STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Healthcare Center	2222 Santa Ana Blvd. Los Angeles, CA 90059

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47092 Based on observation, interview, and record review, the facility staff failed to notify the physician of behavior changes for one out of four sampled residents (Resident 2). This deficient practice had the potential to result in harm for Resident 1 by not informing the physician of Resident 2's mental health decline. Findings: a. During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included dementia (a disease of cognitive impairment that effects memory and the cognition required for daily living), anxiety (feeling of unease, exvessive worry), and paranoid schizophrenia (a mental disorder with hallucinations and delusions accompanied by being distrustful and suspicious of people). During a review of Resident 1's History and Physical (H&P), dated 12/14/2023, the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/21/2024, the MDS indicated Resident 1 was severely cognitively impaired (ability to think and reason). b. During a review of Resident 2's Admission Record, the admisison record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizophrenia, homicidal ideations (thoughts of killing others), and suicidal ideations (thoughts of killing self). During a review of Resident 2's H&P, dated 2/19/2023, the H&P indicated Resident 2 had the capacity to understand and make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident21 was moderately cognitively impaired. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Nursing Progress Note, dated 3/17/2024, the note indicated Resident 2 was on one-to-one (1:1) monitoring (close supervision) for striking out at staff and other residents during the shift. During a review of Resident 1 and Resident 2's Abuse Investigation Reporting Form, the form indicated on 3/23/2024 at 8:00 a.m., there was an unwitnessed incident where Resident 2 attacked Resident 1 in self-defense, after witnessing Resident 1 ball his fists. During a review of Resident 2's Discharge Summary, dated 3/23/2024, the Discharge Summary indicated Resident 2 was picked up by the police. During an observation on 4/9/2024, at 9:10 a.m., Resident 1 was observed lying in bed and was able to make eye contact but did not respond to verbal stimuli. During an interview on 4/9/2024, at 9:31 a.m., with the Activities Director (AD), the AD stated if staff witnessed any resident-to-resident abuse, the charge nurse and abuse coordinator (Administrator) should be informed immediately. During an interview on 4/9/2024, at 10:09 a.m., with Resident 1's Responsible Party (RP) 1, RP 1 stated a few weeks prior she received a phone call from the facility informing her that they were sending Resident 1 to the hospital because he was attacked by Resident 2 and had sustained facial injuries. During a concurrent interview and record review on 4/9/2024, at 1:24 p.m., with Registered Nurse (RN) 2, RN 2 stated Resident 2 always had behavior issues that presented as agitation. RN 2 stated Resident 2 would walk around the halls, hit doors, and scream at people, which was why he was on close monitoring. RN 2 stated prior to the altercation between Resident 1 and Resident 2, Resident 2 was just taken off monitoring for hitting a certified nursing assistant (CNA) on 3/17/2024, but she was not sure who. RN 2 stated there was no documentation that the physician was notified. RN 2 stated there should be a Situation Background Assessment Recommendation ([SBAR] a technique that can be used to facilitate prompt and appropriate communication) note documenting the notification to the physician because there was a change in condition. RN 2 stated per the notes in Resident 2's chart it was not clear what happened and who was involved on 3/17/2024 when Resident 2 hit staff. During a review of the facility policy and procedure (P&P) titled, Change of Condition Notification , dated 5/2018, the P&P indicated the purpose of the P&P was to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The P&P further indicated that: a. Behavioral deviations are considered an acute change in condition. b. The physician will be notified of incidents or accidents involving the resident. c. A licensed nurse will document the date, time, pertinent details of the incident, and the time the physician was contracted.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to implement its abuse prevention policy by failing to report the unusual occurrence of a resident-to-resident altercation to the State Survey Agency (SA) within 2 hours after the allegation occurred for one of four sampled residents (Resident 1). This deficient practice had the potential to place Resident 1 at risk for elder abuse. Findings: a. During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included dementia (a disease of cognitive impairment that effects memory and the cognition required for daily living), anxiety (feeling of unease, excessive worry), and paranoid schizophrenia (a mental disorder with hallucinations and delusions accompanied by being distrustful and suspicious of people). During a review of Resident 1's History and Physical (H&P), dated 12/14/2023, the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/21/2024, the MDS indicated Resident 1 was severely cognitively impaired (ability to think and reason). b. During a review of Resident 2's Admission Record, the record indicated Resident 2 was intially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizophrenia, homicidal ideations (thoughts of killing others), and suicidal ideations (thoughts of killing self). During a review of Resident 2's H&P, dated 2/19/2023, the H&P indicated Resident 2 did had the capacity to understand and make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1 was moderately cognitively impaired. During a review of Resident 1 and Resident 2's Abuse Investigation Reporting Form, the form indicated on 3/23/2024 at 8:00 a.m., there was an unwitnessed incident where Resident 2 attacked Resident 1 in self-defense, after witnessing Resident 1 ball his fists. During a review of Resident 2's Discharge Summary, dated 3/23/2024, the Discharge Summary indicated Resident 2 was picked up by the police. During an observation on 4/9/2024, at 9:10 a.m., Resident 1 was observed lying in bed and was able to make eye contact but did not respond to verbal stimuli. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/2024, at 9:31 a.m., with the Activities Director (AD), the AD stated if staff were to witness any resident-to-resident abuse the charge nurse and abuse coordinator (Administrator) should be informed immediately. During an interview on 4/9/2024, at 10:09 a.m., with Resident 1's Responsible Party (RP) 1, RP 1 stated a few weeks prior she had received a phone call from the facility informing her that they were sending Resident 1 to the hospital because he was attacked by Resident 2 and had sustained facial injuries. During an interview on 4/9/2024, at 10:25 a.m., with the Administrator (Admin), the Admin stated the incident between Resident 1 and Resident 2 was discovered on 3/23/2024 at 8:00 a.m. and he faxed over the report to the SA within two (2) hours, but the fax did not go through. The Admin stated he sent the SA another fax of the report on 3/27/2024 when he sent the 5-day investigative report. During an interview on 4/9/2024, at 1:50 p.m., with Registered Nurse (RN) 1, RN 1 stated abuse had to be reported to the SA within 2 hours. During a review of the facility policy and procedure (P&P) titled, Policy on Patient Abuse and Mistreatment , dated 10/2022, the P&P indicated the following: a. Facility Administrator shall be responsible for ensuring that all alleged and substantiated violations are reported to the state agency, and other agencies as required. b. Facility shall report the incident to state agency within the required timeframes (2-24 hours).