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	10/22/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure residents was free from physical abuse for one of four sampled residents (Resident 1). This deficient practice resulted in Resident 1 being hit with a wet floor sign cone ([12 inch wide and 36-inch height 36 between 5-10 pounds] a safety measure used to notify of a slippery surface) by Resident 2, and left Resident 1 feeling threatened (the sense that something bad might happen) and scared for his life. 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 admitted to the facility on [DATE] with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of Resident 1 ' s Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 9/21/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 31 required supervision assistance (helper sets up or cleans up; resident completes activity) from staff for 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 progress note, dated 10/5/2024 at 7:55 a.m., the progress note indicated Resident 1 was hit with a wet floor sign cone by roommate (Resident 2) and caused Resident 1 to sustain a bruise (skin discoloration) and cut on the right elbow. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/2024 at 1:10 p.m., with Resident 1, Resident 1 stated on 10/5/2024 in the early morning hours, (was not able to recall the time), his roommate (Resident 2) was passing gas and was acting very unpleasant. Resident 1 stated he (Resident 1) asked Resident 2 to stop passing gas and go into the restroom. Resident 1 stated, Resident 2 was upset, ran out of the room, grabbed a wet floor sign cone, and threw it at Resident 1. Resident 1 stated, he was hit on his right elbow. Resident 1 stated he had a right elbow skin cut and bruise. Resident 1 stated he felt threatened and scared for his life. During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia, anxiety (feeling of fear, dread, and uneasiness), and hypertension. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 2 was independent for ADLs. During a review of Resident 2 ' s situation, background, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/5/2024 at 8:15 a.m., the SBAR indicated Residents 1 and 2 had an altercation. The SBAR indicated Resident 2 hit Resident 1 with a wet floor sign cone and Resident 1 sustained a right elbow skin cut. During a telephone interview on 10/22/2024 at 2:17 p.m., with Registered Nurse (RN 1), RN 1 stated on the morning of 10/5/2024, he (RN 1) was in the facility ' s conference room and heard yelling and screaming coming from the hallway. RN 1 stated he (RN 1) came out of the conference room right way and observed Resident 2 who appeared agitated, holding a wet floor sign cone, and running after Resident 1. RN 1 stated, Resident 1 looked scared. RN 1 stated, Resident 1 told him (RN 1) that Resident 2 threw the wet floor sign cone and hit him (Resident 1) on the right elbow. RN 1 stated Resident 1 sustain right elbow skin cut and a bruise. RN 1 stated the wet floor sign cone was left unattended in front of Residents 1 and 2 room. RN 1 stated physical abuse could have been prevented if the wet floor sign cone was not left unattended in front of the residents ' room. During a concurrent observation and interview on 10/22/2024 at 2:52 p.m., with RN 2 in the hallway, a wet floor sign cone was observed placed and left unattended in front of a resident ' s room. RN 2 stated that sign cones left unattended was a safety issue and had the risk for resident-to-resident physical harm, abuse, and injury. During a review of the facility ' s policy and procedure (P&P) titled Policy on patient abuse and mistreatment, dated 10/2022, the P&P indicated facility would uphold resident ' s rights to be free from physical abuse (defined as the willful infliction of injury, unreasonable confinement or punishment with resulting physical harm or pain or mental anguish or derivation by an individual). The P&P indicated residents would not be subjected to abuse by another resident. During a review of the facility ' s P&P tilted Safety of Residents revised 5/1/2023, the P&P indicated the facility would provide a safe environment for residents.

