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	04/02/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy and procedure (P&P) titled Change of Condition Notification, revised 5/1/2018, for one of two sampled residents (Resident 1) when Resident 1's order for oral antibiotics was not transcribed or carried out, and staff failed to document 72-hour monitoring and develop a care plan for Resident 1's change of condition (COC) identified on 3/5/2026. These deficient practices placed Resident 1 at risk for complications from missed antibiotics, including worsening of a potential infection. This also placed Resident 1 at risk for developing unidentified complications requiring nursing or medical intervention.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included gastroesophageal reflux disease without esophagitis (GERD, a chronic condition where stomach acid frequently flows back into the esophagus, causing symptoms like heartburn, regurgitation, chest pain, and a sour taste). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 1 had moderate cognitive impairment (a decline in mental functioning, encompassing problems with memory, language, thinking, and judgment). The MDS indicated Resident 1 required set-up/clean-up assistance for eating and oral hygiene. During a review of Resident 1's Change of Condition (COC) assessment, dated 3/5/2026, the COC assessment indicated Resident 1 had a swollen right jaw related to her wisdom tooth. The COC assessment indicated Licensed Vocational Nurse (LVN) 2 notified Resident 1's physician and orders were received to refer Resident 1 to the dentist and monitor for 72-hours for acute (a condition that comes on suddenly, has severe symptoms, and usually lasts for a short period) changes. During a review of Resident 1's progress note, dated 3/5/2026 at 3:38 p.m., by the Social Services Assistant (SSA), the progress note indicated Resident 1 was referred to the dentist (Dentist 1). The progress note indicated the SSA transferred the phone call to LVN 2 for orders from Dentist 1. During a review of Resident 1's progress note, dated 3/5/2026 at 3:40 p.m., by LVN 2, the progress note indicated LVN 2 communicated with Dentist 1 regarding Resident 1's tooth. The progress note indicated Dentist 1 informed LVN 2 that orders for oral antibiotics were to be faxed to the facility as soon as possible. During a review of Resident 1's dentist order, dated 3/5/2026, the dentist order indicated an order by Dentist 1 to administer amoxicillin (an antibiotic) 500 milligrams every eight (8) hours for seven days. During an interview on 4/2/2026 at 1:02 p.m., with the Director of Social Services (DSS), the DSS stated Resident 1's dentist order, dated 3/5/2026, was faxed to the facility on 3/5/2026 at 3:47 p.m. During an interview on 4/2/2026 at 3:02 p.m., with Registered Nurse (RN) 1, RN 1 stated she was responsible for developing the care plan following a change of condition. RN 1 stated the care plan ensured continuity of care and outlined the care and services to be provided, including medications. RN 1 stated she was not made aware of Resident 1's change of condition and did not develop a care plan for monitoring or interventions. RN 1 stated 72-hour monitoring was also to be completed following a change of condition and stated this was not done because she was not aware of the change of condition. During an interview on 4/2/2026 at 3:24 p.m., with RN 2, RN 2 stated there was no documentation in Resident 1's medical record to indicate Resident 1's antibiotic order was (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transcribed into her record or carried out. RN 2 stated failure to transcribe and carry out the order was a delay in care and stated there was potential for infection or worsening infection. RN 2 stated there was no documentation in Resident 1's medical record indicating 72-hr monitoring was conducted related to Resident 1's change of condition. RN 2 stated 72-hour monitoring would also alert staff to follow-up on Resident 1's dentist's order to ensure it was transcribed and carried out timely. During a review of the facility's policy and procedure (P&P) titled Change of Condition Notification, revised 5/1/2018, the P&P indicated the licensed nurse was to document pertinent details of the incident and update the care plan to reflect the resident's status. The P&P indicated a licensed nurse was to document each shift for at least 72 hours.