STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 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** 49131 Based on interview and record review, the facility failed to implement the care plan by providing a two staff assist when turning and repositioning one of 4 sampled residents (Resident 2). This deficient practice had the potential for Resident 2 to be at risk for a fall or injury. Findings: A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included muscle weakness and unspecified abnormalities of gait (walking pattern) and mobility. A review of Resident 2's Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated 2/8/2024, indicated the resident was moderately impaired in decision making (ability to reason, understand, remember, judge, and learn). The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) rolling left and right, and was dependent on staff for chair/bed to chair transfer and tub/shower transfer. A review of Resident 2 ' s care plan, dated 3/28/23, indicated the resident was at high risk for falls and injuries. The care plan approaches indicated to use 2 staff members to assist in turning and repositioning the resident. A review of Resident 2 ' s Bed Mobility: Self Performance Task, dated 4/2024, indicated the certified nurse assistants (CNA) have been documenting that Resident 2 was totally dependent and required full staff performance in how the resident moved to and from a lying position, turning side to side, and positioning of the body while in bed. The document further showed the CNA ' s have been documenting they had been using only one person to achieve these tasks. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/30/24 at 1:11 PM, with Registered Nurse (RN) 1, Resident 2 ' s care plan, dated 3/28/23, and Bed Mobility: Self Performance Task, dated 4/2024, was reviewed. RN 1 stated if there was anything regarding a resident, the CNAs needed to be aware of how to care for a resident. RN 1 stated it could be communicated to the CNA through word of mouth, during morning huddle, or in the communication function in their charting system. RN 1 stated it was the responsibility of the licensed vocational nurses (LVN), director of staff development (DSD) or the RN to do so because the CNAs did not have the ability to look through the resident ' s health record or care plan. RN 1 reviewed the Bed Mobility: Self Performance Task documentation done by the CNAs and acknowledged the CNAs have been documenting the tasks performed by just 1 staff member. RN 1 was shown Resident 2 ' s care plan where it stated to use 2 staff members to assist in turning and repositioning the resident. RN 1 further stated the LVN or RN should have communicated to the CNA ' s the resident required 2 staff assist and not 1 staff member because it was important for the safety of the resident and could prevent injuries. During an interview on 5/1/24 at 10:07 AM, with CNA 2, CNA 2 stated she has taken care of Resident 2 before and the resident was unable to turn or reposition herself in bed and the staff needed to do it for her. CNA 2 stated she turned and repositioned the resident without the assist of a second staff member unless the resident was being combative. CNA 2 stated she was not aware the resident required 2 staff members to turn and reposition the resident. CNA 2 further stated that if the resident required 2 staff members to assist but only 1 staff member has been providing the care, it could be very risky because the resident may experience a fall, or the staff could injure the resident. A review of the facility policy and procedure (P&P), titled Care Planning, dated 5/1/2018, indicated the care plan serves as a course of action where the resident and the interdisciplinary team (IDT, group of healthcare workers that work together to treat a patient) work to move a resident toward specific goals that address the resident ' s medical, nursing, mental and psychosocial needs. A review of the facility's P&P titled Positioning and Body Alignment, dated 5/1/2018, indicated positioning and body alignment activities are individualized to resident ' s needs, planned, monitored, evaluated, and documented in the resident ' s medical record. The P&P indicated general preparation steps to position the resident include to check the care plan first and to be aware of limitations the resident has in positioning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview and record review, the facility failed to accurately obtain blood pressure readings to determine if two of four sampled residents (Resident 1 and Resident 2) have orthostatic hypotension (a form of low blood pressure that happens when standing after lying down or sitting). This deficient practice had the potential for Resident 1 and Resident 2 to experience delayed medical interventions, falls, and injuries due to not having their orthostatic blood pressures (taken while lying, sitting, and standing to determine orthostatic hypotension) taken appropriately to determine orthostatic hypotension. