

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 06/13/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents and/or responsible party were informed in advance, of the risks and benefits of the use of physical restraints (manual method or device used to restrict freedom of movement or normal access to one's body) for five of 12 sampled residents (Resident 66, Resident 71, Resident 15, Resident 88, and Resident 16).</p> <p>These deficient practices resulted in the violation of Resident 66, 71, 15, 88, and 16's and/or responsible party's right to make an informed decision regarding the use of physical restraints.</p> <p>Findings:</p> <p>a. A review of Resident 66's Admission Record indicated Resident 66 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 66's admitting diagnoses included unspecified abnormalities of gait (manner of walking) and mobility, generalized muscle weakness, and anxiety disorder (mental health disorder characterized by feelings of worry, or fear that are strong enough to interfere with one's daily activities).</p> <p>A review of Resident 66's History and Physical (H&P), dated 2/5/2024, indicated Resident 66 had the capacity to understand and make decisions.</p> <p>A review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 5/26/2024, indicated Resident 66 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 66 required supervision or touching/steadying by staff to reposition himself in bed, transition from sitting to lying position and vice versa, transition from sitting to standing, and transfer from bed to chair and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 66's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 66's bed against the wall.</p> <p>During an observation on 6/11/2024 at 8:39 a.m., at Resident 66's bedside, Resident 66's bed was observed placed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 66's bed.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with 6/13/2024 at 11:04 a.m., with the Director of Medical Records (DMR), the DMR stated Resident 66 did not have an informed consent for use of bedrails, or placement of the resident's bed against the wall.</p> <p>b. A review of Resident 71's Admission Record indicated Resident 71 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 71's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, and encephalopathy (a broad term for any brain disease that alters brain function or structure).</p> <p>A review of Resident 71's H&P, dated 4/17/2024, indicated Resident 71 had the capacity to understand and make decisions.</p> <p>A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had severe cognitive impairment. The MDS indicated Resident 71 required partial to moderate assistance from staff to roll left and right in bed, transition from a sitting to lying position and vice versa, transition from a sitting to standing position and vice versa, and transfer from a chair to bed and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 71's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 71's bed against the wall.</p> <p>During an observation on 6/11/2024 at 9:14 a.m., at Resident 71's bedside, Resident 71's bed was observed placed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 71's bed.</p> <p>During an interview with 6/13/2024 at 11:04 a.m., with the DMR, the DMR stated Resident 71 did not have an informed consent for use of bedrails, or placement of the resident's bed against the wall.</p> <p>c. A review of Resident 15's Admission Record indicated Resident 15 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 15's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, anxiety disorder, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A review of Resident 15's H&P, dated 11/8/2023, indicated Resident 15 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 15's MDS, dated [DATE], indicated Resident 15 had moderate cognitive impairment. The MDS indicated Resident 15 had upper extremity impairment on one side of his body and required the use of a wheelchair. The MDS indicated Resident 15 required partial to moderate assistance from staff to transition from a sitting to standing position and vice versa, and to transition from a sitting to lying position and vice versa. The MDS indicated Resident 15 was dependent on staff to transfer from bed to chair and vice versa.</p> <p>A review of Resident 15's active physician order, dated 11/8/2023, indicated to apply lap tray (a tray with a cushioned underside, designed to rest in a person's lap) when up in wheelchair to prevent resident from sliding off the chair and maintain proper posture.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/10/2024 at 11:26 a.m., outside of Resident 15's room, Resident 15 was observed sitting in his wheelchair with a tray across his lap. The tray was fastened in the rear of the wheelchair, behind the back of the seat.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 9:25 a.m., outside of Resident 15's room, with Licensed Vocational Nurse (LVN) 1 and Resident 15, LVN 1 observed Resident 15's lap tray. Resident 15's lap tray was across his lap and fastened in the rear of the wheelchair. Resident 15 stated the buckle to fasten the lap tray was behind him and he could not reach it. LVN 1 stated that if Resident 15 wanted to get up, staff assisted him.</p> <p>During a concurrent interview and record review, on 6/11/2024 at 1:25 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 15's active physician orders and care plans were reviewed. RNS 1 stated the physician order dated 11/8/2023 indicated to apply the lap tray to prevent Resident 15 from sliding off the chair. RNS 1 stated Resident 15 had a history of falls, and stated the lap tray was being used as a restraint for fall prevention.</p> <p>A review of Resident 15's record titled Restraint Physical, dated 10/3/2021, indicated the use of restraints was discussed with Resident 15's emergency contact and responsible party (RP).</p> <p>During an interview on 6/12/2024 at 2:03 p.m., with Resident 15's responsible party (RP 1), RP 1 stated she was unaware Resident 15's lap tray was being used as restraint. RP 1 stated, I would not have allowed anything that prevents him from getting out of the chair. RP 1 stated she would never approve anything that restricted Resident 15's movement, and stated she had seen the lap tray applied when she visited Resident 15 in the past, and stated she thought it was for his food. RP 1 stated she did not know the lap tray was to keep him bound. RP 1 stated she never consented to use of the lap tray as restraint, and stated the facility staff had never discussed the use of restraints with her.</p> <p>During a concurrent observation and interview on 6/13/2024 at 10:33 a.m., with Resident 15, in the hallway outside of Resident 15's room, Resident 15 was observed sitting in his wheelchair in the hallway, with a lap tray attached to the wheelchair and placed across his lap. Resident 15 stated he fell out of his wheelchair a while ago, and facility staff applied the lap tray to his wheelchair following the fall. Resident 15 stated he wanted to get up on his own, but he could not because of the lap tray. Resident 15 stated he walked in the morning, but wanted to walk more, and stated he sometimes wished he could remove the tray. Resident 15 stated he did not try to get up unassisted and stated I know I can't do it. I call for help.</p> <p>During a concurrent interview and record review, on 6/13/2024 at 9:31 a.m., with the Director of Nursing (DON), the facility policy and procedure (P&P) titled Informed Consent, dated 4/12/2022 was reviewed. The DON stated the P&P dated 4/12/2022 was the current facility policy for informed consent. The DON stated the purpose of informed consent was to inform the resident or their responsible party about the use of restraints, and to provide them the opportunity to decline. The DON stated informed consent needed to be obtained by the physician, and stated there was no documentation that Resident 15's physician discussed the use of a lap tray restraint with RP 1. The DON stated the facility did not obtain informed consent for the use of a lap tray restraint on Resident 15.</p> <p>47679</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. A review of Resident 88 Admission Record, the Admission Record indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 88's diagnoses included encephalopathy, schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>A review of Resident 88's MDS, dated [DATE], indicated Resident 88 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 88's cognition was moderately impaired. The MDS indicated Resident 88 had impairments on both sides of his lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 88 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 88's H&P, dated 7/4/2023, indicated Resident 88 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 88's Comprehensive Assessment, dated 10/13/2023, indicated Resident 88 had left and right side rails on his bed that was indicated for safety and to promote independence with bed mobility. There was no indication that consent was received for bilateral (both sides) side rails.</p> <p>A review of Resident 88's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 88's bed against the wall.</p> <p>During an observation on 6/10/2024 at 10:57 a.m. and on 6/11/2024 at 9:25 a.m., in Resident 88's room, Resident 88 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up.</p> <p>During an interview on 6/11/2024 at 2:17 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated restraints were considered any device used to restrict the residents' movements. LVN 2 stated to use restraints appropriately, the resident's physician would have to determine if restraints were warranted and would place an order. LVN 2 stated the physician would then inform the resident or their responsible party regarding the indication for the restraint and to obtain informed consent on whether they agreed to its use.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:22 p.m., with LVN 2, inside Resident 88's room, Resident 88 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up. LVN 2 stated the use of side rails and the bed against the wall restricted Resident 88's movement and should not be used unless needed.</p> <p>During a concurrent interview and record review on 2/11/2024 at 2:25 p.m., with LVN 2, Resident 88's Informed Consents were reviewed. The Informed Consents did not indicate informed consent was obtained from Resident 88's responsible party. LVN 2 stated when restraints were indicated for a resident, the resident's responsible party should be contacted and the risks and benefits for the use of restraints should be explained. LVN 2 stated the responsible party should then be able to decide on the use the restraints.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. A review of Resident 16's Admission Record, indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 16's diagnoses included encephalopathy, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and dementia.</p> <p>A review of Resident 16's MDS, dated [DATE], indicated Resident 16 was usually able to understand and be understood by others. The MDS indicated Resident 16's cognition was moderately impaired. The MDS indicated Resident 16 had impairments on both sides of his upper extremities and on one side of the lower extremities. The MDS indicated Resident 16 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 16's H&P, dated 1/16/2024, indicated Resident 16 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 16's Comprehensive Assessment, dated 2/8/2024, indicated Resident 16 had left and right side rails. The Comprehensive Assessment indicated there was no indication for the use of the side rails nor indication that consent was received for bilateral side rails.</p> <p>During an observation on 6/10/2024 at 10:23 a.m. and on 6/11/2024 at 9:27 a.m., in Resident 16's room, Resident 16 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:20 p.m., with LVN 2, inside Resident 16's room, Resident 16 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up. LVN 2 stated the use of side rails and the bed against the wall restricted Resident 16's movement and should not be used unless needed.</p> <p>During a concurrent interview and record review on 2/11/2024 at 2:24 p.m., with LVN 2, Resident 16's Informed Consents were reviewed. The Informed Consents did not indicate informed consent was obtained from Resident 16's responsible party. LVN 2 stated when restraints were indicated for a resident, the resident's responsible party should be contacted and provide the risks and benefits for the use of restraints and allow the responsible party to decide if the facility could use the restraint on the resident.</p> <p>During an interview on 6/13/2024 at 10:15 a.m., with the Director of Nursing (DON), the DON stated the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) would discuss the necessity of the restraint for the resident. The DON stated if the IDT approved the necessity, they would inform the resident's physician of the recommendation and discuss how the resident would benefit from the device. The DON stated the IDT would include the resident's responsible party in the discussion so they could be aware of the situation. The DON stated the physician would obtain informed consent from the resident and/or their responsible party to explain the risks and benefits of the restrictive device to allow the resident and/or the responsible party to decline its use.