

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/27/2026
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)		
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 create a comprehensive person-centered care plan (CP) for Resident 1's change of condition (CoC) on 6/22/2026 in accordance with the facility's policy and procedure (P&P) titled Change in Condition and Person-Centered Care Planning. This deficient practice had the potential to result in Resident 1's medical condition to worsen. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs), chronic kidney disease (when kidneys are damaged and cannot filter blood as they should), dementia (a progressive state of decline in mental abilities) and cardiomegaly (an enlarged heart). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/28/2026, the MDS indicated Resident 1 had moderately intact cognitive (ability to think and process information) ability. The MDS indicated Resident 1 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for eating. During a concurrent interview and record review on 6/27/2026 at 11:55 AM with Licensed Vocational Nurse (LVN) 3, Resident 1's SBAR Communication Form (documentation used to communicate a CoC to the attending physician [MD]) dated 6/22/2026 was reviewed. The COC indicated that Resident 1 had pitting edema to the legs and the MD recommendations were to monitor changes in swelling, pain or skin integrity. LVN 3 stated the procedure for a Change of Condition (COC) is to call the MD to get recommendations, put in new orders for the recommendations, follow up on them and update the resident's care plan to address the COC. During a concurrent interview and record review on 6/27/2026 at 12:03 PM with LVN 3, Resident 1's Care Plan History dated 5/21/2026 to 6/23/2026 was reviewed. LVN 3 stated that Resident 1 does not have a care plan for edema monitoring or monitoring for changes in swelling, pain or skin integrity. LVN 3 stated that Resident 1 should have had a care plan for edema monitoring and the monitoring mentioned in the COC. LVN 3 stated that if there is no care plan, a resident's condition may deteriorate. During a concurrent interview and record review on 6/27/2026 at 1:57 PM with the Director of Nursing (DON), the facility's P&P titled, Change in Condition, dated 8/25/2022, was reviewed. The P&P indicated the licensed nurse will document and update the care plan to reflect the resident's current status. The DON stated that the policy indicates that a resident should have a care plan that has measurable objectives and goals to address their needs and behaviors. The DON stated that a resident's care plan needs to be updated after a COC as mentioned in the policy for COC. The DON stated if a resident had edema as a COC, the nurse should have created a care plan to address the edema. During a concurrent interview and record review on 6/27/2026 at 2:15 PM with the DON, the facility's P&P titled, Person-Centered Care Planning, dated 5/22/2025, was reviewed. The P&P indicated: The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights that includes measurable objectives and timeframes to meet a resident's medical needs that are identified (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555816	Facility ID: 555816 If continuation sheet Page 1 of 3

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practical physical well-being must be included in the care plan. The DON stated that the policy indicates that it is important to update the care plan because it reflects the resident's care needs and interventions are implemented to reach a care goal. The DON stated if a resident does not have a care plan their problem is not addressed and their condition may worsen.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow the facility's policy and procedure (P & P) titled Telephone Orders, regarding one of three residents' (Resident 1) change of condition (COC) on 6/22/2026 by failing to: Follow the attending physician's (MD) recommendations of monitoring edema, monitoring for changes in swelling, pain or skin integrity. Document orders for MD's recommendations. Document monitoring of edema, changes in swelling, pain and skin integrity. This deficient practice had the potential to cause Resident 1's medical condition to worsen. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs), chronic kidney disease (when kidneys are damaged and cannot filter blood as they should), dementia (a progressive state of decline in mental abilities) and cardiomegaly (an enlarged heart). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/28/2026, the MDS indicated Resident 1 had moderately intact cognitive (ability to think and process information) ability. The MDS indicated Resident 1 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for eating. During a concurrent interview and record review on 6/27/2026 at 11:55 AM with Licensed Vocational Nurse (LVN) 3, Resident 1's SBAR Communication Form (documentation used to communicate a CoC to the attending physician [MD]) dated 6/22/2026 was reviewed. The COC indicated that Resident 1 had pitting edema to the legs and the MD recommendations were to monitor changes in swelling, pain or skin integrity. LVN 3 stated the procedure for a Change of Condition (COC) is to call the MD to get recommendations, put in new orders for the recommendations, follow up on them and update the resident's care plan to address the COC. During a concurrent interview and record review on 6/27/2026 at 12:03 PM with LVN 3, Resident 1's Care Plan History dated 5/21/2026 to 6/23/2026 was reviewed. LVN 3 stated that Resident 1 does not have a care plan for edema monitoring or monitoring for changes in swelling, pain or skin integrity. LVN 3 stated that Resident 1 should have had a care plan for edema monitoring and the monitoring mentioned in the COC. LVN 3 stated that if there is no care plan, a resident's condition may deteriorate. During a concurrent interview and record review on 6/27/2026 at 1:57 PM with the Director of Nursing (DON), the facility's P&P titled, Change in Condition, dated 8/25/2022, was reviewed. The P&P indicated the licensed nurse will document and update the care plan to reflect the resident's current status. The DON stated that the policy indicates that a resident should have a care plan that has measurable objectives and goals to address their needs and behaviors. The DON stated that a resident's care plan needs to be updated after a COC as mentioned in the policy for COC. The DON stated if a resident had edema as a COC, the nurse should have created a care plan to address the edema. During a concurrent interview and record review on 6/27/2026 at 2:15 PM with the DON, the facility's P&P titled, Person-Centered Care Planning, dated 5/22/2025, was reviewed. The P&P indicated: The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights that includes measurable objectives and timeframes to meet a resident's medical needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the residents' highest practical physical well-being must be included in the care plan. The DON stated that the policy indicates that it is important to update the care plan because it reflects the resident's care needs and interventions are implemented to reach a care goal. The DON stated if a resident does not have a care plan their problem is not addressed and their condition may worsen.		