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included muscles weakness, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), epilepsy (seizures, burst of uncontrolled electrical activity between brain cells), cerebral infarction (disrupted blood flow to the brain), heart failure, and difficulty walking. A review of Resident 1 ' s Minimum Data Set ([MDS]), a standardized assessment and care planning tool), dated 2/10/24 indicated Resident 1 had severe cognitive impairment (ability to reason, understand, remember, judge, and learn). The MDS indicated Resident 1 required supervision or touching assistance when walking 50 feet (ft.) and 150 ft. A review of Resident 1 ' s care plan, dated 4/8/24, indicated Resident 1 was at high risk for falls and injuries related to generalized weakness, psychotropic medications, having lack of awareness, poor judgement of safety, gait (manner of walking) instability, and being able to ambulate (walk) without use of assistive devices. Interventions included instructing Resident 1 and staff to change position slowly from sitting to standing. A review of Resident 1 ' s Medication Administration Record (MAR), dated 4/2023, indicated Resident 1 was to have their orthostatic blood pressure monitored on Wednesdays during the 7:00 AM - 3:00 PM shift. A review of Resident 1 ' s Weights and Vitals Summary, dated 4/2023, showed 3 blood pressure readings on Wednesday, 4/10/2024, on the 7:00 AM - 3:00 PM shift, as follows : 10:50 AM - Blood pressure reading of 110/74 millimeters of mercury (mmHg, unit of measurement). 11:12 AM - Blood pressure reading of 134/81 mmHg, while standing. 11:13 AM - Blood pressure reading of 134/81 mmHg, while sitting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2 ' s Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included muscle weakness, unspecified abnormalities of gait and mobility, paranoid schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and chronic obstructive pulmonary disease (COPD, a chronic lung disease that affects the way someone breathes). A review of Resident 2's MDS dated [DATE], indicated Resident 1 was moderately impaired in decision making (ability to reason, understand, remember, judge, and learn). The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) rolling left and right, and was dependent on staff for chair/bed to chair transfer and tub/shower transfer. A review of Resident 2 ' s care plan, dated 3/28/23, indicated Resident 1 was at high risk for falls and injuries due to generalized weakness, confinement to bed, and being unable to walk. A review of Resident 2 ' s Order Summary Report, dated 4/2023, indicated Resident 2 was to have orthostatic blood pressure monitoring on Saturdays, during the 3:00 PM - 11:00 PM shift. A review of Resident 2 ' s Weights and Vitals Summary, dated 4/2023, showed 3 blood pressure readings on Saturday, 4/6/2024 and 4/13/2024, on the 3:00 PM - 11:00 PM shift, as follows: On 4/6/2024 at 3:29 PM - Blood pressure reading of 122/68 mmHg. On 4/6/2024 at 5:26 PM - Blood pressure reading of 112/78 mmHg while lying. On 4/6/2024 at 11:13 PM - Blood pressure reading of 117/75 mmHg. On 4/13/2024 at 3:25 PM - Blood pressure reading of 117/67 mmHg. On 4/13/2024 at 5:22 PM - Blood pressure reading of 112/74 mmHg while lying. On 4/13/2024 at 11:49 PM - Blood pressure reading of 116/72 mmHg. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, on 4/30/23 at 10:45 AM, Resident 1 and Resident 2's Weights and Vitals Summary for April 2024, was reviewed. LVN 1 stated the procedure to obtain orthostatic blood pressure would be to take the blood pressure when the resident was lying down first. LVN 1 stated then have the resident sit up and then take another blood pressure reading. LVN 1 stated if the resident was able to, staff would have the resident stand up and take another blood pressure reading. LVN 1 stated the purpose of doing it that way was to determine if the resident had a drop in blood pressure from a lying to an upright position. LVN 1 stated the blood pressure readings would not be useful if the nurse took the blood pressures out of order or if too much time passed between each blood pressure reading. LVN 1 stated staff would usually wait 3-5 minutes between each change in position to take a blood pressure. LVN 1 stated Resident 1 and Resident 2's orthostatic blood pressures were done incorrectly and there were issues with the documentation. LVN 1 stated because the nurse did not specify what position the residents were in, and that the time between each reading was either too close together or too far apart to give an accurate reading. LVN 1 further stated it was an issue because it was not an accurate reading, and the nurse would not know if there was a change in blood pressure that needed to be reported to the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 5/1/2024 at 3:05 PM, the DON stated orthostatic blood pressures should first be taken with the resident lying down, then sitting up, and then standing up if they were able to. The DON stated during each change in position, you must wait 3-5 minutes before taking the blood pressure. The DON stated if there was a 20 mmHG drop of the systolic blood pressure, that indicated the resident may have orthostatic hypotension and which needed to be alerted the physician. The DON stated if there was no documentation what position the resident was in when the blood pressure was taken, or the time between each blood pressure reading was taken either too short or too long, it meant the orthostatic blood pressure was not taken appropriately and the physician would not be able to intervene appropriately if the resident did have orthostatic hypotension. A review of the facility's policy and procedure (P&P) titled, Orthostatic Hypotension, dated 1/1/2012, indicated the procedure for taking orthostatic blood pressure is to take the blood pressure with the resident lying down first and then have them stand up or sit if unable to stand, and then take another blood pressure. The P&P indicated that orthostatic hypotension is 20 millimeters of mercury ([mmHg]- a unit of measurement) in the systolic blood pressure (top number of the blood pressure reading) or a 10 mmHG drop in the diastolic blood pressure (bottom number of the blood pressure reading) within 3 minutes of standing up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0689 Level of Harm - 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** 49131 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was