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility P&P titled Restraints, dated 5/1/2018, indicated that before any type of restraint is used, the licensed nursing staff were supposed to verify that informed consent had been obtained from the resident or their RP. The P&P indicated that restraints included any physical device or equipment attached or adjacent to the resident's body that restricted freedom of movement, including bed rails or beds against the wall.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on observation, interview, and record review, the facility failed to ensure 10 of 25 sampled residents (Resident 66, Resident 71, Resident 16, Resident 88, Resident 40, Resident 93, Resident 36, Resident 13, Resident 112, and Resident 15) were free from restraint by failing to:</p> <ol style="list-style-type: none"> 1. Ensure there was a physician order, care plan, and informed consent obtained prior to use of bedrails for Residents 66, 71, 16, 88, 40, 93, 36, 13, and 112. 2. Ensure the bed was not placed against the wall for Residents 66, 71, 16, 88, 40, 93, 36, 13, and 112. 3. Ensure the implementation of less restrictive measures prior to use was performed for Residents 93, 40, 13, 36, and 112. 5. Ensure the Interdisciplinary Team (IDT, a group of different disciplines working together towards a common goal of a resident) performed quarterly assessments to ensure the least restrictive measures were taken in preventing Resident 15's attempts of getting up unassisted. <p>These deficient practices reduced the ability for Residents 66, 71, 16, 88, 40, 93, 36, 13, and 112 to get out of bed freely, increased their risk for entrapment, and potential subsequent injuries. This deficient practice also increased Resident 15's risk to be restrained without an indication, leading to potential physical and psychosocial harm.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 66's Admission Record indicated Resident 66 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 66's admitting diagnoses included unspecified abnormalities of gait (manner of walking) and mobility, generalized muscle weakness, and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). <p>A review of Resident 66's History and Physical (H&P), dated 2/5/2024, indicated Resident 66 had the capacity to understand and make decisions.</p> <p>A review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 5/26/2024, indicated Resident 66 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 66 required supervision or touching/steadying by staff to reposition himself in bed, transition from sitting to lying position and vice versa, transition from sitting to standing, and transfer from bed to chair and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 66's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 66's bed against the wall.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 66's care plans did not indicate a care plan was developed for the use of bed rails or placement of the resident's bed against the wall.</p> <p>During an observation on 6/11/2024 at 8:39 a.m., at Resident 66's bedside, Resident 66's bed was observed placed against the wall, with the left side of the bed touching the wall. There were bed rails observed to the right and left side of Resident 66's bed.</p> <p>During a concurrent observation and interview on 6/11/2024 at 1:22 p.m., at Resident 66's bedside, with Registered Nurse Supervisor (RNS) 1, RNS 1 observed the placement of Resident 66's bed and bed rails. RNS 1 stated Resident 66 had bed rails on both sides of the bed, and stated the bed was also placed against the wall. RNS 1 stated Resident 66 could not get out of the bed on the left side because it was against the wall, and stated the bed placement was a form of a restraint.</p> <p>2. A review of Resident 71's Admission Record indicated Resident 71 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 71's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, and encephalopathy (a broad term for any brain disease that alters brain function or structure).</p> <p>A review of Resident 71's H&P, dated 4/17/2024, indicated Resident 71 had the capacity to understand and make decisions.</p> <p>A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had severe cognitive impairment. The MDS indicated Resident 71 required partial to moderate assistance from staff to roll left and right in bed, transition from a sitting to lying position and vice versa, transition from a sitting to standing position and vice versa, and transfer from a chair to bed and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 71's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 71's bed against the wall.</p> <p>A review of Resident 71's care plans did not indicate a care plan was developed for the use of bed rails or placement of the resident's bed against the wall.</p> <p>During an observation on 6/11/2024 at 9:14 a.m., at Resident 71's bedside, Resident 71's bed was observed placed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 71's bed.</p> <p>47679</p> <p>3. A review of Resident 88 Admission Record, indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 88's diagnoses included encephalopathy, schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 88's MDS, dated [DATE], indicated Resident 88 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 88's cognition was moderately impaired. The MDS indicated Resident 88 had impairments on both sides of his lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 88 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 88's H&P, dated 7/4/2023, indicated Resident 88 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 88's Comprehensive Assessment, dated 10/13/2023, indicated Resident 88 had left and right side rails. The Comprehensive Assessment indicated the side rails were indicated for safety and to promote independence with bed mobility. There was no indication that consent was received for the use of side rails.</p> <p>A review of Resident 88's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 88's bed against the wall.</p> <p>During an observation on 6/10/2024 at 10:57 a.m. and on 6/11/2024 at 9:25 a.m., in Resident 88's room, Resident 88 was observed lying in bed, with his bed against the wall and with the upper bilateral (pertaining to both sides) side rails up.</p> <p>During an interview on 6/11/2024 at 2:17 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated restraints were considered any device used to restrict the residents' movements. LVN 2 stated to use restraints appropriately, the resident's physician would have to determine if restraints were warranted and write an order.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:22 p.m., with LVN 2, inside Resident 88's room, Resident 88 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up. LVN 2 stated the use of side rails and the bed against the wall restricted Resident 88's movement and should not be used unless needed.</p> <p>4. A review of Resident 16's Admission Record, indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 16's diagnoses included encephalopathy, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning).</p> <p>A review of Resident 16's MDS, dated [DATE], indicated Resident 16 was usually able to understand and be understood by others. The MDS indicated Resident 16's cognition was moderately impaired. The MDS indicated Resident 16 had impairments on both sides of his upper extremities and on one side of the lower extremities. The MDS indicated Resident 16 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 16 used bed rails daily.</p> <p>A review of Resident 16's H&P, dated 1/16/2024, indicated Resident 16 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 16's Comprehensive Assessment, dated 2/8/2024, the Comprehensive Assessment indicated Resident 16 had left and right side rails. The Comprehensive Assessment indicated there was no indication for the use of the side rails nor indication that consent was received for bilateral side rails.</p> <p>During an observation on 6/10/2024 at 10:23 a.m. and on 6/11/2024 at 9:27 a.m., in Resident 16's room, Resident 16 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:20 p.m., with LVN 2, inside Resident 16's room, Resident 16 was observed lying in bed, with his bed against the wall and with the upper bilateral side rails up. LVN 2 stated the use of side rails and the bed against the wall restricted Resident 16's movement and should not be used unless needed.</p> <p>During an interview on 6/11/2024 at 2:29 p.m., with LVN 2, LVN 2 stated Resident 16 and 88's use of bed rails and their beds against the wall were not appropriate for them because it restricted their movements. LVN 2 stated these were mainly used for safety purposes, however, they should only be used as a last resort after utilizing less restrictive interventions such as closer monitoring.</p> <p>During an interview on 6/12/2024 at 10:46 a.m., with RNS 2, RNS 2 stated least restrictive methods should be utilized for residents, such as redirecting, assisting them with their needs, changing their surrounds, providing more supervision, or providing additional activities. RNS 2 stated the use of bed rails and the beds against the wall could be seen as a restraint because they restricted the resident's movement. RNS 2 stated Residents 16 and 88 did not have an order or assessment for the use of those devices or restrictive methods. RNS 2 stated these restrictive methods could be used for resident's safety, to prevent falls or injury. RNS 2 stated the use of these restrictive methods could put the residents in harm's way due to the lack of monitoring, supervision, and assessment for the appropriateness of those devices.</p> <p>During an interview on 6/13/2024 at 10:15 a.m., with the Director of Nursing (DON), the DON stated a restraint was anything that restricted the residents' movement. The DON stated restraints could be utilized for residents that were at high risk for falls or injury, however, restraints should be the last resort. The DON stated prior to utilizing restraints, they would have to assess the resident for their behavior that put their safety at risk and determine if a different intervention could be done to address the issue. The DON stated the IDT would discuss the necessity of the restraint for the resident. The DON stated if the IDT approved the necessity, they would inform the resident's physician of the recommendation and discuss how the resident would benefit from the device. The DON stated per their policy, an Entrapment Risk Assessment would be completed prior to the installation of bed rails. The DON stated this process was not done for Residents 16 and 88.</p> <p>48343</p> <p>5. During an observation on 6/10/2024 at 10:36 a.m., in Resident 93's room, Resident 93 was observed lying in bed. Resident 93's bed was observed against the wall, and bilateral siderails upper position.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 93's Admission Record, indicated Resident 93 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 93's diagnoses included chronic obstructive pulmonary disease ([COPD] a chronic lung disease that causes obstructed airflow from the lungs) and chronic kidney disease (loss of kidney function).</p> <p>A review of Resident 93's MDS, dated [DATE], the MDS indicated Resident 93's cognitive skills for daily decision making was intact. The MDS indicated Resident 93 required moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower, and personal hygiene.</p> <p>6. During an observation on 6/10/2024 at 10:47 a.m., in Resident 40's room, Resident 40 was observed lying in bed watching television. Resident 40's bed was observed against the wall, and the bilateral siderails in the up position.</p> <p>A review of Resident 40's Admission Record, indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included muscle weakness, schizophrenia, and anxiety.</p> <p>A review of Resident 40's MDS, dated [DATE], indicated Resident 40's cognitive skills for daily decision making was impaired. The MDS indicated Resident 40 required moderate assistance (helper does less than half the effort) from staff for toileting hygiene, and shower. The MDS indicated Resident 40 required supervision (the helper provides verbal cues, touching contact as resident completes activity) for oral hygiene, and personal hygiene.</p> <p>During a concurrent observation and interview on 6/11/2024 at 12:00 p.m., in Resident 40's room, Resident 40 was observed seating on the bed and watching television. Resident 40's bed was observed against the wall, and the bilateral siderails up. Resident 40 stated he would like to have more space around the bed to be able to sit by the window and enjoy the view on the outside patio. Resident 40 stated he was not aware why there were siderails. Resident 40 stated he did not the siderails.</p> <p>7. During and observation on 6/10/2024 at 11:21 a.m., in Resident 13's room, Resident 13's bed was observed with the bilateral siderails up.</p> <p>A review of Resident 13's Face Sheet, indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included dementia, dysphagia (difficulty swallowing), and Parkinson's disease (a brain disorder that cause uncontrollable movements, such as shaking, and difficulty with balance).</p> <p>A review of Resident 13's MDS, dated [DATE], indicated Resident 13 had moderate impairment in cognitive skills. The MDS indicated Resident 13 required assistance from staff for activities of daily living (ADLs, self-care activities performed daily such as dressing, personal hygiene, and toileting).</p> <p>8. During an observation on 6/10/2024 at 12:06 a.m., in Resident 36's room, Resident 36's bed was observed against the wall with the bilateral siderails up.