

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Lawndale Healthcare & Wellness Centre LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 S Prairie Lawndale, CA 90260	

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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to: 1.Ensure a written room change with a reason was provided for one of 4 sampled residents (Resident 1). This deficient practice resulted in Resident 1 losing his bed while in the hospital.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] with diagnoses which included metabolic encephalopathy (a condition where the brain's metabolism is disrupted, leading to altered brain function), pneumonia (an infection/inflammation in the lungs), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's history and physical (H&amp;P), dated 8/28/2025, the H&amp;P indicated Resident 1 did not have the capacity to make decisions and was unable to make his needs known. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/2/2025, the MDS indicated Resident 1 was cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 1 was dependent on staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Change of Condition (COC) form, dated 9/2/2025, the COC indicated Resident 1 was transferred to the general acute care hospital (GACH) due to persistent cough, increased secretions despite receiving intravenous (IV) antibiotic treatment for pneumonia. During a review of the facility's census, dated 9/3/2025, the census showed Resident 1's bed was occupied by another resident. During a concurrent interview and record review, on 9/10/2025 at 10:23 a. m., with the Director of Nursing (DON), the DON reviewed the census for 9/2/2025 and 9/3/2025. The DON stated Resident 1 was transferred to the hospital on 9/2/2025 and on 9/3/2025, Resident 1's bed was occupied by another resident due to a room change. The DON stated she did not know why a room change occurred. The DON stated, This should not have happened. The DON stated the risk of conducting a room change when a resident is transferred to the hospital could result in a resident losing their bed. During a review of the facility's policy and procedures (P&amp;P), titled Room or Roommate Change, revised 3/2019, the P&amp;P indicated, Prior to changing a room or roommate assignment, the resident, the resident's representative (if available), and the resident's new roommate will be provided timely advance notice of such a change. and The notice of a change in room or roommate assignment must be in writing and will be given the reason(s) for such change.</p>

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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based upon interview and record review, the facility failed to: 1.Ensure one of 4 sample residents (Resident 1) was readmitted to the facility after being admitted to the General Acute Care Hospital. This deficient practice resulted in Resident 1 not being re-admitted to the facility and prolonging his GACH stay (four days). 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] with diagnoses which included metabolic encephalopathy (a condition where the brain's metabolism is disrupted, leading to altered brain function), pneumonia (an infection/inflammation in the lungs), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's history and physical (H&amp;P), dated 8/28/2025, the H&amp;P indicated Resident 1 did not have the capacity to make decisions and was unable to make his needs known. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/2/2025, the MDS indicated Resident 1 was cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 1 was dependent on staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Change of Condition (COC) form, dated 9/2/2025, the COC indicated Resident 1 was transferred to the general acute care hospital (GACH) due to persistent cough, increased secretions despite receiving intravenous (IV) antibiotic treatment for pneumonia. During a review of the facility's September 2025 census, there was no open male beds from 9/6/2025 to 9/10/2025. During a review of the facility's census on 9/10/2025, Resident 1 remained out of the facility. During a telephone interview, on 9/10/2025 at 8:15 a.m., with the GACH Social Worker (GACHSW), the GACHSW stated the facility's Regional Marketer (RM) informed her that Resident 1 was not coming back to the facility. The GACHSW stated the RM also stated the facility will not honor Resident 1's bed hold. GACH SW stated Resident 1 had discharge orders for 9/6/2025 and the facility stopped answering the phone. The GACHSW stated, If we can get him back to the facility, then that will be fine. During an interview, on 9/10/2025, at 9:03 a.m., with the admission Coordinator (AC), the AC stated he was responsible for facilitating residents' return to the facility after hospitalization. The AC stated all residents who were transferred to a hospital were required to have a 7-day bed hold. The AC stated Resident 1 was transferred to the GACH on 9/2/2025. The AC stated he was informed by the facility's RM stating she spoke with Resident 1's Public Guardian (PG) who stated she did not want Resident 1 to return to the facility. The AC stated the risk of not being readmitted to a resident could result in a resident not being able to return to their home. During an interview, on 9/10/2025 at 9:46 a.m., with the Regional Marketer (RM), the RM stated she was responsible for being the liaison between the hospitals and the facility. The RM stated all residents required a bed hold for up to 7 days. The RM stated a case manager from the GACH called and informed her that Resident 1 would not be returning to the facility per Resident 1's PG request due to being unhappy with the care at the facility. The RM stated she called Resident 1's PG and Resident 1's PG stated she did not speak to anyone at the hospital. The RM stated the GACH's discharge planner called on the facility on 9/8/2025 stating Resident 1 was able to return to the facility. The RM stated she informed the GACH's discharge planner that she spoke with the GACH's case manager who stated Resident 1 was not returning to the facility. The RM stated the GACH's case manager stated she did not tell the facility that Resident 1 would not be returning. The RM stated the risk of not readmitting a resident could result in, I don't know, I just know it's not something I've done before so I wouldn't know what the risk are. During a concurrent interview and record review, on 9/10/2025 at 10:23 a.m., with the Director of Nursing (DON), the DON stated the protocol for readmitting a resident required her (the DON) to be notified if a resident was to be readmitted to the facility by the AC and RM. The DON stated she was not aware of Resident 1 being denied readmission to the facility. The DON reviewed the census for 9/2/2025-9/3/2025 and stated Resident 1 was transferred to the hospital on 9/2/2025. The DON stated on 9/3/2025, Resident 1's bed was occupied by another resident. The DON stated Resident 1's bed hold was not honored. The DON stated the risk of not readmitting a resident could result in a resident's rights issue. The DON stated, It is a resident's right to want to come back to their home. During an interview on 9/10/2025 at 11:00 a.m. with the Administrator (Admin) the admin stated he was informed</p>		