

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 05/02/2025
NAME OF PROVIDER OR SUPPLIER Lighthouse Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) was offered and provided showers and baths, who required assistance with Activities of Daily Living (ADLs).</p> <p>This failure had the potential to cause skin irritation, infections and negatively affect the residents' psychosocial well-being.</p> <p>Findings:</p> <p>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 to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and cellulitis (a skin infection that causes swelling and redness).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/11/2024, the MDS indicated Resident 1 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform ADLs such as shower/bathing self and personal hygiene. The MDS indicated that Resident 1 was at risk for developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 3/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During an observation on 5/1/2025 at 10:02 a.m. Resident 1 was observed wheeling herself from her room. Resident 1 was observed with oily, unwashed hair.</p> <p>During an interview on 5/1/2025 at 11:32 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated, staff should offer residents shower every day. CNA 1 stated, if a resident refused to shower, CNAs would inform the Charge Nurse and document the refusal in the medical records.</p> <p>During an interview on 5/2/2025 at 11:21 a.m. with CNA 3, CNA 3 stated not providing showers or baths to residents could cause skin breakdown and dry skin for the residents.</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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/2/2025 at 1:13 p.m. with the Director of Staff Development (DSD), Resident 1's ADL Sheet for Bathing dated 4/2025 was reviewed. The DSD stated there's no documentation to indicate Resident 1 received or was offered a shower or bath on 4/1/2025-4/10/2025 and 4/12/2025-4/16/2025, 4/20/2025-4/22/2025 and 4/24/2025- 4/28/2025. The DSD stated the risk of not offering a shower or bath to a resident could cause harm to the resident's skin integrity.</p> <p>During an interview on 5/2/2025 at 3:11 p.m. with the Director of Nursing (DON), the DON stated residents should be offered a shower or bath every day and any refusals should be reported to the Charge Nurse.</p> <p>During a review of facility's policy and procedure (P&P) titled, Showering a Resident, dated 5/1/2018, P&P stated, A shower bath is given to the residents to provide cleanliness, comfort, and to prevent body odors and Residents are offered a shower at a minimum of once weekly and given per resident request.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on interview and record review, the facility failed to ensure one of five residents (Resident 1) received treatment and care in accordance with professional standards of practice by failing to ensure Resident 1's Primary Care Provider (PCP) was notified of the resident's refusals of showers/baths and wound care treatment.</p> <p>This failure had the potential to place Resident 1 at risk for worsening skin conditions and complications from wound care noncompliance such as sepsis (a life-threatening blood infection), hospitalization and death.</p> <p>Findings:</p> <p>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 to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and cellulitis (a skin infection that causes swelling and redness).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/11/2024, the MDS indicated Resident 1 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as shower/bathing self and personal hygiene. The MDS indicated that Resident 1 was at risk for developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 3/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Order Summary Report dated 4/17/2025, the Report indicated the following treatment orders for Resident 1:</p> <p>On 12/13/2024, the physician ordered to apply dermaphor (medication used to treat or prevent dry, rough, scaly, itchy skin and minor skin irritation) moisturizing ointment to the resident's dry skin on the left and right foot every day shift.</p> <p>On 4/1/2025, the physician ordered to wipe the resident's right lower leg cellulitis with exudate (wound drainage) with normal saline (NS- a saltwater solution) pat dry, apply xeroform sheets (dressing designed to provide non-adherent packing for wounds and create an environment that facilitates wound healing) and wrap leg with dry dressing every day shift for 30 days.</p> <p>During a review of Resident 1's Treatment Administrator Record (TAR) dated 4/2025, the TAR indicated Resident 1 refused wound care treatments on 4/3/2025, 4/5/2025, 4/12/2025, 4/16/2025, 4/17/2025, 4/19/2025, and 4/20/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes dated 4/2025, the Notes did not indicate Resident 1's PCP was notified of the wound care treatment refusals on 4/3/2025, 4/5/2025, 4/12/2025, 4/16/2025, 4/17/2025, 4/19/2025, and 4/20/2025.