</p> <p>A review of Resident 36's Face Sheet, indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 36's diagnoses included dementia, anxiety, epilepsy, and diabetes (high blood sugar).</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 36's MDS, dated [DATE], indicated Resident 36 cognitive skills for daily decision making was impaired. The MDS indicated Resident 36 required moderate assistance from staff for toileting hygiene, shower, and personal hygiene.</p> <p>9. During a concurrent observation and interview on 6/10/2024 at 12:58 p.m., in Resident 112's room, Resident 112 was observed sitting on the bed. Resident 112's bed was observed against the wall with the bilateral siderails in the up position. Resident 112 stated she did not need siderails and was not aware why her bed had siderails.</p> <p>A review of Resident 112's Face Sheet, indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses included schizophrenia, and seizures.</p> <p>A review of Resident 112's MDS, dated [DATE], indicated Resident 112 cognitive skills for daily decision making was intact. The MDS indicated Resident 112 required supervision for toileting hygiene, dressing, showering, and personal hygiene.</p> <p>During a concurrent observation and interview on 6/11/2024 at 12:04 p.m., in Resident 112's room, with Certified Nursing Assistant (CNA) 3. CNA 3 confirmed Resident 112's bed was observed against the wall, with the bilateral siderails in the up position. CNA 3 stated the resident's bed against the wall, and the siderails were considered a physical restraint. CNA 3 stated that prior to the use of physical restraints, the facility should have a physician order and informed consent.</p> <p>During a concurrent interview and record review on 6/12/2024 at 11:15 a.m., with RNS 1, Resident 93, Resident 40, Resident 13, Resident 36, and Resident 112's Electronic Medical Record (EMR) were reviewed. RNS 1 stated the facility placed residents' bed against the wall to provide more open space inside the residents' room. RNS 1 stated the siderails were for residents' safety and mobility. RNS 1 stated the bed against the wall, and the use of siderails should have a physician order and informed consent. RNS 1 stated there was no documentation that least restrictive measures were performed, physician orders, or informed consents were obtained prior to the use of siderails and prior to placing the residents' beds against the wall.</p> <p>10. A review of Resident 15's Admission Record indicated the facility originally admitted Resident 15 on 12/9/2018, and most recently readmitted Resident 15 on 4/11/2021. Resident 15's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, anxiety disorder, and dementia.</p> <p>A review of Resident 15's H&P, dated 11/8/2023, indicated Resident 15 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 15's MDS, dated [DATE], indicated Resident 15 had moderate cognitive impairment. The MDS indicated Resident 15 had upper extremity impairment on one side of his body and required the use of a wheelchair. The MDS indicated Resident 15 required partial to moderate assistance from staff to transition from a sitting to standing position and vice versa, and to transition from a sitting to lying position and vice versa. The MDS indicated Resident 15 was dependent on staff to transfer from bed to chair and vice versa.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 15's active physician order, dated 11/8/2023, indicated to apply lap tray (a tray with a cushioned underside, designed to rest in a person's lap) when up in wheelchair to prevent resident from sliding off the chair and maintain proper posture.</p> <p>A review of Resident 15's care plans did not indicate a care plan was developed for the use or monitoring of Resident 15's lap tray.</p> <p>During an observation on 6/10/2024 at 11:26 a.m., outside of Resident 15's room, Resident 15 was observed sitting in his wheelchair with a tray across his lap. The tray was fastened in the rear of the wheelchair, behind the back of the seat.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 9:25 a.m., outside of Resident 15's room, with LVN 1 and Resident 15, LVN 1 observed Resident 15's lap tray. Resident 15's lap tray was observed across his lap and fastened in the rear of the wheelchair. Resident 15 stated the buckle to fasten the lap tray was behind him and he could not reach it. LVN 1 stated that if Resident 15 wanted to get up, staff assisted him.</p> <p>During a concurrent interview and record review, on 6/11/2024 at 1:25 p.m., with RNS 1, Resident 15's active physician orders dated 11/8/2023 and care plans were reviewed. RNS 1 stated the physician order indicated to apply the lap tray to prevent Resident 15 from sliding off the chair. RNS 1 stated Resident 15 had a history of falls, and stated the lap tray was being used as a restraint for fall prevention. RNS 1 stated she was not sure of the facility's policy for the use of restraints, or whether the resident needed to be monitored. RNS 1 also stated there was no care plan for Resident 15's use of a lap tray as a restraint.</p> <p>During a concurrent interview and record review with the DON, on 6/11/2024 at 2:36 p.m., Resident 15's assessment titled Restraint - Physical, dated 9/15/2023, was reviewed. The DON stated Resident 15's continued need for restraints was supposed to be assessed quarterly (every three months). The DON stated the assessment dated [DATE] was the last time Resident 15's use of restraints was assessed, and stated the facility was way overdue for the next assessment. The DON stated the assessment indicated Resident 15's lap tray restraint was continued because Resident 15 continued to get up unassisted. The DON stated there were less restrictive measures that staff could implement to prevent Resident 15 from getting up unassisted and falling. The DON stated there was no documentation to indicate that less restrictive measures had been attempted since 9/2023. The DON stated facility staff were not routinely documenting the frequency of Resident 15's attempts to get up unassisted.</p> <p>During a concurrent observation and interview on 6/13/2024 at 10:33 a.m., with Resident 15, in the hallway outside of Resident 15's room, Resident 15 was observed sitting in his wheelchair in the hallway, with a lap tray attached to the wheelchair and placed across his lap. Resident 15 stated he fell out of his wheelchair a while ago. Resident 15 stated facility staff applied the lap tray to his wheelchair following the fall. Resident 15 stated he wanted to get up on his own but could not because of the lap tray. Resident 15 stated he walked in the morning, but wanted to walk more, and stated he sometimes wished he could remove the tray. Resident 15 stated he did not try to get up unassisted and stated I know I can't do it. I call for help.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility P&P titled Restraints, dated 5/1/2018, indicated it was the facility policy to provide residents with an environment that was restraint free, and that the least restrictive measures would be used if a restraint was necessary to treat a medical symptom. The P&P defined a physical restraint as any physical or mechanical device attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement including bedrails and beds against the wall. The P&P indicated:</p> <ul style="list-style-type: none"> a. Alternative methods of behavioral control must be attempted and documented in the resident's medical record before a physical restraint is used. b. The Facility will not use restraints as needed PRN or as necessary basis. c. Informed consent will be obtained from the resident or responsible party if a restraint will be used. d. Restrained residents will be reviewed regularly (at a minimum of quarterly by the IDT to determine the continued need for restraints. e. The IDT will consider the elimination of restraints, or a less restrictive device whenever possible. f. Bed rail use will be addressed in the same manner as any other device that has the potential to risk movement. g. If the Facility is utilizing bed rails, the Bed Rail Entrapment Risk Assessment will be completed by a Licensed Nurse prior to the installation of bed rails. h. To determine if a bed rail is being used as an enabler, the resident must be able to easily and voluntarily get in and out of bed when the equipment is in use. If the resident cannot easily and voluntarily release the bed rails and/or use the bed rails to reposition, the use of the bed rails may be considered a restraint. i. The IDT will discuss with the resident and/or resident representative the risk and benefits involved with bed rails and described alternatives that may be feasible prior to installing bed rails. j. Care plans for restraints are to be developed and implemented. <p>A review of facility's P&P titled Siderails, revised 3/2010, the P&P indicated:</p> <ul style="list-style-type: none"> a. Facility to use siderails based on residents assessed medical needs. b. Used for treatment of medical symptoms or condition. c. A physician's order and signed release by resident is required. d. Used for resident's mobility and /or transfer. e. To protect the resident from falling out of bed. <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994</p> <p>Based on interview and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS, a standardized resident assessment care screening tool) were accurate for two of seven sampled residents (Resident 17 and 88) when the facility failed to:</p> <ol style="list-style-type: none"> 1. Include the presence of hallucinations (an experience involving the apparent perception of something not present) for Resident 17. 2. Include a diagnosis of anxiety disorder per information in the medical record for Resident 88. <p>Theses deficient practices had the potential to negatively affect Resident 17 and Resident 88's plan of care and delivery of necessary care and services.</p> <p>Findings:</p> <p>a. A review of Resident 17's Admission Record (Face Sheet), indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 17's diagnoses included chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow), schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), major depressive disorder (MDD, a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (a group of mental disorders characterized by significant feelings of fear).</p> <p>A review of Resident 17's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 6/2/2024, indicated Resident 17 was able to understand and be understood by others. The MDS indicated Resident 17's cognition (process of thinking) was intact. The MDS indicated Resident 17 had delusions (misconceptions of beliefs that are firmly held, contrary to reality). The MDS indicated Resident 17 required setup or clean-up assistance with eating, oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS indicated Resident 17 received antipsychotic (medication to treat psychosis [severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality], antianxiety (medication to treat anxiety [feeling of unease, excessive worry]), and antidepressant (medication to treat depression) medication.</p> <p>A review of Resident 17's History and Physical (H&P), dated 2/19/2024, indicated Resident 17 had the capacity to understand and make decisions.</p> <p>A review of Resident 17's Order Summary Report, dated 2/9/2024, indicated to administer Risperdal (an antipsychotic medication) 2 milligrams (mg, a unit of measurement) two times a day for paranoid schizophrenia, manifested by auditory hallucinations (an experience involving the apparent perception of something not present) by hearing voices to internal stimuli.</p> <p>A review of Resident 17's Monthly Psychotropic Drug Management, dated 6/3/2024, indicated between 5/1/2024 through 5/31/2024, Resident 17 exhibited the behavior of auditory hallucinations by hearing voices to internal stimuli a total of 5 times.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 17's Medication Administration Record (MAR), dated 5/1/2024 through 5/31/2024, indicated Resident 17 exhibited the behavior of auditory hallucinations by hearing voices to internal stimuli on 5/16/2024 and 5/21/2024.</p> <p>A review of Resident 17's Psychiatric Note, dated 5/2/2024, indicated Resident 17 was seen in her room presenting with auditory hallucinations, angry outbursts, and verbalized sadness.</p> <p>During an interview on 6/12/2024 at 9:41 a.m., with the Director of Social Services (DSS), the DSS stated she was responsible for assessing the behavior portion of the MDS. The DSS stated she was responsible for reviewing the residents' H&P from the hospital to see if there were any history of the presence of hallucinations or delusions. The DSS stated during the assessment period, she would monitor and observe the resident to see if they were talking to someone that was not there or responding to internal stimuli.</p> <p>During a concurrent interview and record review on 6/12/2024 at 9:44 a.m., with the DSS, Resident 17's MDS, dated [DATE], was reviewed. The MDS indicated Resident 17 only experienced delusions. The DSS stated Resident 17's MDS did not indicate that Resident 17 experienced hallucinations. The DSS stated the MDS was incorrect because Resident 17 experienced hallucinations during the review period and was on antipsychotic medication for that behavior. The DSS stated the MDS assessment had to be accurate to monitor the resident, especially when they are on medications for the specific behavior and could prompt the team to decrease the dose or discontinue the medication entirely if the assessment indicated no hallucinations. The DSS stated because the MDS assessment for Resident 17's behavior was inaccurate; the assessment could mislead the healthcare team and could negatively affect Resident 17's plan of care.