supervised while walking. Resident 1 was allowed to walk independently after being assessed by the physical therapist (PT, professionals who educate patients about exercises for muscle strength, coordination, and balance) as requiring moderate assistance (staff does half the work for the resident) while walking. This deficient practice resulted in an avoidable fall. Resident 1 fell at the front lobby and sustained a bump on the back side of her head, a right hip fracture (broken bone) that required admission and surgical intervention at the general acute care hospital (GACH) for six days. Findings: A review of Resident 1 ' s admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included muscles weakness, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), epilepsy (seizures-sudden electrical activity in the brain), cerebral infarction (disrupted blood flow to the brain, heart failure, and difficulty walking. A review of Resident 1 ' s Minimum Data Set ([MDS]), a standardized assessment and care planning tool), dated 2/10/24 indicated Resident 1 had severe cognitive impairment (ability to reason, understand, remember, judge, and learn). The MDS indicated Resident 1 required supervision or touching assistance (staff provides touching and/or steadying assistance) when walking 50 feet ([ft.] unit of measurement) and 150 ft. A review of Resident 1 ' s care plan, dated 4/8/24, indicated Resident 1 was at high risk for falls and injuries related to generalized weakness, psychotropic medications (any drug that affects brain activities associated with mental processes and behavior), having lack of awareness, poor judgement of safety, and gait (manner of walking) instability. Staff ' s interventions included to check the environment that increased risk of falls such as wet spots on the floor and broken handrails, educate resident to change position slowly from sitting to standing, educate resident to use call light to ask for assistance, and referral to rehabilitation services (healthcare services to improve skills for daily living). A review of Resident 1 ' s Fall Risk Evaluation, dated 4/8/24 indicated Resident 1 was at risk for falls and had a balance problem while standing and walking, had decreased muscular coordination and required the use of assistive devices (a device to help someone perform a task). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s PT Evaluation and Plan of Treatment, dated 4/9/24, indicated Resident 1 was referred to PT for a decline in functional capacity (capability for an individual to perform tasks necessary or desirable in their life), functional ambulation (ability to walk), and functional mobility. The PT evaluation indicated precautions (measures taken in advanced to prevent something dangerous) and contraindications (anything that serves as a reason not to provide a procedure or treatment) for Resident 1 included being a fall risk. The PT evaluation indicated Resident 1 had a significant decline in function and generalized weakness due to deconditioning (a decline in physical function because of inactivity), unsteady gait (a person ' s manner of walking) and has poor endurance in functional mobility. A review of Resident 1 ' s Situation Background Appearance Review (SBAR) Communication Form, dated 4/14/24, indicated Resident 1 fell on [DATE] at approximately 11:15 AM. The SBAR indicated Resident 1 had a head injury with a bump on the back side of her head. The SBAR indicated Resident 1 complained of right leg pain. A review of Resident 1 ' s GACH History and Physical (H&P) Final Report dated 4/14/24, indicated Resident 1 was being evaluated for right leg pain and headache after a fall on 4/14/24. The H&P indicated a right hip x-ray (a medical test that takes pictures of bones in the body) showed mildly displaced (movement from its usual position) intertrochanteric (area on the femur [thigh bone] where the hip and thigh meet) fractured on the right femur. During a concurrent interview and record review on 4/30/24 at 2:36 PM with the PT Assistant (PTA), Resident 1 ' s PT Treatment Encounter Notes dated 4/9/24- 4/14/24 were reviewed. The PTA stated Resident 1 was referred to PT due to a need in performing activities of daily living ([ADL]-tasks related to personal care), decreased coordination, reduced balance, decrease in strength and a high risk for falls. The PTA stated Resident 1 was last evaluated on the morning of 4/14/24 before the fall occurred. The PTA stated Resident 1 ' s functional status indicated that Resident 1 ' s gait on level surfaces required moderate assistance, the distance on level surfaces was 50 ft., and an assistive device used was handheld assistance which means they would hold their hand to guide the resident while walking. The PTA stated moderate assistance was defined as the resident performing 50 percent (%) of the activity or task and the staff did the other 50% which could include verbal and tactile cues (physical touch to guide or remind completion of a task or activity), setup of equipment such as siderails and wheelchairs, holding onto the residents gait belt (device put on a person with mobility issues to help them move around), or resident holding or using assistive devices such as the staff members hand or a handrail. The PT Treatment Encounter Notes from 4/10/24 to 4/14/24 indicated Resident 1 ' s gait on level surfaces required moderate assistance going 50 ft on level surfaces with assistive device being handheld assist. The PTA stated that her method of communication to the nursing staff was done verbally, and it was assumed the information would be endorsed to the nurses on the next shift. The PTA stated the PTA ' s did not have access to document in the system the nurses used. During a concurrent interview and record review on 4/30/24 at 9:51 AM with the Registered PT (RPT), Resident 1 ' s PT Discharge Summary was reviewed. The RPT stated she has worked with Resident 1, and the resident was sometimes non-compliant with safety measures and could be impulsive (doing something without thought). The RPT stated Resident 1 did not like using a walker and preferred to walk on her own. