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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056478 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>08/28/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lighthouse Healthcare Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2222 Santa Ana Blvd.<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0579</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide information about how to apply for and use Medicare and Medicaid benefits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</b></p> <p>Based on interview and record review, the facility staff failed to ensure one out of two sampled residents (Resident 1) was informed about her medical coverage during her stay at the facility by:</p> <ol style="list-style-type: none"> <li>1. Not informing Resident 1 that she did not have a secondary coverage (insurance that pays after primary coverage, it will cover the remaining costs that the primary insurance did not cover) for the length of her stay at the facility.</li> <li>2. Not assisting Resident 1 with the process of applying for a secondary coverage.</li> </ol> <p>These deficient practices resulted in Resident 1 to live at the facility without being informed she had no medical coverage and Resident 1 received a medical bill for the uncovered amount.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including depression (a common and serious medical illness that negatively affects how a person feels, thinks, and acts) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>During a review of Resident 1's History and Physical (H&amp;P) dated 3/19/2021, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/25/2021, the MDS indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 required supervision for oral hygiene, toileting hygiene, dressing, and shower/bathing.</p> <p>During a review of Resident 1's electronic medical record, the electronic medical record indicated there was no documentation indicating Resident 1 was informed of no secondary coverage for her stay at the facility. The electronic medical record did not indicate the staff attempted to discuss Resident 1's medical coverage.</p> <p>During a review of Resident 1's Medicare Eligibility form, dated 2/19/2021, the Medicare Eligibility form indicated there was no recorded eligibility for requested date of service 2/1/2021.</p> <p>(continued on next page)</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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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |  |  |
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| <p>F 0579</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 8/28/2024 at 1:12 p.m. with the Administrator, the Administrator stated Resident 1's last day of medical coverage was on 3/18/2021. The administrator stated Resident 1 was charged for her stays between 3/18/2021 - 4/28/2021.</p> <p>During an interview on 8/28/2024 at 1:32 p.m. with Resident 1, Resident 1 stated no one from the facility informed her that she did not have secondary coverage. Resident 1 stated the facility staff did not assist her in applying for a secondary coverage. Resident 1 stated if someone told her she did not have a secondary coverage she would have not stayed at the facility. Resident 1 stated she wanted to leave the facility because she completed her rehabilitation for her arm and was ready to live independently. Resident 1 stated she expected the facility staff to inform her of her medical benefits and to assist her with any issues but they did not.</p> <p>During an interview on 8/28/2024 at 2:28 p.m. with the Business Office Manager (BOM), the BOM stated a resident ' s medical benefits were verified before a resident was admitted to the facility. The BOM stated when the resident arrived to the facility their medical benefits were checked again to make sure they continue to have coverage. The BOM stated on admission staff must verify if a resident has a secondary coverage. The BOM stated within two weeks of admission to the facility a resident must be notified that they need secondary coverage. The BOM stated she never had a conversation with Resident 1 about not having a secondary coverage. The BMO stated the facility did not have any documentation that indicated Resident 1 was informed that she had an outstanding bill at the time of discharge.</p> <p>During an interview on 8/28/2024 at 3:14 p.m. with the BOM, the BOM stated during the admission process, all residents must be informed what their insurance covers and what it did not. The BOM stated on admission everything must be explained to the resident.</p> <p>During an interview on 8/28/2024 at 3:28 p.m. with the BOM, the BOM stated Resident 1 ' s medical benefits were checked in February 2024 and the resident did not have eligibility for Medicare (federal health insurance for anyone age 65 and older). The BOM stated residents' medical benefits should be checked monthly and the resident must be informed if they did not have a secondary coverage. The BOM stated facility staff must assist residents to apply for a secondary coverage. The BOM stated the facility did not have any documentation to indicate they attempted to assist Resident 1 with applying for a secondary coverage. The BOM stated it was important for residents not to have issues with their medical coverage because they need the reassurance that all services would be provided to them. The BOM stated if a resident did not have a secondary coverage, the resident might have issues with continuous care and would be responsible for paying the uncovered portion of care.</p> <p>During an interview on 8/28/2024 at 3:54 p.m. with the Director of Nursing (DON), the DON stated staff from the business office and from admissions should have knowledge on residents ' medical coverage. The DON stated those staff were responsible for talking to the residents on admission about their medical benefits and if they needed a secondary coverage. The DON stated it was the residents right to be informed about their status on a secondary coverage. The DON stated if a resident was not informed that they did not have a secondary coverage they would receive a bill for the uncovered portion. The DON stated it was the responsibility of the facility staff to assist the residents with applying for Medicare. The DON stated if a resident did not receive the assistance needed to apply for Medicare services, they would not have a secondary coverage and would be responsible to pay for the uncovered portion. The DON stated she expected her staff to continuously check on resident benefit eligibility and inform the residents if they needed a secondary coverage.</p> |  |  |