</p> <p>During an interview on 6/13/2024 at 10:06 a.m., with the Director of Nursing (DON), the DON stated when the MDS assessment was inaccurate, the resident's plan of care could be negatively affected. The DON stated the error on Resident 17's behavior could affect the decision making whether her antipsychotic medication had to be adjusted or continued.</p> <p>47679</p> <p>b. A review of Resident 88's Admission Record, dated 6/12/2024, indicated Resident 88 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 88's diagnoses included schizophrenia and MDD.</p> <p>A review of Resident 88's H&P, dated 7/4/2023, indicated Resident 88 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 88's Physician Order Summary (a monthly summary of all active physician orders), dated 6/12/2024, indicated Resident 88 was prescribed buspirone (a medication used to treat anxiety) 5 mg by mouth once daily for anxiety on 4/24/2024.</p> <p>A review of Resident 88's Psychiatric Progress Note (a note recording the findings from a psychiatrist's periodic assessment), dated 6/5/2024, indicated Resident 88 had psychiatric diagnoses including schizophrenia, MDD, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 88's MDS Section I, dated 3/22/2024, indicated Resident 88 did not have anxiety disorder as an active diagnosis.</p> <p>During an interview on 6/12/24 at 9:41 a.m. with the DON, the DON stated Resident 88's MDS assessment Section I for 3/22/2024 was inaccurate as it did not include anxiety disorder in his active diagnoses. The DON stated because this diagnosis was included on Resident 88's psychiatric consult note dated 6/5/2024 and the resident had been receiving medication for anxiety disorder since well before the MDS assessment was completed, it should have been included in the MDS assessment on 3/22/2024. The DON stated inaccurate MDS assessments could negatively impact care planning which increased the risk that a resident's needs were not fully met, leading to a decline in their quality of life.</p> <p>A review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument Process- MDS Assessment, Processing, and Documentation, revised 1/1/2012, indicated, to provide residents assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal submission requirements.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals with a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) assessments were accurate, and that determination for the necessity of potential necessary services was completed for two of 25 sampled residents (Resident 109 and Resident 25).</p> <p>This deficient practice had the potential for Resident 109 and Resident 25 to not receive the required services and care needed for their diagnosed mental disorders.</p> <p>Findings:</p> <p>1. A review of Resident 109's Admission Record indicated the facility admitted Resident 109 on 1/19/2024. Resident 109's admitting diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>A review of Resident 109's Minimum Data Set (MDS, a comprehensive care-screening and care-planning tool), dated 4/27/2024, indicated Resident 109 had diagnoses of schizophrenia and depression.</p> <p>A review of Resident 109's PASRR Level I Screening, dated 1/19/2024, indicated the assessment was completed at the facility upon Resident 109's admission.</p> <p>A review of Resident 109's untitled record, dated 1/19/2024, indicated a PASRR Level II Mental Health Evaluation could not be completed because Resident 109 already had a duplicate PASRR Level I Screening on file.</p> <p>During a concurrent interview and record review, on 6/12/2024 at 10:06 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 109's untitled record, dated 1/19/2024 was reviewed. RNS 2 stated the record indicated a Level II Mental Health Evaluation was required, and stated the facility did not follow up to ensure it was completed. RNS 2 stated the purpose of the PASRR screenings and evaluations was to ensure that residents with mental illness received the appropriate services. RNS 2 stated that failure to ensure Resident 109's Level II Mental Health Evaluation was completed created the potential for Resident 109 to not receive recommended mental health services.</p> <p>2. A review of Resident 25's Admission Record indicated the facility originally admitted Resident 25 on 4/15/2011, and most recently readmitted Resident 25 on 5/8/2024. Resident 25's admitting diagnoses included schizophrenia and depression.</p> <p>A review of Resident 25's MDS, dated [DATE], indicated Resident 25 had diagnoses of schizophrenia and depression.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 25's PASRR Level I Screening, dated 5/10/2024, indicated the individual completing the screening was supposed to mark yes or no to indicate if Resident 25 had a serious diagnosed mental disorder such as depressive disorder, and schizophrenia. The PASRR was marked no, indicating Resident 25 did not have a serious mental disorder.</p> <p>During a concurrent interview and record review on 6/12/2024 at 10:21 a.m., with RNS 2, Resident 25's Admission Record and MDS dated [DATE] were reviewed. RNS 2 stated the Admission Record and MDS dated [DATE] indicated Resident 25 had diagnoses of schizophrenia and depression. The RNS then reviewed Resident 25's PASRR Level I Screening, dated 5/10/2024, and stated the PASRR Level I Screening, dated 5/10/2024, was not accurate. RNS stated a Level II Mental Health Evaluation was not required due to the inaccurate assessment, and stated that without the Level II Mental Health Evaluation, there was potential for Resident 25 to miss out on any recommended mental health services.</p> <p>A review of the facility policy and procedure (P&P) titled Pre-Admission Screening and Resident Review (PASRR), dated 7/1/2023, indicated it was the facility's policy to ensure that all facility applicants are screened for mental illness and to ensure coordination with the appropriate state agencies, if indicated.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994</p> <p>Based on observation, interview, and record review, the facility failed to develop, implement, and update the comprehensive care plan for 15 out of 25 residents (Resident 88, 10, 13, 66, 109, 11, 71, 15, 16, 17, 93, 40, 13, 36, and 112) by failing to:</p> <ol style="list-style-type: none"> 1. Develop a comprehensive care plan for Resident 88's use of Buspirone (a medication used to treat mental illness) and to address the problematic behavior of auditory hallucinations (hearing voices to harm self or others), and Resident 17's use of Ativan (a medication used to treat anxiety [feeling of unease, excessive worry]). 2. Develop a comprehensive care plan for Resident 10's behavior of wandering into Resident 13's room. 3. Develop a comprehensive care plan for Resident 66's use of dentures. 4. Develop a comprehensive care plan for Resident 109's diagnosis of schizophrenia (mental disorder that affects a person's ability to think, feel, and behave clearly), and Resident 11's diagnoses of paranoid schizophrenia, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). 5. Develop a comprehensive care plan for Resident 15's use of a lap tray restraint. 6. Develop a comprehensive care plan for the use of physical restraints for Residents 71, 16, 88, 93,40, 13, 36, and 112. <p>These deficient practices of failing to create a resident-centered care plan for Residents 88 and 17 to address problematic behaviors increased the risk that psychotropic medications (medications that affect brain activities associated with mental processes and behavior) used to manage those behaviors would not be periodically reevaluated as intended. This increased the risk that Residents 88 and 17 may have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medications possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status.</p> <p>These deficient practices of failing to create a resident-centered care plan placed Residents 10 and 13 at risk for harm.</p> <p>These deficient practices also had the potential to result in weight loss and choking hazards for Resident 66, placed Residents 109 and 11 at risk of not having their mental and psychosocial needs met, and also had the potential to negatively affect Resident 93, 40, 13, 36, 112, 66, 16, 88, 71, and 15's physical wellbeing, and placed the residents at risk for unnecessary physical restraints.</p> <p>Findings:</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. A review of Resident 88's Admission Record (a document containing a resident's diagnostic and demographic information), dated 6/12/2024, indicated Resident 88 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 88's diagnoses included schizophrenia (a mental illness characterized by seeing and hearing things that are not there) and major depressive disorder (MDD - a mental disorder characterized by depressed mood, poor appetite, difficulty sleeping, and lack of interest in normally enjoyable activities).</p> <p>A review of Resident 88's History and Physical (H&P), dated 7/4/2023, indicated Resident 88 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 88's Physician Order Summary (a monthly summary of all active physician orders), dated 6/12/2024, indicated Resident 88 was prescribed the following psychotropic medications on 4/24/2024:</p> <ol style="list-style-type: none"> 1. Buspirone (a medication used to treat anxiety) 5 milligrams (mg - a unit of measure for mass) by mouth once daily for anxiety. 2. Risperidone (a medication used to treat schizophrenia) 1.5 mg by mouth every morning and 2 mg by mouth every evening for schizophrenia. <p>A review of Resident 88's Medication Administration Record (MAR) indicated Resident 88 was being monitored for auditory hallucinations: hearing voices to harm self or others related to the use of Risperidone.</p> <p>A review of Resident 88's available care plans indicated there was no care plan addressing the use of Buspirone or the problematic behavior of auditory hallucinations: hearing voices to harm self or others.</p> <p>During an interview on 6/12/2024 9:41 a.m. with the Director of Nursing (DON), the DON stated the facility failed to include a care plan to address Resident 88's behavior of auditory hallucinations. The DON stated Resident 88's care plan for schizophrenia which included Risperidone as a targeted intervention listed other problematic behaviors, but not the auditory hallucinations for which the resident was continually monitored. The DON stated the failure to create a care plan for the resident's problematic behaviors increased the risk to the resident and to other residents or staff that the resident may cause harm because of his auditory hallucinations. The DON stated the facility failed to create a care plan to monitor the adverse effects of Resident 88's Buspirone medication. The DON stated it was important that a care plan exists to monitor adverse effects of psychotropic medications to ensure they were periodically reevaluated and did not decrease quality of life.</p> <p>2. A review of Resident 17's Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow), schizophrenia, major depressive disorder, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 17's MDS, dated [DATE], indicated Resident 17 was able to understand and be understood by others. The MDS indicated Resident 17's cognition was intact. The MDS indicated Resident 17 had delusions (misconceptions of beliefs that are firmly held, contrary to reality). The MDS indicated Resident 17 required setup or clean-up assistance with eating, oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS indicated Resident 17 received antipsychotic and antidepressant (medication to treat depression) medication.</p> <p>A review of Resident 17's H&P, dated 2/19/2024, indicated Resident 17 had the capacity to understand and make decisions.</p> <p>A review of Resident 17's Order Summary Report, dated 2/9/2024, the indicated to administer Ativan 1 mg, by mouth, three times a day, for anxiety with agitation and angry outbursts.</p> <p>During an interview on 6/12/2024 at 10:33 a.m., with RNS 2, RNS 2 stated the purpose of care plans was to provide individualized care to the residents. RNS 2 stated care plans were developed for anything that was happening with the resident. RNS 2 stated controlled medications (medication that is tightly controlled by the government because it may be abused or cause addiction) were care planned due to the side effects that the staff would need to monitor.</p> <p>During a concurrent interview and record review on 6/12/2024 at 10:37 a.m., with RNS 2, Resident 17's Care Plans were reviewed. There were no care plans that addressed Resident 17's use of Ativan. RNS 2 stated Resident 17 did not have a care plan for Ativan use in her medical record, however, a care plan should have been developed. RNS 2 stated without a care plan that addressed Resident 17's use of Ativan, there was the potential the resident would not be monitored for side effects. RNS 2 stated any other interventions that should be done while a resident was on a controlled medication could also be missed.