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	06/26/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) titled, Unusual Occurrence (an unexpected event or accident that results in significant harm or requires significant additional measures) Reporting , which indicated the facility will report unusual occurrence by phone and in writing to the appropriate Stated or Federal agencies, within 24 hours, when one of three sampled residents (Resident 1), sustained fracture (broken bone) on the left tibia/fibula (long bone in the lower leg), and distal fibula (lower end of the 2 long bones in the lower leg) on 6/8/2026. This failure delayed the investigation by the California Department of Public Health (CDPH) and placed Resident 1 and other residents at risk for potential neglect and abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including quadriplegia (symptom of paralysis that affects all limbs and body from the neck down), rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing pain, swelling, and stiffness) and dementia. During a review of Resident 1's History and Physical examination (H&P) dated 12/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's MDS dated [DATE], the MDS indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent (helper does all the effort) on staff with activities of daily living (ADLs) such as oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/off footwear, personal hygiene, chair/bed-to-chair transfer, tub and shower transfer. Resident 1 required substantial/maximal (helper does more than half) assistance in rolling left and right of the bed. The MDS did not indicate prior devices were used and had no mobility devices used in the last 7 days (from 4/3/2026). During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/9/2026 at 3:15 a.m., the SBAR indicated Resident 1 was crying while lying in bed in a supine (lying flat on back) position. The SBAR indicated Resident 1 complained of pain to her foot rated at 6/10 (a numerical pain scale with 0 = no pain, 1-3= mild pain, 4-6 moderate pain, 7-8 = severe pain, 9-10 = worst pain possible), extending from the left knee to the foot. The SBAR indicated Resident 1's skin on the left foot was abnormally tight (unspecified), the resident could not move the left leg and cried uncontrollably when the left foot was lightly touched. During a review of Resident 1's Incident/ Accident Report (Non-Fall), dated 6/9/2026 at 10 a.m., the report indicated per resident, she hit her left leg on the geri-chair (also known as a geriatric chair or medical recliner- a specialized seating device designed for patients with limited mobility) but did not report it. The report indicated the assigned CNA did not use a hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). During a review of Resident 1's Radiology (Xray, process of taking pictures to diagnose and treat diseases) Results Report dated 6/9/2026 at 3:36 p.m., the result indicated Resident 1 had an acute nondisplaced fracture on the proximal left tibia/fibula, medial malleolus and distal fibula. During an interview on 6/26/2026 at 3:50 p.m. with Registered Nurse (RN) 1, RN 1 stated the facility conducted an internal (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation of Resident 1's left leg fracture but failed to report to the CDPH. RN 1 stated the facility should have reported the incident to CDPH to ensure Resident 1's safety. During an interview on 6/26/2026 at 4:50 p.m. with the Administrator (ADM), the ADM stated that when an incident occurs involving a resident's safety (Resident 1 sustaining a fracture), the facility was responsible for investigating and reporting the injury to CDPH within 24 hours. The ADM confirmed the facility did not report the incident involving Resident 1 to CDPH. During a review of facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 5/1/2018, the P&P indicated occurrences that affect the welfare, safety, or health of residents, employees, or visitors should be reported to the State and Federal agencies within 24 hours by telephone and then confirmed in writing.

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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 - 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** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), received adequate supervision and assistance devices to prevent accidents. The facility failed to: 1). Implement Resident 1's care plan titled, At high risk for falls and injuries related to diagnosis of quadriplegia (paralysis from the neck down, including legs, and arms) and dementia (a progressive state of decline in mental abilities), which indicated to use a hoyer lift (a mechanical device used to lift and/or transfer a person from place to place) during transfers. 2). Ensure Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/3/2026, indicated the resident required the use of a hoyer lift for transfers. 3). Implement its policy and procedure (P&P) titled, Transfer of Residents, which indicated mechanical lifts (hoyer lift) be used for non-weight bearing (unable to bear weights on one or more parts of the legs) residents. These failures resulted in Resident 1 hitting her left leg on a geri-chair (also known as a geriatric chair or medical recliner- a specialized seating device designed for patients with limited mobility) sustaining an acute (recent) nondisplaced fracture (a broken bone where the crack goes all the way through but the pieces stay lined up) on the proximal (a location near the center of the body) left tibia/fibula (long bone in the lower leg), medial (middle) malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either sides of the ankle) and distal fibula (lower end of the two long bones in the lower leg), and was transferred to a general acute care hospital (GACH) for evaluation and treatment. