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	11/28/2024

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 - Immediate jeopardy to resident health or safety 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** 45009 Based on interview and record review, the facility failed to provide a safe transfer to a medical appointment for one resident of three sampled residents (Resident 1) by failing to: 1. Ensure a transportation vehicle was parked in a designated parking space to transport Resident 1 to a dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) appointment. The medical transportation van was double parked (parked beside a row of vehicles already parked parallel to the curb) in the middle of a street. 2. Ensure staff was in-serviced on safe resident transportation to medical appointments. 3. Follow its policy and procedure (P&P) titled Accidents and Incidents, which indicated the facility will comply with current rules and regulations to prevent accidents. 4. Follow its P&P titled and Safety Committee-Composition and Duties, which indicated the facility will develop a reporting system for staff to identify potential safety risks, hazardous areas, and unsafe work practices. As a result, Resident 1 ' s medical transportation van was hit by a speeding vehicle while strapped in his wheelchair in the back of the medical transportation van. Resident 1 was pinned to the floor inside the van by the moving car. Resident 1 sustained life threatening injuries and was transported to the general acute care hospital (GACH) where he died on [DATE]. On [DATE] at 3:58 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) due to the facility ' s failure of not having a designated area to pick up and drop off residents, in-servicing staff on safe transportation to medical appointments, complying with rules and regulations to prevent accidents, and not identifying a potential safety risk, hazardous areas, and an unsafe work practice. On [DATE] at 2:27 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After verification of the IJRP implementation through observation, interview, and record review, the IJ was removed onsite on [DATE] at 2:58 p.m., in the presence of Registered Nurse (RN) Supervisor 1. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJPR included the following immediate actions: 1. On [DATE] and on [DATE], Social Services Staff sent a written notice to all outside transportation providers via fax and e-mail to inform them of the accident that occurred on [DATE] and to remind transportation companies that provide service to this facility to never double-park or park in the flow of traffic lanes while loading and unloading residents and staff in front of the facility and that they are required to comply with all applicable traffic laws and best practices to ensure the safety and well-being for all parties. 2. The ADM checked to ensure that signs were posted to designate a space for loading and unloading residents from transportation vehicles, located in the parking lot closest to the entrance to the facility on [DATE]. 3. On [DATE], the Director of Staff Development (DSD) in-serviced licensed nurses, Certified Nursing Assistants (CNAs), and front Lobby staff to ask drivers upon entry to the facility as to where they are parked to ensure that residents are transferred onto vehicles that are parked safely and not double-parked in the flow of traffic. 4. All staff in the facility, beginning 5:00 p.m. on [DATE] were in-serviced by the DSD/ RN Supervisor/ ADM regarding transportation safety with emphasis upon: a. The incident / accident that occurred on [DATE]. b. Importance of informing transportation services to use only designated parking space when transferring residents to/ from the facility. c. Ensure there will be no double parking in front of the facility while loading and unloading residents. d. Ensure the transportation vehicle must park at the marked loading area at all times. e. Ensure Residents are transported / escorted to and from the facility in a safe manner. f. The importance of reporting any safety hazards or unsafe work practices having potential for possible harm or danger to Residents [i.e. double-parked transportation vehicles] to the RN Supervisor and/or ADM to ensure timely corrective action. g. Instruct staff to not park in areas designated for transportation services. 5. The RN Supervisor will report any unwanted findings to the facility ADM during daily stand-up meetings to ensure timely corrective action and implementation into the Safety Committee for systemic review and additional corrective action. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The Quality Assurance and Performance Improvement (QAPI, a data driven proactive approach to improvement used to ensure services are meeting quality standards) nurse and facility ADM will develop a Performance Improvement Plan, with completion on [DATE] and report the findings to the QAPI committee on a monthly basis for 3 months to monitor and ensure the effectiveness of the corrective action and systemic changes. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included end stage renal disease ([ESRD] irreversible kidney failure) and dependence on renal (relating to the kidneys) dialysis. During a review of Resident 1 ' s History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 did not have capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 ' s cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 required set up assistance (helper sets up or clean up) for eating and supervision (helper provides verbal cues and/or touching) for dressing, toileting hygiene, and oral hygiene. During a review of Resident 1 ' s Order Summary Report dated [DATE], the order summary report indicated Resident 1 had an order for ESRD treatment on Tuesdays, Thursdays, and Saturdays. During a review of Resident 1 ' s Nursing Progress Note dated [DATE] at 8:27 a.m., the Nursing Progress Note indicated on [DATE] at 6:50 a.m., RN Supervisor 1 witnessed Resident 1 lying on his abdomen inside the transportation vehicle. The Nursing Progress Note indicated Resident 1 was bleeding from the right frontal head area and was transferred to a GACH for further evaluation/treatment. During a review of Resident 1 ' s Nursing Progress Note dated [DATE] at 1:23 p.m., the Nursing Progress Note indicated a licensed nurse received a report from the GACH on [DATE] at 12:30 p.m., that Resident 1 was in critical condition due to extensive injuries as a result of the incident. During a review of Resident 1 ' s Los Angeles Fire Department (LAFD) Report, dated [DATE] at 6:58 a.m., the LAFD report indicated Resident 1 was alert and oriented times one (person knows who they are but not where they are, what time it is, or what is happening to them). The LAFD report indicated Resident 1 had bilateral (both sides) femur (thigh bone) fractures (broken bone), scrapes and abrasions at various locations of the body. The LAFD report indicated Resident 1 was placed on a stretcher (flat structure covered with cloth which is used to carry someone who is sick or injured) and transferred to a GACH. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Emergency Department (ED) Triage Notes dated [DATE] at 7:43 a.m., the ED Triage Notes indicated Resident 1 was brought in by an ambulance with mild cognitive impairment. The ED Triage Notes indicated Resident 1 was rearended by another vehicle and extricated (process of removing injured or potentially injured people from their vehicles) by Emergency Medical Services (EMS) with lower extremities deformity. The ED Triage Notes indicated Resident 1 had a brief loss of pulses and received one round of cardiopulmonary resuscitation ([CPR] combines rescue breathing (mouth-to-mouth) and chest compressions to temporarily pump enough blood to the brain). The ED Triage Notes indicated on [DATE] at 10:38 a.m. Resident 1 was intubated (a tube inserted through a person's mouth or nose, then down into the airway/windpipe) due to respiratory failure (serious condition that occurs when the lungs can't get enough oxygen into the blood). During a review of Resident 1 ' s GACH History and Physical (H&P) Report dated [DATE] at 9:59 a.m., the H&P indicated Resident 1 sustained 8 left rib fractures (broken bones), 5 right rib fractures, pulmonary contusion (a lung injury that occurs when blunt force trauma to the chest causes bleeding and swelling in the lungs) of the right lung, paraspinal hematoma (collection of blood in the soft tissues around the spine), pubic rami (pelvis) fractures, transverse fracture of through the sacrum (large triangular bone that forms the base of the spine and the back wall of the pelvis - transverse fracture occurs when the bone of the sacrum breaks across its width, running perpendicular to the length of the bone, often resulting from high-impact trauma like falls from a significant height or severe motor vehicle accidents), bilateral fibula (outer and usually smaller of the two bones between the knee and ankle) fractures, left and right tibial (large bone in the lower leg) fractures, bilateral right femoral (thigh bone) fractures, and multiple fractures to the spine. The H&P indicated Resident 1 required 3 units of whole red blood. During a review of Resident 1 ' s Inpatient Progress Notes dated [DATE] at 3:55 p.m., the Progress Notes indicated on [DATE] at 3:47 p.m. Resident 1 was in asystole (no pulse), and unresponsive to painful or verbal stimulation. The Progress Notes indicated Resident 1 did not have any heart and lung sounds and was pronounced dead on [DATE] at 3:51 p.m. The Progress Notes indicated Resident 1 ' s cause of death was multisystem shock (reduced perfusion [flow of bodily fluids] of vital tissue) due to polytrauma (multiple injuries to different parts of the body or organ systems). During a review of Resident 1 ' s Death Record dated [DATE] at 4:28 p.m., the Death Record indicated Resident 1 ' s cause of death was multisystem shock due to polytrauma. During an interview on [DATE] at 10:48 a.m. with CNA 1, CNA 1 stated on [DATE] at 6:55 a.m., she observed the transportation vehicle double parked in front of the facility. CNA 1 stated Transportation Driver (TD) 1 wheeled Resident 1 over the sidewalk through two parked cars to get to the van. CNA 1 stated she did not instruct the transportation driver to move the van before transferring Resident 1 into the van because she was never in-serviced on transportation safety. CNA 1 stated while TD 1 was at the back of the van with Resident 1, she (CNA 1) observed TD 1 use a mechanical lift to transfer Resident 1 into the van. CNA 1 states she walked around to the passenger side to enter the van from the front, and suddenly heard a loud crash, turned around and saw that a car had crashed into the back of the transportation vehicle. CNA 1 stated TD 1 was pinned under the van while Resident 1 was inside the van. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation and interview on [DATE] at 11:17 a.m., with the Social Services Director (SSD), in front of the facility ' s main entrance, the SSD pointed to the street where Resident 1 ' s accident occurred on [DATE]. The SSD stated the transportation driver doubled parked because there was no street parking at the time. The SSD stated the facility did not have a system in place to for staff to identify potential safety risks, and unsafe work practices. During an interview on [DATE] at 11:54 p.m. with CNA 2, CNA 2 stated transportation vehicles parked on the street when picking up residents all the time. CNA 2 stated the facility did not provide training on transportation safety to staff and staff were not aware not to hand residents to transportation vehicles, when not parked in designated areas. During an interview on [DATE] at 12:21 p.m. with CNA 3, CNA 3 stated when residents were being picked up for medical appointments, she wheeled the residents outside to look for the transportation vehicles . CNA 3 stated the transportation vehicles either parked in the green zone (30-minute parking), red zone (no parking), or regular street parking when loading and unloading residents. CNA 3 stated transportation vehicles did not park in any of the three (3) employee parking lots to pick up or drop off residents. CNA 3 stated the facility did not have a designated resident loading area. CNA 3 stated she witnessed transportation vehicles double park in the street when picking up residents when street parking was not available. CNA 3 stated she had not been trained on safety transportation of residents. During an interview on [DATE] at 12:41 p.m. with CNA 4, CNA 4 stated all transportation drivers should not park on the street when picking up residents but would always double park on the street because all the street parking was taken. CNA 4 stated the facility had not provided any training on transportation safety. During an interview on [DATE] at 1:22 p.m., with the DSD, the DSD stated she had not provided training on escorting residents to appointments and resident safety. The DSD stated she had not provided training on what to look out for during the transportation of a resident into a transportation vehicle. The DSD stated it was important to keep residents safe during transportation. The DSD stated she should have identified potential safety risks regarding resident transportation and in-serviced staff. The DSD stated CNAs must standby as residents were transferred into the transportation vehicle and must enter the vehicle after the resident was safely inside. During an interview on [DATE] at 2:30 p.m., with the transportation company ' s Transportation Service Manager (TSA), the TSA stated his drivers previously informed him all parking spots in front of the facility were always taken by the facility staff. The TSA stated his drivers double parked because the facility did not have a safe designated area to pick up and drop off residents. The TSA stated the facility staff never told his drivers not to double park or to park in the staff parking lot to pick up or drop off residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:10 p.m. with RN Supervisor 1, RN Supervisor 1 stated on [DATE] at 6:50 a.m., he heard loud screams and went outside. RN Supervisor 1 stated he observed the back of the transportation van was hit by another vehicle. RN Supervisor 1 stated he observed Resident 1 lying on his abdomen inside the van bleeding from the front of his head. RN Supervisor 1 stated transportation vehicles did not have a designated area to pick up or drop off residents because facility staff took all the street parking. RN Supervisor 1 stated he had never been told not to park in the street to keep open parking spaces for transportation vehicles. RN Supervisor 1 stated transportation vehicles always doubled parked to pick up or drop off residents. RN Supervisor 1 stated it was important not to allow transportation vehicles to double park to prevent accidents. RN Supervisor 1 stated CNA 1 should have said something to the transportation driver about not parking on the street. During an interview on [DATE] at 2:34 p.m., with the ADM, the ADM stated transportation vehicles could park anywhere on the street and in the facility, parking lots to pick up and drop off residents. The ADM stated the best practice was for CNAs to inform transportation drivers to move when they were double park. During an interview on [DATE] at 3:47 p.m., with the ADM, the ADM stated it was not safe to transfer a resident while the transportation vehicle was parked in the middle of the street. The ADM stated CNA 1 should have informed the RN Supervisor the driver was double parked to prevent accidents. During a review of the facility ' s P&P titled Accidents and Incidents undated, the P&P indicated the facility would comply with current rules and regulations to prevent accidents. During a review of the facility ' s P&P titled Safety Committee-Composition and Duties dated [DATE], the P&P indicated the facility would develop a reporting system for staff to identify potential safety risks, hazardous areas, and unsafe work practices.