</p> <p>During an interview on 6/13/2024 at 9:57 a.m., with the DON, the DON stated the purpose of care plans was to communicate the plan of care for the residents. The DON stated a care plan should be developed when a resident was on any psychotropic medications to communicate the reason they are taking it, their diagnosis, and any monitoring that was required to keep the resident safe. The DON stated Resident 17 should have had a care plan developed since she was taking Ativan. The DON stated without a care plan, there was the possibility that the side effects and other interventions that need to be done would be missed and could affect Resident 17's quality of care and safety.</p> <p>A review of the facility's policy and procedure (P&P) titled Psychotherapeutic Drug Management, revised 5/17/2024, indicated the care plan will reflect an individualized team approach emphasizing person-centered interventions with measurable goals, timetables, and specific interventions for the management of behavioral and psychological symptoms. The P&P indicated the resident's care plan will include the reason(s) for the drug and described the behaviors the drugs was prescribed to treat. The P&P indicated the care plan will include the problem/symptoms the resident is experiencing, goals for the resident, a sticker or note describing the side effects of the drug, non-pharmacologic interventions to help the resident cope with the problem.</p> <p>47092</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. A review of Resident 10's Admission Record indicated the facility originally admitted Resident 10 on 7/22/2016, and most recently readmitted Resident 10 on 12/21/2022. Resident 10's admitting diagnoses included dementia (a brain disease that effects memory and cognitive function, interfering with daily life), schizophrenia, and bipolar disorder (a mood disorder with manic and depressive episodes).</p> <p>A review of Resident 10's H&P, dated 12/19/2022, indicated Resident 10 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 10's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/1/2024, indicated Resident 10 was mildly cognitively impaired (ability to think and reason). The MDS indicated Resident 10 had required total assistance with toileting hygiene, showering/bathing, and personal hygiene.</p> <p>A review of Resident 13's Admission Record indicated the facility originally admitted Resident 13 on 5/18/2016, and most recently readmitted the Resident 13 on 12/12/2022. Resident 13's admitting diagnoses included dementia and schizophrenia,</p> <p>A review of Resident 13's H&P, dated 12/19/2022, indicated Resident 13 had the capacity to understand and make decisions.</p> <p>A review of Resident 13's MDS, dated [DATE], indicated Resident 13 was severely cognitively impaired. The MDS indicated Resident 13 was had required partial assistance (helper does less than half the effort) for personal hygiene only.</p> <p>A review of Resident 13's care plan for At Risk for Aggression to Others dated 5/28/2024, indicated Resident 13 was at risk for aggression to others. The care plan indicated Resident 13 was seen with another female resident in his room. The care plan interventions indicated to assess other residents visiting Resident 13's room to ensure their safety.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 9:50 a.m., with Resident 10, Resident 10 was observed awake and alert. Resident 10 stated she did not know Resident 13 and denied ever going into his room.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 10:08 a.m., with Resident 13, Resident 13 was observed awake and alert, sitting in his wheelchair outside on the patio. Resident 13 denied knowing Resident 10 and denied her ever being in his room.</p> <p>During an interview on 6/11/2024 at 10:54 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated on 5/18/2024 around 4:00 p.m., she had heard a door slam in Resident 13's room so she rushed in there to make sure everyone was safe. CNA 5 stated when she opened Resident 13's room door she saw Resident 13 naked next to Resident 10, who had her top unbuttoned and her bra showing. CNA 5 separated Resident 10 and Resident 13 and reported the sexual activity to Licensed Vocational Nurse (LVN) 3 and Registered Nurse Supervisor (RNS) 3.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2024 at 12:34 a.m., with Resident 10's Responsible Party (RP) 2, RP 2 stated she received a phone call from RNS 4 who informed her staff found Resident 10 in Resident 13's room undressed. RP 2 stated she was upset because she believed Resident 10 was molested since she did not have capacity to make decisions, had dementia, and was confused. RP 2 stated she told the staff in the past Resident 10 needed to be monitored more since she had fallen one year ago.</p> <p>During a concurrent interview and record review, on 6/11/2024 at 2:12 p.m., with RNS 1, Resident 10's Resident Behavior Care Plan, dated 5/27/2024 was reviewed. RNS 1 verified the care plan indicated Resident 10 went into another resident's room (Resident 13) and had forgetfulness. The care plan further indicated to check Resident 10's whereabouts and to not allow Resident 10 into male residents' rooms. RNS 1 stated prior to 5/18/2024, when Resident 10 was witnessed going into Resident 13's room, the resident was on monitoring for and had a history of going into male residents' rooms. RNS 1 stated there should have been a care plan in place for Resident 10 wandering into male residents' rooms prior to 5/18/2024, but the care plan was created on 5/27/2024. RNS 1 stated Resident 10 needed full assistance with dressing and did not understand how she could have unbuttoned her blouse herself when she was found in Resident 13's room with an unbuttoned shirt.</p> <p>During an interview on 6/12/2024 at 1:27 p.m., with the Director of Nursing (DON), the DON stated Resident 10 had a history of dementia, forgetfulness, and wandering into residents' rooms, but it was not care planned. The DON stated Resident 10's wandering into rooms should have been care planned due to her history.</p> <p>47286</p> <p>4. A review of Resident 66's Admission Record indicated the facility originally admitted Resident 66 on 7/9/2021, and most recently readmitted the Resident 66 on 1/27/2023. Resident 66's admitting diagnoses included generalized muscle weakness, dysphagia (difficulty swallowing), unspecified abnormalities of gait (manner of walking) and mobility, and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>A review of Resident 66's H&P, dated 2/5/2024, indicated Resident 66 had the capacity to understand and make decisions.</p> <p>A review of Resident 66's MDS, dated [DATE], indicated Resident 66 had moderate cognitive impairment. The MDS indicated Resident 66 required set-up or clean-up assistance from staff to eat. The MDS indicated Resident 66 required supervision or touching/steadying by staff to reposition himself in bed, transition from sitting to lying position and vice versa, transition from sitting to standing, and transfer from bed to chair and vice versa. The MDS did not indicate the use of bedrails.</p> <p>a. During a concurrent observation and interview on 6/11/2024 at 8:37 a.m., with Resident 66, at Resident 66's bedside, Resident 66 was observed sitting up in bed, with no apparent upper or lower dentition. Resident 66 stated he had dentures.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview, on 6/11/2024 at 1:04 p.m., with CNA 4, at Resident 66's bedside, CNA 4 was observed looking through Resident 66's belongings. CNA 4 stated Resident 66 did not have any dentures at the bedside. CNA 4 stated she did not know if Resident 66 had dentures or required dentures. CNA 4 stated she had never seen Resident 66 wearing dentures. CNA 4 stated she should know if the resident required dentures to ensure he did not choke on his food.</p> <p>During a concurrent interview and record review, on 6/13/2024 at 9:48 a.m., with the DON, the Resident 66's care plans were reviewed. The DON stated Resident 66 did not have a care plan for dentures or denture use. The DON stated that the care plans would be where staff would check to determine if the Resident 66 required dentures to eat. The DON stated it could affect Resident 66's ability to speak clearly and ability to chew if he required dentures and staff did not ensure they were available to him.</p> <p>During an interview on 6/13/2024 at 9:59 a.m., with CNA 1, CNA 1 stated Resident 66 told her on 6/12/2024 that he did not want to eat because he choked on his food, and stated he only wanted liquids. CNA 1 stated Resident 66 was not using dentures while eating.</p> <p>During a concurrent observation and interview on 6/13/2024 at 10:04 a.m., with the Director of Social Services (DSS), at Resident 66's bedside, the DSS was at looking Resident 66's dentures. The DSS located Resident 66's dentures and stated they were not stored in a proper denture container. The DSS stated the dentures were buried deep in the dresser.</p> <p>During a concurrent observation and interview on 6/13/2024 at 10:05 a.m., with Resident 66, at Resident 66's bedside, Resident 66 was observed without dentures on. Resident 66 stated he had breakfast that morning and he choked on his food. Resident 66 stated he did not choke on liquids, so he only wanted liquids. Resident 66 stated he was afraid to choke on his food. Resident 66 stated the last time he used his dentures was four months ago. Resident 66 was observed with dried food on his shirt.</p> <p>During an interview on 6/13/2024 at 10:27 a.m., with RNS 1, RNS 1 stated that if Resident 66 required dentures, he needed to wear them to prevent aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident).</p> <p>b. During an observation on 6/11/2024 at 8:39 a.m., at Resident 66's bedside, Resident 66's bed was observed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 66's bed.</p> <p>A review of Resident 66's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 66's bed against the wall.</p> <p>A review of Resident 66's care plans did not indicate a care plan had been developed for the use of bed rails or placement of the resident's bed against the wall.</p> <p>During a concurrent interview and record review on 6/13/2024 at 10:22 a.m., with RNS 1, Resident 66's physician orders were reviewed. RNS 1 stated Resident 66 did not have a care plan for the use bed rails, or for placement of his bed against the wall.</p> <p>5. A review of Resident 109's Admission Record indicated the facility admitted Resident 109 on 1/19/2024. Resident 109's admitting diagnoses included schizophrenia and depression.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 109's MDS, dated [DATE], indicated Resident 109 had diagnoses of schizophrenia and depression.</p> <p>During a concurrent interview and record review on 6/12/2024 at 10:15 a.m., with RNS 2, Resident 109's admission record and care plans were reviewed. RNS 2 stated Resident 109 had a diagnosis of schizophrenia, and stated there were special care considerations and specific interventions required for residents with schizophrenia. RNS 2 stated these care considerations and interventions would be in Resident 109's care plans. RNS 2 there were no care plans in place for Resident 109's diagnosis of schizophrenia. RNS 2 stated there should be a care plan in place to indicate the current plan of care for facility staff to follow related to Resident 109's diagnosis of schizophrenia.</p> <p>6. A review of Resident 11's Admission Record indicated the facility originally admitted Resident 11 on 9/5/2017, and most recently readmitted Resident 11 on 5/1/2024. Resident 11's admitting diagnoses included paranoid schizophrenia, major depressive disorder, and anxiety disorder.</p> <p>A review of Resident 11's MDS, 5/8/2024, indicated diagnoses of paranoid schizophrenia, major depressive disorder, and anxiety disorder.</p> <p>During a concurrent interview and record review, on 6/12/2024 at 9:57 a.m., with RNS 2, Resident 11's Admission Record and care plans were reviewed. RNS 2 stated the Admission Record indicated Resident 11 had diagnoses of paranoid schizophrenia, major depressive disorder, and anxiety disorder, and stated there were special considerations for care of residents with these diagnoses. RNS 2 stated the resident might need special interventions to address certain behaviors or the cause of the behaviors. RNS 2 stated any behaviors also needed to be monitored, especially if medications were being administered to treat the behaviors. RNS 2 stated these interventions would be found in the care plan, and stated Resident 11 did not have any care plans in place for her diagnoses of paranoid schizophrenia, major depressive disorder, and anxiety disorder. RNS 2 stated the care plan indicated the care being provided to the resident, and instructions for the nurses to know the specific care required of the resident.</p> <p>7. A review of Resident 15's Admission Record indicated the facility originally admitted Resident 15 on 12/9/2018, and most recently readmitted Resident 15 on 4/11/2021. Resident 15's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, anxiety disorder, and dementia.</p> <p>A review of Resident 15's H&P, dated 11/8/2023, indicated Resident 15 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 15's MDS, dated [DATE], indicated Resident 15 had moderate cognitive impairment. The MDS indicated Resident 15 had upper extremity impairment on one side of his body and required the use of a wheelchair. The MDS indicated Resident 15 required partial to moderate assistance from staff to transition from a sitting to standing position and vice versa, and to transition from a sitting to lying position and vice versa. The MDS indicated Resident 15 was dependent on staff to transfer from bed to chair and vice versa.</p> <p>A review of Resident 15's active physician order, dated 11/8/2023, indicated to apply lap tray (a tray with a cushioned underside, designed to rest in a person's lap) when up in wheelchair to prevent resident from sliding off the chair and maintain proper posture.