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including quadriplegia (symptom of paralysis that affects all limbs and body from the neck down), rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing pain, swelling, and stiffness) and dementia. During a review of Resident 1's Physical Therapy evaluation and plan of treatment dated 10/27/2023, indicated Resident 1's level of function required maximum assistance with bed mobility and mechanical lift with transfer. During a review of Resident 1's History and Physical examination (H&P) dated 12/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's MDS dated [DATE], the MDS indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent (helper does all the effort) on staff with activities of daily living (ADLs) such as oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/off footwear, personal hygiene, chair/bed-to-chair transfer, tub and shower transfer. Resident 1 required substantial/maximal (helper does more than half) assistance in rolling left and right of the bed. The MDS did not indicate prior devices were used and had no mobility devices used in the last 7 days (from 4/3/2026). During a review of Residents 1's Fall Risk Evaluation, dated 4/3/2026, the assessment indicated Resident 1 was at high risk for potential falls. During a review of Resident 1's care plan titled, Requires use of geri-chair for out of bed activities, inability to tolerate use of wheelchair due to poor trunk control, revised 4/10/2026, the care plan interventions indicated to place Resident 1 in geri-chair for as tolerated for out of bed activities. The care plan had no interventions indicating the use of transfer equipment or number of staff's assistance during resident's transfer. During a review of Resident 1's care plan titled, At high risk for falls and injuries related to diagnosis quadriplegia, dementia, revised 4/10/2026, the care plan interventions indicated to use hoyer lift when transferring Resident 1. During a review of Resident 1's care plan titled, Resident has limited physical mobility and fluctuations in all ADLs related to contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), weakness, impaired mobility and requiring maximum assistance from the staff in all ADLs, revised 4/10/2026, the care plan had no interventions indicating the use of transfer equipment or number of staff needed during (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's transfer. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/9/2026 at 3:15 a.m., the SBAR indicated Resident 1 was observed crying while laying in bed in a supine (lying flat on back) position. The SBAR indicated Resident 1 complained of pain to her foot rated at 6/10 (a numerical pain scale with 0 = no pain, 1-3= mild pain, 4-6 moderate pain, 7-8 = severe pain, 9-10 = worst pain possible), extending from the left knee to the foot. The SBAR indicated Resident 1's skin on the left foot was abnormally tight (unspecified), the resident could not move the left leg and cried uncontrollably when the left foot was lightly touched. During a review of Resident 1's Incident/ Accident Report (Non-Fall), dated 6/9/2026 at 10 a.m., the report indicated per resident, she hit her left leg on the geri-chair but did not report it. The report indicated the assigned Certified Nurse Assistant) CNA did not use a hoyer lift. During a review of the facility's Investigation Summary, conclusion report for Resident 1, dated 6/9/2026 at 10 a.m., the summary report indicated per Resident 1, on 6/8/2026, CNA 2 transferred the resident from the bed to a geri-chair by herself (CNA2) and hit Resident 1's leg on the chair. The report indicated it was an accident which resulted in Resident 1's injury. During a review of Resident 1's Radiology (xray, process of taking pictures to diagnose and treat diseases) Results Report dated 6/9/2026 at 3:36 p.m., the result indicated Resident 1 had an acute nondisplaced fracture on the proximal left tibia/fibula, medial malleolus and distal fibula. During a review of Resident 1's progress notes dated 6/9/2026, the progress notes indicated on 6/9/2026, around 6:29 p.m., Resident 1's physician was notified of Resident 1's x-ray result. Resident 1's physician ordered Resident 1's transfer to the GACH for evaluation and treatment. During a review of Resident 1's GACH Emergency Department (ED) admission record, dated 6/10/2026 at 4:49 a.m., the GACH ED record indicated a left tibia and fibula fracture at the extended-care facility (skilled nursing facility [Facility 1]), with left leg pain and swelling. During a review of Resident 1's GACH Orthopedic (a branch of medicine dealing with conditions affecting the bones or muscles) Surgery progress notes, dated 6/10/2026 at 4:05 p.m., the progress notes indicated Resident 1 had a minimally displaced left tibia shaft (the fracture along the central length of the tibia) and proximal (upper portion) fibula fracture. Resident 1 will be non-weight bearing and will be placed in a knee immobilizer (a brace or supportive device that prevents the knee from bending, protects injured tissues, and promotes proper healing). The progress notes indicated there were no plans for surgery on Resident 1. During an interview on 6/26/2026 at 9:35 a.m. with Resident 1 in her room, Resident 1 stated that when Certified Nurse Assistant (CNA) 2 carried her back to bed from the geri-chair (date unspecified), she was pushed to the side of the bed and twisted her foot. CNA 2 did not use a hoyer lift. During an interview on 6/26/2026 at 1:32 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 required a two-person assist during transfer, with the assistance of a hoyer lift. Resident 1's bilateral lower extremities were rigid (unable to bend) and Resident 1 could not stand. LVN 1 stated on 6/8/2026, around lunchtime, Resident 1 was seen in the activity room, on a geri-chair without a transfer sling (a specialized device used together with the hoyer lift to safely transfer individuals with limited mobility) under her back. LVN 1 stated she asked CNA 2 about Resident 1's sling and