indicated the facility received Resident 1's X-ray results of a fracture of the right humeral head. The COC indicated Resident 1 complained of four out of ten pain to her right upper extremity (right arm). The COC indicated Resident 1's physician ordered to transfer Resident 1 to the general acute care hospital (GACH) for further medical evaluation and treatment. During a review of the GACH Emergency Department (ED) Note, dated 5/18/2026, the ED Note indicated Resident 1 arrived to the ED with her right shoulder in a sling (supportive device used to immobilize and protect an injured arm) with complaints of right elbow and right shoulder trauma following a fall. The ED Note indicated an X-ray was done which resulted with a nondisplaced fracture (when the bone is cracked or broken, but the fragments remain in their proper alignment) of the right humeral head. The ED Note indicated to admit Resident 1 to the GACH. During a review of the GACH Orthopedic Surgery Note, dated 5/19/2026, the GACH Orthopedic Surgery Note indicated Resident 1's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	humeral head fracture could be treated nonoperatively and immobilization (process of fixing or limiting the movement of an injured body part to stabilize the area, reduce pain, and promote proper tissue healing) in a sling was appropriate. During an interview on 6/5/2026 at 10:44 a.m., with Resident 1, Resident 1 stated her right arm hurt but could not recall how she fell or hurt her right arm.During an interview on 6/5/2026 at 11:43 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated she provided the ordered therapy to Resident 1. RNA 1 stated Resident 1 had to ambulate with a one person assist and either with a FWW or HHA. During a phone interview on 6/5/2026 at 11:49 a.m., with Occupational Therapist (OT) 1, OT 1 stated, on 5/17/2026, he saw Resident 1 ambulating near the entrance of the Special Care Unit (SCU). OT 1 stated Resident 1 was not safe to ambulate by herself. OT 1 stated he tried to rush into the unit to catch Resident 1, however, by the time he reached Resident 1, Resident 1's legs buckled and fell to the floor on her right side. OT 1 stated Resident 1 had the behavior of getting up on her own and ambulating unassisted. OT 1 stated Resident 1 required contact guard assistance (CGA- helper keeps one or two hands on the resident's body to steady and provide balance) with a FWW when ambulating. OT 1 stated Resident 1 required a staff member to be close by to her to safely ambulate in the unit because Resident 1 had issues with weakness and coordination. OT 1 stated he did not see anyone near Resident 1 or in the hallway to provide supervision or assistance. OT 1 stated he was the only person to see Resident 1 fall and was the first person to assist Resident 1. OT 1 stated Resident 1 did not have the safety insight to not stand up and ambulate on her own. During a phone interview on 6/5/2026 at 12:02 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated, on 5/17/2026 at approximately 9:30 a.m., she last saw Resident 1, who wanted to rest, inside her room. CNA 3 stated she assisted another resident and was told at approximately 10 a.m. that Resident 1 fell in the hallway. CNA 3 stated most of the time Resident 1 would ambulate in the hallway on her own. CNA 3 stated there should always be staff members in the hallways to supervise the residents and provide assistance, when necessary. During a concurrent observation and interview on 6/5/2026 at 12:38 p.m., with Director of Staff Development (DSD) 1, in the SCU hallway, observed the Maintenance Supervisor (MS) measure the distance from Resident 1's previous room to the location of Resident 1' fall. The distance was 127 ft. DSD 1 stated the CNAs were instructed to be present in the hallways to visually monitor the residents and intervene if residents needed to be redirected. DSD 1 stated the facility did not have assigned hallways monitors, however, the CNAs took turns monitoring the hallways. DSD 1 stated there should at a minimum of three CNAs in the hallways with one located at each end of the unit and in the middle of the unit. DSD 1 stated the distance Resident 1 ambulated from her room to near the entrance of SCU, someone should have seen her if there was adequate supervision in the hallway. DSD 1 stated Resident 1 should have been redirected to her wheelchair, if she wanted to sit, or should have been provided HHA, if she wanted to continue ambulating. During an interview on 6/5/2026 at 2:13 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the RNAs worked with Resident 1 to safely ambulate in the hallway. LVN 2 stated many times she observed Resident 1 ambulating in the hallway on her own by pushing her wheelchair or holding onto the side rails along the wall. LVN 2 stated Resident 1 could not tolerate ambulating for an extending amount of time and had to be redirected to sit and rest. LVN 2 stated Resident 1 should always have supervision and assistance when ambulating. LVN 2 stated there should always be staff members in the hallway to monitor the residents and intervene to prevent a fall and/or injury. LVN 2 stated she could not recall if there were staff members in the hallway when Resident 1 ambulated and fell. LVN 2 stated if there were staff members in the hallway, they could have redirected or assisted Resident 1 and Resident 