</p> <p>During a review of Resident 1's ADL Sheet for Bathing dated 4/2025, the ADL Sheet indicated Resident 1 refused showers/baths on 4/17/2025, 4/18/2025, 4/19/2025, and 4/23/2025.</p> <p>During an interview on 5/2/2025 at 11:21 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated, CNAs performed skin checks on residents during showers, bathing and ADL care. CNA 3 stated, CNAs could identify new skin issues that should be reported to the Charge Nurse during showers. CNA 3 stated that if a resident did not shower, staff could miss any changes to the resident's skin.</p> <p>During an interview on 5/2/2025 at 12:36 p.m. with LVN 4, LVN 4 stated, nurses should inform the PCP if a resident refused to shower after three attempts. LVN 4 stated if a resident had cellulitis, refused to shower, there was a potential for new problems to develop.</p> <p>During an interview on 5/2/2025 at 2:26 p.m. with the Director of Staff Development (DSD), the DSD stated, licensed nurses should notify the resident's PCP for any refusals of wound care and document it under the progress notes and change of condition (COC).</p> <p>During a concurrent interview and record review on 5/2/2025 at 3:33 p.m. with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Care and Service, dated 5/1/2018 was reviewed. The P&P indicated, The licensed nurse or designee documents and notifies the resident's physician and responsible party of Resident refusal of care or services. The DON stated the facility was not following the P&P by not informing the PCP of Resident 1's refusals to shower and receive wound care.</p> <p>During a review of facility's P&P titled, Wound Management dated 5/1/2018, the P&P indicated, The Attending Physician and Interdisciplinary Team (IDT)-Skin Committee will be notified of residents refusing treatment.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on interview and record review, the facility failed to ensure weekly skin checks were documented timely for one out of five sampled residents (Resident 1).</p> <p>This failure had the potential to result in inaccurate information communicated between healthcare providers and a delay in the provision of care or interventions for Resident 1.</p> <p>Findings:</p> <p>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 to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and cellulitis (a skin infection that causes swelling and redness).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/11/2024, the MDS indicated Resident 1 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as shower/bathing self and personal hygiene. The MDS indicated that Resident 1 was at risk for developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 3/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Weekly Skin Check dated 3/18/2025, 3/25/2025, 4/1/2025, 4/15/2025, 4/22/2025 and 4/29/2025, were reviewed. The weekly skin checks indicated Skin Assessments charted to have been performed on 3/18/2025, 3/25/2025, 4/1/2025, 4/15/2025, 4/22/2025 and 4/29/2025 were created on 5/1/2025.</p> <p>During a concurrent interview and record review on 5/1/2025 at 5:00 p.m. with LVN 3, Resident 1's weekly skin checks dated 3/18/2025, 3/25/2025 and 4/2025, were reviewed. LVN 3 stated she created and added the documentation for the skin checks she performed on 3/18/2025, 3/25/2025 and 4/2025, on 5/1/2025 based on what she remembered seeing on the resident's skin.</p> <p>During a concurrent interview and record review on 5/2/2025 at 4:01 p.m. with the Director of Nursing (DON), Resident 1's weekly skin checks for 3/18/2025, 3/25/2025 and 4/2025 were reviewed. The DON stated residents with existing skin issues must be assessed every seven days by the licensed nurse. The DON stated skin assessments should have been charted the same day it was completed to ensure accuracy because the nurse could forget important information. The DON stated there was potential that Resident 1's skin assessments were not accurately documented for 3/18/2025, 3/25/2025 and 4/2025.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's Policy and Procedure (P&P) titled, Record Content: Documentation Principles, dated 11/2017, the P&P indicated, Resident health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. The P&P also indicated, Complete entries must be accurate and timely - recorded within the required time period.</p> <p>During a review of facility's P&P titled, Wound Management, dated 5/1/2018, the P&P indicated, A licensed nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident and stated, Licensed nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis.</p>		