CNA 2 stated she did not use the hoyer lift in transferring Resident 1 from the bed to the geri-chair. LVN 1 stated later in the afternoon when Resident 1 was back to bed, Resident 1 complained of left knee pain (pain level unspecified). LVN 1 stated it was very important to follow Resident 1's care plan for safety and to prevent any injuries. During an interview on 6/26/2026 at 1:55 p.m. with CNA 2, CNA 2 stated on 6/8/2026 after providing Resident 1's ADL, she (CNA 2) transferred Resident 1 to the geri-chair by herself without using the hoyer lift. CNA 2 stated, I was able to carry her (Resident 1) to the geri-chair, and that was what I did. CNA 2 stated she did not know she was required to use the hoyer lift for the transfer. CNA 2 stated she did not remember seeing a picture of a hoyer lift posted at the door or at the headboard. CNA 2 stated CNA 4 assisted in transferring Resident 1 back to bed after lunch by carrying Resident 1 back to her bed. CNA 2 stated it was important to use proper equipment before transferring a resident to ensure patient safety and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	prevent falls or injuries. During an interview on 6/26/2026 at 2:26 p.m. with CNA 4, CNA 4 stated Resident 1 was in the geri-chair when CNA 2 asked him to help transfer Resident 1 back to bed. CNA 4 stated they (CNA 2 and CNA 4) did not use the hoyer lift because there was no sling under Resident 1. CNA 4 stated he held Resident 1 by the upper arms, and CNA 2 held the resident by her legs. CNA 4 stated Resident 1 required a hoyer lift during transfer, but because there was no sling placed under the resident, Resident 1 was carried back to her bed. CNA 4 stated it was not safe to carry Resident 1 back to bed, as the resident could fall or hit on something (unspecified). CNA 4 stated staff should use the hoyer lift to ensure residents' safety during transfers if residents were dependent on assistance. During a concurrent interview and record review on 6/26/2026 at 3:50 p.m. with the Registered Nurse (RN) 1, Resident 1's care plan titled, Resident has limited physical mobility and fluctuations in all ADLs related to contractures, weakness, impaired mobility and requiring maximum assistance from the staff in all ADLs, revised 4/10/2026, was reviewed. RN 1 stated the interventions did not indicate the use of hoyer lift during transfer or the number of persons required during the resident's transfer. RN 1 stated Resident 1 had contractures and could not bear weight on both feet. Resident 1 required a hoyer lift to be transferred to the geri-chair. RN 1 stated a hoyer lift sign was posted in Resident 1's room and there was no reason for CNA 2 to not know that Resident 1 required a hoyer lift during transfers. RN 1 stated charge nurses conduct a huddle to inform CNAs of all the residents' transfer needs. RN 1 stated failure to follow Resident 1's individualized care plan could result in injuries and/or fractures. During an interview on 6/26/2026 at 4:00 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 1's baseline was bed rest. Resident 1's mobility included full use of her upper extremities (parts of the body extending from the shoulders, arms, forearms, wrists, and hands) with no limitations, while her lower extremities were non-weight bearing. The DOR stated Resident 1 was dependent on assistance and it was important to use the hoyer lift to prevent her from getting hurt or falling during transfers. The DOR stated it was essential to maintain Resident 1's safety using the proper equipment for transfer. During a concurrent interview and record review on 7/8/2026 at 9:00 a.m., with LVN 4, the MDS dated [DATE], section GG (Section in MDS for Functional Abilities) on mobility devices and Resident 1's care plan titled, Requires use of geri-chair for outˆofˆbed activities; inability to tolerate use of wheelchair due to poor trunk control, dated 4/10/2026, were reviewed. LVN 4 stated Resident 1 required a mechanical lift transfer which was not accurately reflected in Resident 1's MDS section GG. LVN 4 stated nurses were required to use a hoyer lift for all residents who were dependent on staff assistance to prevent injuries. LVN 4 stated if staff had used the hoyer lift during Resident 1's transfer, it could have prevented the injury. LVN 4 stated the interventions in Resident 1's care plan did not specify the number of staff or the equipment required to safely transfer Resident 1 to the geri-chair and back to bed. LVN 4 stated that failure to develop the appropriate care plan interventions contributed to Resident 1's injury. During a review of facility's policy and procedure (P&P) titled, Transfer of Residents, dated 2/24/2026, the P&P indicated a licensed nurse and/ or the Director of Rehabilitation should assess and determine lifting and transfer requirements and the procedure to be used for each resident. The type of transfer should be recorded in the resident's care plan. The P&P indicated mechanical lifts are used for non-weight bearing residents. Residents must be lifted or transferred according to the determined need for staff assistance. Residents who required assistance in transferring may be transferred using a gait (manner of walking)/transfer belt or with a lift. During a review of the facility's P&P titled, Total Mechanical Lift, dated 5/1/2018, the P&P indicated the purpose of the policy was to use mechanical lift appropriately to facilitate transfer of residents. The P&P indicated to put sling under the resident, with at least two people present while residents are being transferred with mechanical lift. During a review of the facility's Certified Nursing Assistant (CNA) Job Description, dated 12/8/1998, the job description indicated CNA responsibilities and duties were to adhere to the facility's injury and illness prevention program, to consistently perform job duties in accordance with the facility's safe work practice and adhere to prescribed safety practices.