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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 0689 Level of Harm - Minimal harm or potential for 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** 48343 Based on observation, interview, and record review, the facility failed to ensure residents ' environment remained free of accident hazards by keeping housekeeping cones (wet floor signs) unattended in residents ' rooms. This deficient practice resulted in Resident 1 being hit by Resident 2 with a wet floor sign-cone ([12 inch wide and 36-inch height 36, and between 5-10 pounds] a safety measure used to notify of a slippery surface) and had the potential to cause physical harm to other residents in the facility. Findings: During an observation on 10/22/2024 at 1:40 p.m., 2:00 p.m., and 2:40 p.m., in the facility ' s hallway, a wet floor sign cone and housekeeping cart was observed unattended and placed in front of a residents ' room. 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 admitted to the facility on [DATE] with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of Resident 1 ' s Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 9/21/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 31 required supervision assistance (helper sets up or cleans up; resident completes activity) from staff for 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 progress note, dated 10/5/2024 timed 7:55 a.m., the progress note indicated Resident 1 was hit with a wet floor sign cone by roommate (Resident 2) and caused Resident 1 to sustain a bruise (skin discoloration) and cut on the right elbow. During an interview on 10/21/2024 at 1:10 p.m., with Resident 1, Resident 1 stated on 10/5/2024 in the early morning hours, (unable to remember the time), his roommate (Resident 2) was passing gas. Resident 1 stated he told Resident 2 to stop passing gas and go into the restroom. Resident 1 stated, Resident 2 became upset, ran out of the room, and grabbed a wet floor sign cone and threw at Resident 1. Resident 1 stated was hit on his (Resident 1) right elbow. Resident 1 stated he sustained a right elbow skin cut and bruise. Resident 1 stated he felt threatened and scared for his life. During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia, anxiety (feeling of fear, dread, and uneasiness), and hypertension. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 2 was independent for ADLs. During a review of Resident 2 ' s situation, background, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/5/2024 at 8:15 a.m., the SBAR indicated Residents 1 and 2 had an altercation. The SBAR indicated Resident 2 hit Resident 1 with a wet floor sign cone and Resident 1 sustained right elbow cut. During a telephone interview on 10/22/2024 at 2:17 p.m., with Registered Nurse (RN 1), RN 1 stated on the morning of 10/5/2024, he (RN 1) was in the facility ' s conference room and heard yelling and screaming coming from the hallway. RN 1 stated he (RN 1) came out of the conference room right way and observed Resident 2 who appeared agitated, holding a wet floor sign cone, and running after Resident 1. RN 1 stated, Resident 1 looked scared. RN 1 stated, Resident 1 told him (RN 1) that Resident 2 threw the wet floor sign cone and hit him (Resident 1) on the right elbow. RN 1 stated Resident 1 sustain right elbow skin cut and a bruise. RN 1 stated the wet floor sign cone was left unattended in front of Residents 1 and 2 room. RN 1 stated physical abuse could have been prevented if the wet floor sign cone was not left unattended in front of the residents ' room. During a telephone interview on 10/22/2024 at 2:17 p.m., with Registered Nurse (RN 1), the RN 1 stated on the morning of 10/5/2024 he (RN 1) was in the facility ' s conference room and heard yelling and screaming coming from the hallway. RN 1 stated he (RN 1) came out of the conference room right way and observed Resident 2 was agitated holding a wet floor sign cone and running after Resident 1. RN 1 stated Resident 1 was visibly (can be seen by the eye) scared. RN 1 stated Resident 1 told him (RN 1) that Resident 2 threw the wet floor cone and hit him (Resident 1) on the right elbow. During an interview on 10/22/2024 at 2:35 p.m., with housekeeping (HK1), t HK 1 stated, residents ' room were cleaned every 20 minutes throughout the day. HK 1 stated she would clean one residents ' room floor and would place wet floor sign cone and then go and clean another residents ' room floor. HK 1 stated she would leave the wet floor sign cone in place unattended for about 10 to 20 minutes until the floor was dry then remove it. HK 1 stated she was cleaning multiple residents ' room at the facility during her shift and did not have time to stay in the residents ' room and wait until the floor was dry. During a concurrent observation and interview on 10/22/2024 at 2:52 p.m., with RN 2 in the hallway, a wet floor sign cone was observed placed and left unattended in front of residents ' rooms. RN 2 stated that cleaning equipment left unattended was a safety issue, and placed residents at risk for physical harm, and injury. During a review of the facility ' s policy and procedure (P&P) titled Safety Committee- Composition and Duties, revised 5/1/2018, the P&P indicated: a) Facility would monitor the quality of resident care and safety practices. b) Facility safety committee (SC) would oversee safety practices on the grounds of the facility and environmental factors related to safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Facility would maintain facility grounds in a manner to allow the safety of residents and facility staff. During a review of the facility ' s P&P titled Housekeeping- General, revised 5/1/2018, the P&P indicated housekeeping staff while performing job duties (tasks that an employee performs) would watch cleaning equipment carefully and keep it out the way of the residents. During a review of the facility ' s P&P titled Housekeeping job description, dated 12/16/2022, the P&P indicated housekeeping responsibilities and duties included keep cleaning equipment out of the residents ' way.