1's fall and fracture could have been prevented. During a concurrent interview and record review on 6/8/2026 at 10:42 a.m., with the Director of Rehab (DOR), Resident 1's Physical Therapy (PT) Discharge summary, dated [DATE], was reviewed. The PT Discharge Summary indicated, on 2/26/2026, Resident 1 met her goal of safely ambulating 100 ft using a FWW on level surfaces with supervision or touching assistance, with a comment of CGA with FWW. The PT Discharge Summary indicated for Resident 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be added to the Restorative Ambulation Program to ambulate with FWW or HAA, as tolerated, to maintain Resident 1's current gait (the way an individual walks) level and reduce the risks for functional decline. The DOR stated Resident 1 required CGA with a FWW or HHA when ambulating. The DOR stated the helper's hand should be placed on Resident 1 for guidance. The DOR stated the purpose of providing CGA or HHA was to ensure safety measures were in place if Resident 1 lost balance and to prevent falls and injuries. The DOR stated, on 5/17/2026, Resident 1 did not have any assistance when ambulating in the hallway. The DOR stated if there were adequate supervision and monitoring, Resident 1 would have had the assistance she needed when ambulating therefore preventing Resident 1's fall and shoulder fracture. During an interview on 5/8/2026 at 12:55 p.m., with the Director of Nursing (DON), the DON stated a good standard of practice was to ensure staff members were present in SCU's hallway to redirect residents, as needed. The DON stated the CNAs took turns monitoring the hallways and should communicate with other staff if they had to attend to their resident and needed someone to take over the hallway monitoring. The DON stated if there was adequate supervision in SCU's hallway, Resident 1's fall and fracture could have been prevented. During a review of the facility's Policy and Procedure (P&P) titled, Fall Management Program, revised 8/28/2025, the P&P indicated the facility would maintain an environment free of accident hazards, provide adequate supervision, and assistive devices to prevent avoidable accidents. 2. During an interview on 6/8/2026 at 9:45 a.m., with Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated the Fall Risk Evaluation was a tool to determine the residents' fall risk level and to determine the factors contributing to the residents' risk. MDSN 1 stated the factors included the residents' history of falls, cognition, ambulation ability, diagnoses, and medications. MDSN 1 stated a fall risk score of ten and above would categorize the residents as a high fall risk. MDSN 1 stated the Fall Risk Evaluation had to be conducted accurately and completely to ensure the staff were aware of the residents' fall risk status and the contributing factors to know how to safety care for them. During a concurrent interview and record review on 6/8/2026 at 9:57 a.m., with MDSN 1, Resident 1's Fall Risk Evaluation, dated 5/15/2026, was reviewed. The Fall Risk Evaluation indicated Resident 1 was not at a high risk for falls due to: no falls in the past three months, disoriented at all times, chairbound, incontinent (unable to control bladder and bowel), no drop in blood pressure, adequate vision, one to two predisposing diseases, a change in condition in the last 14 days, and no recent hospitalization. The Fall Risk Evaluation indicated the section of gait/balance and medications were not answered. MDSN 1 stated, on 5/15/2026, she completed Resident 1's Fall Risk Evaluation. MDSN 1 stated Resident 1's Fall Risk Evaluation was not accurate because Resident 1 was ambulatory and was on RNA services to ambulate with a FWW or HHA. MDSN 1 stated the section for gait/balance was left blank because, at the time of the evaluation, she did not observe Resident 1 ambulate. MDSN 1 stated she was unsure why she did not answer the section regarding Resident 1's medications. MDSN 1 stated Resident 1 was on a medication regimen that included antihypertensives (medications to lower blood pressure), psychotropics (medications to manage behavior and mood), and hypoglycemics (medications to manage blood glucose levels). MDSN 1 stated Resident 1's Fall Risk Evaluation, if completed accurately and completely, would have categorized Resident 1 as a high risk for falls and provided the staff with the contributing risk factors to safely care for Resident 1. MDSN 1 stated by having an incorrect Fall Risk Evaluation, the staff would not have an accurate depiction of Resident 1's fall risk level and may not provide the necessary safety precautions. During an interview on 6/8/2026 at 1:20 p.m., with the DON, the DON stated the Fall Risk Evaluations were used to determine each resident's risk for falls and their contributing factors. The DON stated the Fall Risk Evaluation must be done accurately and completely to ensure the contributing factors are identified and the necessary interventions are created and implemented. The DON stated by having an inaccurate and incomplete Fall Risk Evaluation, Resident 1's plan of care may not be correct. During a review of the facility's P&P titled, Fall Management Program, revised 8/28/2025, the P&P indicated the licensed nurse would complete the fall risk evaluation for each resident to develop a care plan according to the identified risk factors.