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/29/24 at 12:50 PM with the Security Guard (SG), the SG stated she saw Resident 1 fall in the front lobby on 4/14/24 around 11:00 AM. The SG stated she was sitting at her desk and saw Resident 1 walking out the door from the patio across from the front lobby when Resident 1 turned, fell , and hit the ground. The SG stated Resident 1 was walking by herself without a walker. The SG stated she noticed Resident 1 had blood on her head that looked like an abrasion (a rub or wearing off of the skin). The SG stated she has often saw Resident 1 walking by herself. During an interview on 4/29/24 at 1:00 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was the charge nurse on the day the resident fell , 4/14/24but did not witness the fall. LVN 1 stated she was alerted of the fall by Activities Assistant (AA) 1. LVN 1 stated the resident was wearing non-skid socks and the resident was alert with no change in her level of consciousness (state of being awake). LVN 1 stated Resident 1 often walked on her own without the use of assistive devices and could be impulsive. LVN 1 stated staff had to remind Resident 1 to slow down when walking or hold onto the handrails. During an interview on 4/29/24 at 1:50 PM with LVN 2 and Certified Nurse Assistant (CNA) 1, LVN 2 and CNA 1 both stated they were familiar with Resident 1, and often walked around the facility by herself, and did not use any assistive devices when doing so. CNA 1 stated the staff did not walk with Resident 1 but would check up on to make sure she was okay. CNA 1 stated staff did not need to help her when getting up off the bed or chair and going to the restroom. LVN 2 stated he was not aware that Resident 1 required more assistance or supervision while walking. During a concurrent observation and interview on 4/30/24 at 11:20 AM with Resident 1, in Resident 1 ' s room, Resident 1 was observed lying on her bed with a dressing noted on her right hip. Resident 1 stated she had surgery for a broken bone after she fell . Resident 1 stated she finished smoking in the patio and was walking back to her room when she felt dizzy. Resident 1 stated she could not catch herself and fell to the ground. Resident 1 stated she was working with physical therapy to be able to walk again. During an interview on 4/30/24 at 3:20 PM with the Director of Rehabilitation (DOR), the DOR stated the bulk of the rehabilitation department ' s documentation was done in their own system that did not cross over to the system the nursing staff used and could not see their assessment and notes. The DOR stated if there was something important that needed to be discussed regarding a resident, they would have a verbal conversation with the nursing staff. The DOR stated Resident 1 could be impulsive and needed some verbal or visual cues from staff to remind her to walk slower. During a concurrent interview and record review, on 5/1/24 at 11:14 AM with LVN 1, Resident 1 ' s PT Treatment Encounter Notes dated 4/9/24- 4/14/24 was reviewed. LVN 1 stated based on the notes from the rehabilitation department, Resident 1 was not as independent as she thinks when ambulating and required more assistance and supervision from staff. LVN 1 stated she was not made aware of this assessment from PT and was not aware of any special instructions for Resident 1. LVN 1 stated if she knew the resident required more assistance and supervision, there would have been more interventions in place to keep the resident safe while walking and the resident might have avoided the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	05/03/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/1/24 at 12:39 PM with RPT, Resident 1 ' s PT Discharge Summary was reviewed. RPT stated one of Resident 1 ' s long-term goals were to ambulate on level surfaces for 150 ft. using no assistive devices but with contact guard assist (CGA) which means the staff was standing by to provide reminders and nudges as necessary. RPT stated on the day Resident 1 fell , she did not meet this goal of having CGA and ambulating 150 ft. with no assistive devices and Resident 1 still required moderate assistance from staff. During an interview on 5/1/24 at 2:30 PM with RN 1, RN 1 stated Resident 1 had a history of seizures, was a high fall risk and needed redirection at times. During an interview on 5/1/24 at 3:05 PM with the Director of Nursing (DON), the DON stated Resident 1 walked independently with a short stride, was a high fall risk, had a history of seizures, and was impulsive. The DON stated Resident 1 could ambulate independently and did not require staff to be by her side constantly to supervise her. The DON stated if there were concerns or precautions to take regarding a resident but was not communicated or followed up on, the resident might get hurt. A review of the facility policy and procedure (P&P) titled, Fall Prevention and Management, revised 2018, indicated the facility will have a fall prevention and management program that provides an environment free from hazards over which the facility has control. A review of the facility P&P titled, Resident Rights- Quality of Life, dated 5/1/2023, indicated facility staff provide care and services that ensure the resident ' s abilities in activities of daily living do not diminish while in the care of the facility, except when unavoidable as evidenced by clinical condition.