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 15's care plans did not indicate a care plan had been developed for the use or monitoring of Resident 15's lap tray.</p> <p>During an observation on 6/10/2024 at 11:26 a.m., outside of Resident 15's room, Resident 15 was observed sitting in his wheelchair with a tray across his lap. The tray was fastened in the rear of the wheelchair, behind the back of the seat.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 9:25 a.m., outside of Resident 15's room, with Licensed Vocational Nurse (LVN) 1 and Resident 15, LVN 1 observed Resident 15's lap tray. Resident 15's lap tray was across his lap and fastened in the rear of the wheelchair. Resident 15 stated the buckle to fasten the lap tray was behind him and he could not reach it. LVN 1 stated that if Resident 15 wanted to get up, staff assisted him.</p> <p>During a concurrent interview and record review, on 6/11/2024 at 1:25 p.m., with RNS 1, Resident 15's active physician orders and care plans were reviewed. RNS 1 stated the physician order dated 11/8/2023 indicated to apply the lap tray to prevent Resident 15 from sliding off the chair. RNS 1 stated she was not sure of the facility's policy for the use of restraints, or whether they needed to be monitored. RNS 1 also stated there was no care plan for Resident 15's use of a lap tray as a restraint.</p> <p>During a concurrent interview and record review with the DON, on 6/11/2024 at 2:36 p.m., Resident 15's care plans were reviewed. The DON stated Resident 15 did not have any care plans in place related to use of a lap tray restraint. The DON stated a care plan for restraint use should have been developed to indicate specific interventions, including monitoring Resident 15 for complications related to use of restraints.</p> <p>8. A review of Resident 71's Admission Record indicated the facility originally admitted Resident 71 on 1/10/2013, and most recently readmitted Resident 71 on 4/12/2024. Resident 71's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, and encephalopathy (a broad term for any brain disease that alters brain function or structure).</p> <p>A review of Resident 71's H&P, dated 4/17/2024, indicated Resident 71 had the capacity to understand and make decisions.</p> <p>A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had severe cognitive impairment. The MDS indicated Resident 71 required partial to moderate assistance from staff to roll left and right in bed, transition from a sitting to lying position and vice versa, transition from a sitting to standing position and vice versa, and transfer from a chair to bed and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 71's care plans did not indicate a care plan had been developed for the use of bed rails or placement of the resident's bed against the wall.</p> <p>During an observation on 6/11/2024 at 9:14 a.m., at Resident 71's bedside, Resident 71's bed was observed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 71's bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/13/2024 at 9:57 a.m., at Resident 71's bedside, Resident 71's bed was observed against the wall, with the left side of the bed touching the wall. There were bed rails to the right and left side of Resident 71's bed.</p> <p>During a concurrent interview and record review on, 6/13/2024 at 10:18 a.m., with RNS 1, Resident 71's care plans were reviewed. RNS 1 stated Resident 71 did not have a care plan in place for the use of bed rails, or for placement of Resident 71's bed against the wall.</p> <p>During an interview on 6/13/2024 at 10:41 a.m., with the DON, the DON stated Resident 71 was at risk for entrapment and getting caught between the bed mattress and the bedrails. The DON stated interventions for bedrail safety would be in the care plan, and stated bedrail use was supposed to be included in Resident 71's care plans.</p> <p>47679</p> <p>9. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 16's diagnoses included encephalopathy, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and dementia.</p> <p>A review of Resident 16's MDS, dated [DATE], indicated Resident 16 was usually able to understand and be understood by others. The MDS indicated Resident 16's cognition was moderately impaired. The MDS indicated Resident 16 had impairments (the state of function being weakened or damaged) on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand) and on one side of the lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 16 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 16's H&P, dated 1/16/2024, indicated Resident 16 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 16's Comprehensive Assessment, dated 2/8/2024, indicated Resident 16 had left and right siderails. There was no indication for the use of the side rails nor indication that consent was received for the use of bilateral (pertaining to both sides) siderails.</p> <p>A review of Resident 16's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 16's bed against the wall.</p> <p>During an observation on 6/10/2024 at 10:23 a.m. and on 6/11/2024 at 9:27 a.m., in Resident 16's room, Resident 16 was observed lying in bed. The bed was against the wall and the upper bilateral siderails in the up position.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:20 p.m., with LVN 2, inside Resident 16's room, Resident 16 was observed lying in bed. The bed was against the wall and with the upper bilateral siderails in the up position. LVN 2 stated the use of siderails and the bed against the wall restricted Resident 16's movement and should not be used unless needed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/11/2024 at 2:25 p.m., with LVN 2, Resident 16's Care Plans were reviewed. There were no care plans that addressed the use of side rails or the bed positioned against the wall. LVN 2 stated care plans were used to reflect what was currently happening with the residents. LVN 2 stated the use of bed rails and the bed against the wall should be included in Resident 16's care plans to communicate to the rest of the staff the indication of use and how to monitor the use of the devices to ensure Resident 16's safety.</p> <p>10. A review of Resident 88's Comprehensive Assessment, dated 10/13/2023, the Comprehensive Assessment indicated Resident 88 had left and right side rails on his bed that was indicated for safety and to promote independence with bed mobility. There was no indication that consent was obtained for bilateral side rails.</p> <p>A review of Resident 88's active physician orders did not indicate any orders for the use of bedrails or the placement of Resident 88's bed against the wall.</p> <p>During an observation on 6/10/2024 at 10:57 a.m. and on 6/11/2024 at 9:25 a.m., in Resident 88's room, Resident 88 was observed lying in bed. The bed was against the wall and with the upper bilateral siderails in the up position.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:22 p.m., with LVN 2, inside Resident 88's room, Resident 88 was observed lying in bed. The bed was against the wall with the upper bilateral siderails in the up position. LVN 2 stated the use of side rails and the bed against the wall restricted Resident 88's movement and should not be used unless needed.</p> <p>During a concurrent interview and record review on 6/11/2024 at 2:25 p.m., with LVN 2, Resident 88's Care Plans were reviewed. There were no care plans that addressed the use of side rails or the bed positioned against the wall. LVN 2 stated care plans were used to reflect what was currently happening with the residents. LVN 2 stated the use of bed rails and the bed against the wall should be included in Resident 88's care plans to communicate to the rest of the staff the indication of use and how to monitor the use of the devices to ensure Resident 88's safety.</p> <p>During an interview on 6/12/2024 at 11 a.m., with RNS 2, RNS 2 stated the use of side rails and placing the resident's bed against the wall should be care planned. RNS 2 stated the interventions in the care plan would dictate how to monitor and care for Resident 88 to ensure his safety.</p> <p>During an interview on 6/13/2024 at 10:44 a.m., with the DON, the DON stated any device used on the residents should be included in their care plan. The DON stated the use of side rails, regardless of the indication as a restraint, for safety, or for mobility, should be included in the care plan. The DON stated positioning the residents' bed against the wall should be care planned to properly care for the resident.</p> <p>48343</p> <p>11. During an observation on 6/10/2024 at 10:36 a.m., in Resident 93's room, Resident 93's bed was observed against the wall. The bilateral siderails were in the up position.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 93's Admission Record indicated Resident 93 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 93's diagnoses included COPD, chronic kidney disease (loss of kidney function).</p> <p>A review of Resident 93's MDS, dated [DATE], indicated Resident 93's cognitive skills for daily decision making was intact. The MDS indicated Resident 93 required moderate assistance from staff for toileting hygiene, shower, and personal hygiene.</p> <p>12. During an observation on 6/10/2024 at 10:47 a.m., in Resident 40's room, Resident 40 was observed lying in bed. Resident 40's bed was against the wall, with the bilateral siderails in the up position.</p> <p>A review of Resident 40's Admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40 [TRUNCATED]</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 47092</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services to maintain good grooming and personal hygiene for four of 14 residents (Resident 13, Resident 16, Resident 47, and Resident 98) by failing to:</p> <ol style="list-style-type: none"> 1. Check Resident 98's soiled diaper in a timely manner per facility policy and professional standards. 2. Keep Residents 13, 16, and 47's nails clean and neat. <p>These deficient practices had the potential to result in a negative impact on Resident's 98, 13, 16, and 47's quality of life and self-esteem, and had the potential for the development of infection.</p> <p>Findings:</p> <p>a. A review of Resident 98's Admission Record indicated Resident 98 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 98's admitting diagnoses included hemiplegia (paralysis on one side) and hemiparesis (weakness or the inability to move on one side) following a cerebral vascular infarction (brain tissue death resulting from disrupted blood flow to the brain) affecting the right dominant side, and epilepsy (abnormal electrical brain activity and is also known as a seizure).</p> <p>A review of Resident 98's History and Physical (H&P), dated 4/13/2024, indicated Resident 98 was able to make needs known but did not have the capacity to make medical decisions.</p> <p>A review of Resident 98's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/15/2024, indicated Resident 98 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 98 required total assistance with toileting hygiene, showering/bathing, dressing, and personal hygiene.</p> <p>A review of Resident 98's care plan titled, At Risk for Skin Breakdown dated 3/20/2024, indicated to wash Resident 98's skin with soap and water every diaper change, and to encourage to reposition every 2 hours and as needed to prevent skin breakdown (an opening of the skin in various degrees which occurs because of pressure and/or moisture).</p> <p>During an observation on 6/10/2024 at 9:54 a.m., in Resident 98's room, Resident 98 was observed lying in bed, bedbound, awake, but was unable to speak.</p> <p>During an interview on 6/10/2024 at 12:31 p.m., with Resident 98's Responsible Party (RP) 3, RP 3 stated she was concerned about Resident 98 because he was hospitalized [DATE] for a urinary tract infection (UTI, an infection of any part of the urinary tract). RP 3 stated the hospital physician told her the infection occurred because Resident 98 needed to be changed more frequently. RP 3 stated since Resident 98 could not walk or talk he relied on the nurses to change him.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/10/2024 at 12:45 p.m., with Certified Nursing Assistant (CNA) 6 and Resident 98, Resident 98 was observed lying in bed face up. CNA 6 stated she last changed Resident 98 at 9:45 a.m. but planned to change the resident after the food trays were passed out to all the residents. CNA 6 stated staff were supposed to check on bedbound residents every 2 hours for a soiled diaper and to reposition them.</p> <p>During an interview on 6/11/2024 at 2:39 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated residents should be checked at least once every 2 hours or as needed to change soiled residents, and also to reposition them to prevent skin breakdown.</p> <p>During an interview on 6/12/2024 at 1:59 p.m., with the Director of Nursing (DON), the DON stated if residents were not turned or cleaned within 2 hours, they could be uncomfortable and at risk for breakdown.</p> <p>A review of the facility's policy and procedure (P&P) titled Perineal Care, dated 5/1/2018, indicated the purpose of the policy was to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown. The P&P indicated to provide perineal care a minimum once daily and per resident need.</p> <p>47679</p> <p>b. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 16's diagnoses included encephalopathy (a broad term for any brain disease that alters brain function or structure), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning).</p> <p>A review of Resident 16's MDS dated [DATE], indicated Resident 16 was usually able to understand and be understood by others. The MDS indicated Resident 16's cognition was moderately impaired. The MDS indicated Resident 16 had impairments (the state of function being weakened or damaged) on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand) and on one side of the lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 16 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 16's H&P, dated 1/16/2024, indicated Resident 16 did not have the capacity to understand and make decisions.</p> <p>During observations on 6/10/2024 at 10:23 a.m. and on 6/11/2024 at 9:28 a.m., in Resident 16's room, Resident 16 was observed with a black substance underneath his right thumb and right index fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/12/2024 at 8:41 a.m., with CNA 2, in Resident 16's room, Resident 16 was observed with black substance underneath his right thumb and right index fingers. CNA 2 stated Resident 16's right thumb and index fingernails were dirty. CNA 2 stated nail care was one of the duties that the CNAs had to attend to daily. CNA 2 stated the CNAs were allowed to clean underneath the resident's fingernails and to clip them if they were too long. CNA 2 stated Resident 16's nails should have been cleaned sooner before there was a buildup of the black substance. CNA 2 stated ensuring the residents' fingernails were clean was essential to prevent infection. CNA 2 stated Resident 16 was prone to scratching himself and others, therefore, keeping clean fingernails would help prevent the spread of germs. CNA 2 stated if Resident 16 were to scratch his skin too hard, he may have developed a cut which could get infected due to his dirty fingernails.</p> <p>During an interview on 6/12/2024 at 9:08 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if Resident 16's nails had the black substance underneath them for three days, that would indicate that no one was cleaning the resident's nails. LVN 2 stated the nursing staff were responsible for keeping the residents' nails clean, especially for the residents that were dependent on the nurses for personal hygiene. LVN 2 stated dirty fingernails placed Resident 16 at risk for infection because any germs or bacteria that were underneath his fingernails could enter his bloodstream.</p> <p>During an interview on 6/12/2024 at 9:21 a.m., with the Infection Preventionist (IP), the IP stated keeping residents' fingernails clean was important because the fingernails could harbor bacteria that could make the residents sick. The IP stated a resident could suck on their thumb and ingest any bacteria on their hands and could cause some kind of infection and cause them to fall ill. The IP stated it was important for the staff to be very vigilant for the residents' personal hygiene to prevent infection.</p> <p>During an interview on 6/12/2024 at 10:39 a.m., with RNS 2, RNS 2 stated the nursing staff should assess the residents' nails daily to see if they need to be cleaned or trimmed. RNS 2 stated Resident 16's unkept nails were an issue because that could affect the resident's comfort, dignity, and cleanliness.</p> <p>During an interview on 6/13/2024 at 10:10 a.m., with the DON, the DON stated the when the CNAs provide their daily care to the residents, part of their responsibilities was to look at their nails and clean or trim them, if needed. The DON stated anyone who provided care to Resident 16 should have looked at his nails and coordinated to clean them if they needed assistance. The DON stated dirty fingernails could lead to the resident scratching themselves and could cause skin breakdown and infection of the skin.</p> <p>49606</p> <p>c. A review of Resident 47's Admission Record (Face Sheet), the Admission Record indicated Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a group of diseases that cause airflow blockage and breathing-related problems), heart failure (heart condition in which the heart muscle is unable to pump enough blood to meet the body's needs), cerebral infarction (disrupted blood flow to the brain), diabetes (abnormal blood sugar), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 47's MDS, dated [DATE], indicated Resident 47 was totally dependent (helper does all of the effort) on staff for toileting hygiene, shower, and moderate assistance (helper does less than half) for oral hygiene, and personal hygiene. The MDS indicated Resident 47 was self-understood and had the ability to understand others.</p> <p>During an observation on 6/10/2024 at 3:57 p.m., Resident 47 was observed sitting in a wheelchair in the facility's hallway, with long and black substance under all ten fingernails.</p> <p>During an observation on 6/11/2024 at 11:44 a.m., Resident 47 was observed sitting in a wheelchair in the facilities lobby room watching television, with long and black substance under all ten fingernails.</p> <p>During an interview on 6/12/2024 at 9:10 a.m., with CNA 3, CNA 3 stated CNAs were responsible to clean residents' fingernails daily and trim as needed. CNA 3 stated keeping Resident 47's fingernails clean and trimmed was important to prevent the growth of bacteria (infection) and hospitalization .</p> <p>d. A review of Resident 13's Admission Record (Face Sheet), the Admission Record indicated Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia, dysphagia (difficulty swallowing), Parkinson's disease (a brain disorder that cause uncontrollable movements, such as shaking, and difficulty with balance), and schizophrenia (mental health condition that effects how person think, feel, and behave).</p> <p>A review of Resident 13's MDS, dated [DATE], indicated Resident 13 had impairment in cognitive skills. The MDS indicated Resident 13 required assistance from staff for activities of daily living (ADL).</p> <p>During a concurrent observation and interview on 6/10/2024 at 11:21 a.m., in Resident 13's room, Resident 13 was observed with long and fingernails with black substance under all ten fingernails. Resident 13 stated he does not remember when last time his fingernails were cleaned or cut. Resident 13 stated he would like to have his fingernails cleaned and cut by staff.</p> <p>During a concurrent observation and interview on 6/12/2024 at 8:03 a.m., in Resident 13's room, with RNS 1, RNS 1 stated Resident 13's fingernails were long and dirty. RNS 1 stated CNAs were responsible to clean fingernails daily and trim as needed. RNS 1 stated it was important for Resident 13's fingernails clean and trim to prevent infection, cuts, and injury.</p> <p>During an interview on 6/13/2024 at 9:57 a.m., with the DON, the DON stated was CNA's responsibility to make sure the residents' fingernails were cleaned daily and trimmed as needed. The DON stated residents' dirty fingernails was an issue because residents could touch their eyes and could cause an eye infection, could scratched themselves and create skin breakouts, or injure themselves, or other residents. The DON stated residents should be provided with care and services necessary to maintain good personal hygiene.</p> <p>A review of facility's P&P titled Nail Care, revised 3/2010, indicated, the facility was to promote cleanliness, safety, and neat appearance of residents.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of facility's P&P titled Certified Nursing Assistant Job Description, dated 12/8/1998, indicated, under Responsibilities and Duties included assists residents to ensure their cleanliness grooming, nourishment, rest, activity, and elimination in a manner conducive to the resident's comfort and safety.</p>

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<p>F 0684</p> <p>Level of Harm - 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** 47286</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Communication Barriers, which indicated the facility will provide effective interpretation or arrange for a qualified interpreter to meet the needs of residents who had a hearing, visual, or speech disability, for one of one sampled resident (Resident 107). The facility failed to:</p> <ol style="list-style-type: none"> 1. Provide Resident 107 with communication aides to enable Resident 107 communicate her needs to staff. 2. Ensure staff used communication tools such as a writing board or American Sign Language (ASL) when communicating with Resident 107. 3. Assess Resident 107's behaviors of agitation, frustration, and desire to leave the facility. 4. Assess the cause of Resident 107's poor oral intake starting on 6/8/2024. 5. Revise Resident 107's care plan titled The resident has a communication problem related to expressive aphasia (a condition where a person may understand speech, but they have difficulty speaking fluently themselves), hearing deficit (deaf), which indicated staff would use a communication board to communicate with Resident 107, when Resident 107 was assessed as unable to use a communication board for effective communication. <p>These deficient practices resulted in Resident 107's attempt to elope (to leave unnoticed and unsupervised) from the facility, and display signs of frustration, agitation (irritability, easily annoyed) and restlessness due to her inability to effectively communicate with facility staff. These deficient practices also led to Resident 107 experiencing a nine-pound ([lb.] a unit of measurement) weight loss from 4/12/2024 to 6/7/2024, and a transfer to general acute care hospital (GACH) 2 on 6/12/2024 due to abdominal pain.</p> <p>Findings:</p> <p>A review of Resident 107's History and Physical (H&P) from a general acute care hospital (GACH) 1, dated 4/8/2024, indicated Resident 107 had a history of deafness, visual impairment/blindness, and dementia (loss of memory, language, problem-solving and other thinking abilities). The H&P further indicated history collection was limited due to Resident 107's hearing and visual deficits.</p> <p>A review of Resident 107's Admission Record indicated Resident 107 was admitted to the facility on [DATE]. Resident 107's admitting diagnoses included dementia, deaf nonspeaking, history of falling, and generalized muscle weakness. The Admission Record also indicated Family Member (FM) 1 was Resident 107's responsible party and decision maker.</p> <p>A review of Resident 107's H&P, dated 4/17/2023, indicated Resident 107 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 107's Minimum Data Set (MDS, a standardized care-planning and care-screening tool), dated 4/19/2024, indicated Resident 107 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 107 had highly impaired hearing, did not speak, and had moderately impaired vision requiring the use of corrective lenses. The MDS indicated Resident 107 was unable to respond when asked how often she needed to have someone help her read instructions or written material. The MDS indicated Resident 107 exhibited rejection of care necessary to achieve goals for health and well-being for one to three days over a period of seven days. The MDS indicated Resident 107 required partial to moderate assistance from staff for hygiene after toileting, dressing her upper body, personal hygiene activities, mobility while in bed, and transitioning between surfaces (bed to chair, getting on and off the toilet). The MDS indicated Resident 107 required verbal cues and/or touching/steadying assistance from staff when eating, brushing her teeth, dressing her lower body, putting on/taking off her shoes, and walking.</p> <p>A review of Resident 107's Progress Note, dated 4/12/2024 at 10:59 p.m., indicated Resident 107 had an episode of aggressive behavior due to frustration from inability to communicate her needs.</p> <p>A review of Resident 107's Admission Summary, dated 4/13/2024, indicated Resident 107 was admitted from GACH 1, was deaf and used American Sign Language (ASL, a language expressed by movements of the hands and face) to communicate. The Admission Summary indicated due to frustration from being unable to talk, Resident 107 spat water at the nursing staff who were attempting to assess her.</p> <p>A review of Resident 107's Progress Note, dated 4/14/2024 at 8:20 a.m., indicated Resident 107 was agitated, and displayed restlessness, walked up and down the hallway, and communicated that no one could understand her. The progress note did not indicate any attempts to assess Resident 107's preferred method of communication, or staff attempts to communicate with the resident in her preferred method of communication. The progress note indicated Resident 107's admission weight was 104 lbs.</p> <p>A review of Resident 107's Progress Note, dated 4/14/2024 at 9:59 p.m., indicated Resident 107 was observed with episodes of restlessness, wandering, and continuously trying to leave the facility. The progress notes further indicated Resident 107 was exhibiting increased frustration evidenced by her facial expressions. The progress note indicated Resident 107 was redirected to her room and placed under direct supervision. The progress note did not indicate any attempts to assess Resident 107's preferred method of communication, or staff's attempts to communicate with her in her preferred method of communication.</p> <p>A review of Resident 107's Progress Note, dated 4/15/2024 at 12:29 p.m., indicated FM 1 notified facility staff that the effective way to communicate with Resident 107 was through ASL.