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	04/07/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of quality, for one of three residents (Resident 1), by failing to: 1). Ensure Resident 1's pain level was reassessed and documented within one hour, after the pain medications were administered on 3/13/2026, 3/15/2026, 3/16/2026, 3/17/2026, 3/19/2026, 3/20/2026, 3/21/2026, 3/26/2026, 3/27/2026, 3/28/2026 and on 4/2/2026 and 4/3/2026.2). Clarify from Resident 1's physician, the orders of Tylenol (a pain-relieving medication), 500 milligrams ([mg], metric unit of measurement, used for medication dosage and/or amount) given for moderate pain and Tylenol 325 mg two (2) tablets (650 mg.) given for mild pain.3). Ensure the physician's order was complete with numerical pain scale (a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible) for mild, moderate and severe pain. These failures placed Resident 1 at risk of unresolved pain and the potential for poor quality care in pain management.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. The admission Record indicated Resident 1's diagnoses included Post-Traumatic Stress Disorder ([PTSD], a mental health condition triggered by experiencing or witnessing a terrifying event) and unspecified osteoarthritis (a degenerative joint disease where cartilage breaks down, causing pain, stiffness, and reduced mobility), unspecified (unknown) site. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 1 had moderate (not extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with Activities of Daily Living (ADLs) such as showering/bathing self and personal hygiene. During a review of Resident 1's Order Summary Report (a list of resident's orders), dated 4/7/2026, the Order Summary Report indicated Resident 1 had the following orders: Monitor pain every (q) shift and document using the 0-10 rating every shift for pain management. Ibuprofen Oral Tablet 200 mg, give 2 tablets orally every six (6) hours as needed (PRN) for pain at the back and shoulder. Tylenol Oral Tablet 325 mg, give 2 tablets by mouth every 6 hours PRN for mild pain. Tylenol Extra Strength Tablet 500 mg, give 1 tablet by mouth every eight (8) hours PRN for moderate pain, not to exceed three (3) grams ([g], a metric unit of mass and weight equal to one-thousandth of a kilogram) per 24 hours. During a concurrent interview and record review on 4/7/2026 at 1:41 p.m., with Licensed Vocational Nurse (LVN) 1, the following were reviewed:Resident 1's Medication Administration Record (MAR), for the month of 3/2026.Order Administration Notes, dated 3/13/2026, 3/19/2026, 3/20/2026, 3/21/2026, 3/26/2026, 3/27/2026, and 3/28/2026.Facility's policy and procedure (P&P) titled, Pain Management, dated 5/2022.LVN 1 stated the MAR indicated Resident 1 received Ibuprofen during the following dates and times, but the resident's pain level was not reassessed after 30 minutes to 1 hour, to see if the pain medication was effective or not. LVN 1 stated that staff should document when the reassessment occurred to determine what should be done if the pain medication was ineffective. 3/13/2026 at 9:11 a.m. - reassessed at 2:12 p.m.3/19/2026 at 9:42 a.m. - reassessed at 1:37 p.m.3/20/2026 at 10:16 a.m.- reassessed at 1:25 p.m. 3/20/2026 at 8:30 p.m. - reassessed on 3/21/2026 at 1:00 a.m.3/21/2026 at 9:18 a.m.- reassessed at 11:08 a.m. (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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Lighthouse Healthcare Center	2222 Santa Ana Blvd. Los Angeles, CA 90059

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/21/2026 at 4:45 p.m. - reassessed at 6:43 p.m. 3/26/2026 at 5:00 p.m.- reassessed at 7:37 p.m.3/27/2026 at 5:00 p.m. - reassessed at 6:32 p.m.3/28/2026 at 4:00 p.m. - reassessed at 8:57 p.m.LVN 1 stated the facility's P&P indicated that pain reassessments should be documented within one hour of administration of pain medication. LVN 1 stated the staff ask the residents who are verbal to rate their pain using a scale of 1-10 (1, being little to no pain and 10 with excruciating pain). During a concurrent interview and record review on 4/7/2026 at 2:44 p.m., with LVN 2, Resident 1's MAR for the month of 4/2026 was reviewed. LVN 2 stated staff assessed Resident 1's pain level by asking Resident 1 to rate their pain on a scale of 1-10. LVN 2 stated staff do not ask residents to rate their pain as, mild, moderate, or severe. LVN 2 also stated Resident 1's Tylenol orders should have been clarified with Resident 1's physician. The current physician's order for Tylenol did not specify any pain level. The Tylenol order for mild pain was 650 mg and the Tylenol ordered for moderate pain was 500 mg. During a concurrent interview and record review on 4/7/2026 at 3:11 p.m., with the Registered Nurse (RN), Resident 1's MAR for the month of 3/2026 and 4/2026, were reviewed. RN stated the MAR indicated Resident 1 received Tylenol 500 mg on the following dates and time, but were not reassessed within one hour:3/13/2026 at 12:39 p.m.- reassessed at 9:45 p.m.3/15/2026 at 4:30 p.m. - reassessed at 7:56 p.m.3/16/2026 at 5:00 p.m. - reassessed at 9:24 p.m.3/17/2026 at 5:00 p.m. - reassessed at 7:30 p.m.4/3/2026 at 2:15 p.m. - reassessed at 3:32 p.m.RN stated not reassessing Resident 1's pain level timely (within 1 hour) after the Tylenol 500 mg. medications were administered on 3/13/2026, 3/15/2026, 3/16/2026, 3/17/2026 and on 4/3/2026, had the potential that Resident 1's pain was not resolved. RN stated, the MAR indicated, on 4/2/2026 at 10:45 a.m. and 6:59 p.m., the staff did not reassess and document Resident 1's pain level after the Ibuprofen medication was given. RN stated that Resident 1's Tylenol orders were not clarified with Resident 1's physician. RN stated Tylenol 325 mg is a standard order for mild pain, not moderate pain. The ordered should have been clarified with the physician because the resident's pain is subjective (based on feelings rather than verifiable facts). During a review of facility's P&P titled, Administration of Pain Medication, dated 5/1/2018, the P&P indicated to, review the physician order and administer the pain medications as ordered. During a review of facility's P&P titled, Pain Management, dated 5/2022, the P&P indicated, the licensed nurse should instruct the resident/and or surrogate regarding the pain scale (a tool used by healthcare professionals to quantify a patient's subjective pain intensity, typically ranging from 0 [no pain] to 10 [worst imaginable pain] utilized by the facility. The P&P indicated, the licensed nurse should administer pain medication as ordered and document on the MAR the drug, time of administration, dose, pain scale rating, and resident's response to medication within one hour.