</p> <p>A review of Resident 107's Progress Note, dated 4/15/2024 9:29 p.m., indicated Resident 107 was agitated, restless, and communicating through hand gestures and no one could understand her. The progress note did not indicate any staff interventions to address Resident 107's agitation, restlessness, or any attempts to communicate with Resident 107 in her preferred method of communication, to meet her needs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 107's Dietary Progress Note, dated 4/17/2024 at 10:45 a.m., indicated Resident 107 was unable to answer questions verbally, and was asked by the Dietary Supervisor (DS) about her food and beverage preferences by writing with a pen and paper. The notes indicated Resident 107 responded by nodding her head. The progress note indicated Resident 107 requested to have coffee and the facility would honor her preferences. The progress note did not indicate that an ASL interpreter or other communication devices/methods were used to verify the accuracy of the interview. The progress note did not indicate Resident 107's responsible party, (FM 1), was contacted for additional information related to Resident 107's dietary restrictions or preferences.</p> <p>A review of Resident 107's Progress Note, dated 4/17/2024 at 4:06 p.m., indicated Resident 107 wrote on pen and paper, indicating she wanted to go home.</p> <p>A review of Resident 107's Change in Condition Evaluation (COC), dated 4/18/2024 at 9:23 p.m., indicated Resident 107 was non-verbal and communicated in sign language. The COC indicated Resident 107 attempted to leave the facility. The COC indicated Resident 107 had episodes of restlessness and agitation. The COC indicated attempts to redirect the resident were less effective due to a communication barrier between Resident 107 and the staff. The COC indicated Resident 107 refused to go back to her room and continued to try to communicate in sign language and gestures. The COC did not indicate that attempts were made to communicate with Resident 107 in her preferred method of communication, or address Resident 107's restlessness and attempts to leave the facility.</p> <p>A review of Resident 107's Progress Note, dated 6/6/2024 at 4:10 a.m., indicated on 5/15/2024, Resident 107's weight was 100 pounds (lbs).</p> <p>A review of Resident 107's Progress Note, dated 6/8/2024 at 12:23 p.m., indicated staff attempted to contact FM 1 to notify her of Resident 107's weight change, inadequate eating patterns, and Resident 107's behavior of pointing to her flank (the side of the body between the ribs and the hip). The progress note indicated Resident 107 had no complaints of pain or discomfort. The progress note did not indicate if a formal assessment was conducted, or an interpreter was used to assess Resident 107.</p> <p>A review of Resident 107's COC, dated 6/8/2024 at 4:59 p.m., indicated Resident 107 had weight loss, and on 6/7/2024 Resident 107's weight was 95 lbs. The COC indicated Resident 107 exhibited signs of inadequate food intake and was not eating or drinking at all. The COC indicated abdominal/gastrointestinal (relating to the stomach and the intestines) and pain status evaluations were not clinically applicable to the change being reported. The COC further indicated Resident 107 was unable to speak. The COC did not indicate that staff used an interpreter to perform any of the assessments.</p> <p>A review of Resident 107's Progress Note, dated 6/8/2024 at 5:23 p.m., indicated FM 1 returned the facility's call from 12:23 p.m. and was notified of Resident 107's weight loss and that Resident 107 had been pointing to her stomach. The progress note indicated FM 1 informed staff that Resident 107 had chronic problems with gastrointestinal discomfort and hyperacidity. The progress note indicated FM 1 informed staff that Resident 107 was not supposed to have acidic beverages, including coffee.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 107's Progress Note, dated 6/11/2024 at 8:30 p.m., indicated Resident 107 had a weight loss of nine (9) lbs. since admission on 4/12/2024. The progress notes f indicated Certified Nursing Assistant (CNA) staff reported Resident 107 ate less of her meals and sometimes pointed to her stomach. The progress note did not indicate that any further assessment was conducted to assess the cause of the decreased intake or why Resident 107 was pointing to her stomach. The progress notes indicated Resident 107's primary physician (MD) was notified, and the MD gave an order for Resident 1 to be transferred to a GACH.</p> <p>A review of Resident 107's Progress Note, dated 6/12/2024 at 3:15 p.m., indicated Resident 107 displayed facial grimacing, and pointed her hands to her stomach, back and shoulder. The progress note indicated FM 1 was contacted to assist with interpreting Resident 107's gestures. The progress note indicated Resident 107's covering MD ordered for Resident 107 to be transferred to a GACH for further evaluation. The progress note did not indicate that a formal assessment was conducted using interpreter services.</p> <p>A review of Resident 107's COC, dated 6/12/2024 at 3:35 p.m., indicated Resident 107 had abdominal pain that started on 6/11/2024. The COC indicated 500 milligrams (mg, a unit of measurement) of Tylenol was administered for the abdominal pain.</p> <p>A review of Resident 107's Progress Note, dated 6/12/2024 at 4:18 p.m., indicated Resident 107 complained of severe abdominal pain since the evening of 6/11/2024. The progress note indicated Resident 107's primary MD was on vacation and staff received orders from the facility's Medical Director (MD 2) to transfer Resident 107 to a GACH.</p> <p>A review of Resident 107's Progress Note, dated 6/12/2024 at 4:18 p.m., indicated Resident 107 was observed eating dinner and she was a poor eater. The progress note indicated staff encouraged Resident 107 to eat by pointing to the food. The progress note indicated Resident 107 ate 50% of her meal. The progress note did not indicate staff used an interpreter or alternative communication method to assess the cause of Resident 107's poor intake, or to encourage Resident 107 to eat.</p> <p>A review of Resident 107's Progress Note, dated 6/12/2024 at 10:10 p.m., indicated Resident 107 was transferred to GACH 2 due to intractable pain to her right lower abdomen and right shoulder.</p> <p>During an observation on 6/10/2024 at 10:10 a.m., in the doorway of Resident 107's room, Resident 107 was observed sitting up at the right edge of her bed. Resident 107 did not respond to vocalized questions. Upon entering the room, Resident 107 vocalized unintelligible sounds, and pointed to her ears and eyes. No communication board, writing pad, or any other communication devices were observed readily available at Resident 107's bedside.</p> <p>During an observation on 6/10/2024 at 10:13 a.m., in Resident 107's room, a Licensed Vocational Nurse (LVN) 1 entered Resident 107's room holding a blood pressure machine. LVN 1 approached Resident 107, pointed at her (LVN 1's) own arm, and told Resident 107 that she was to check the resident's blood pressure. LVN 1 showed Resident 107 the machine. LVN 1 did not use any communication device to communicate with or explain the care to be provided to Resident 107. LVN 1 then directed Resident 107 to the bed using hand gestures and checked Resident 107's blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview, on 6/10/2024 at 10:14 a.m., with LVN 1, in Resident 107's room, LVN 1 was observed providing care to Resident 107. LVN 1 stated staff used hand gestures or wrote with pen and paper to communicate with Resident 107. LVN 1 told Resident 107 she was going to go through Resident 107's belongings, then proceeded to go through Resident 107's bedside dresser. Resident 107 frowned while LVN 1 went through her belongings. LVN 1 did not use any communication board, pen, paper, or any other communication device to explain her actions to Resident 107. LVN 1 exited the room and did not communicate further with Resident 107.</p> <p>During an observation on 6/10/2024 at 10:18 a.m., in Resident 107's room, Resident 107 was observed pacing at her bedside and pointing at her eyes and ears.</p> <p>During an observation on 6/11/2024 at 9:04 a.m., in Resident 107's room, Resident 107 was observed sitting upright in bed, staring at the wall across from her bed. There were no communication boards, writing pads, or other communication devices readily observed at her bedside.</p> <p>During an interview on 6/11/2024 at 9:16 a.m., with the Director of Staff Development (DSD), outside of Resident 107's room, the DSD stated there were no staff trained or certified in ASL. The DSD stated Resident 107 was one of the facility's first residents with severe hearing impairment. When asked how Resident 107 communicated or expressed her needs, the DSD stated Resident 107 made gestures with her hands and arms. When asked how staff communicated with Resident 107, or explained the care provided, the DSD stated staff also used hand gestures. The DSD stated hand gestures were not a reliable method of communication. The DSD stated Resident 107 also had visual impairments. The DSD stated the Social Services Assistant (SSA) attempted to set up interpreter services for Resident 107 but was unsure of the outcome.</p> <p>During a concurrent observation and interview on 6/11/2024 at 9:20 a.m., at Resident 107's bedside, with the DSD, the DSD was observed going through Resident 107's bedside dresser. The DSD removed a printed communication board from the drawer. When the DSD was asked to demonstrate how the communication board was used to communicate with Resident 107, the DSD stated Resident 107 did not use the communication board. The DSD stated FM 1 previously informed the facility that Resident 107 used ASL. Resident 107 was observed attempting to communicate through hand gestures with the DSD. The DSD was observed attempting to understand what Resident 107 was trying to communicate by verbally asking Resident 107 what she needed, in an attempt to illicit a response from Resident 107. The DSD did not use a written communication method or communication device to communicate with Resident 107. Resident 107 rolled her eyes and continued to make hand gestures, then proceeded to grab the DSD's arm and guided the DSD out of the room to the nurse's station. At the nurse's station, Resident 107 gestured to her stomach and the DSD stated Resident 107 was hungry. The DSD then redirected Resident 107 back to her room. The DSD did not communicate any plan of action to Resident 107 related to Resident 107's alleged hunger.</p> <p>During an interview on 6/11/2024 at 9:23 a.m., in Resident 107's room, with the DSD, the DSD stated staff were trying the best they could with the tools they had available. The DSD stated it was not safe for Resident 107 to rely on communicating with staff through unofficial hand gestures when her preferred method of communication was ASL.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/2024 at 10:01 a.m., with CNA 1, CNA 1 stated she was not aware of the Telecommunications Relay Service (TRS- a service that allows persons who are deaf, hard of hearing, deafblind, or with speech disabilities to communicate by telephone in a way that is equivalent to telephone services used by persons without such disabilities), text telephones (TTY- a device that enables individuals who are deaf, hard of hearing or who have a speech impairment to make and receive telephone calls), or Telecommunications Devices for the Deaf (TDD-special telecommunications equipment used by people who cannot use a regular telephone due to hearing loss or speech impairment). CNA 1 stated she had not received training on how to use the devices and was not aware if the devices were available for the residents.</p> <p>During an interview on 6/13/2024 at 11:41 a.m., with the MDS Nurse (MDSN), the MDSN stated she was responsible for the admission process and ensuring the services required of the resident were readily available prior to admitting the resident to the facility. The MDSN stated staff were aware of Resident 107's hearing impairment and aware the facility did not have interpreter services available, even before the resident was admitted to the facility. The MDSN stated the facility planned to rely on Resident 107's FM 1 as an interpreter. The MDSN stated interpreter services should have been available prior to accepting Resident 107 to the facility, and Resident 107 should not have been admitted without the necessary services available.</p> <p>During a concurrent observation and interview, on 6/12/2024 at 11:59 a.m., with CNA 2, in Resident 107's room, a binder was observed on Resident 107's bedside table. The ASL alphabet and associated hand gesture to communicate the specific letters, were printed on a piece of paper on the front of the binder. CNA 2 stated the tool was intended to be used to communicate with Resident 107. CNA 2 stated she did not know how to use the tool and did not know ASL. During the interview, Resident 107 was observed pointing to the ASL hand gestures and gesturing with her own hands. CNA 2 stated she could not understand what Resident 107 was trying to communicate. When asked if Resident 107 wore glasses, CNA 2 stated she was not sure. CNA 2 told Resident 107 that she was going to check the resident's bedside dresser for glasses. CNA 2 did not use the printed ASL graphic, a written communication method, or any other communication device to explain to Resident 107 what she was doing. CNA 2 went through Resident 107's belongings and stated Resident 107 did not have any glasses. After going through the bedside dresser, CNA 2 continued to communicate verbally to Resident 107. CNA 2 stated staff were supposed to explain all care and services provided, and it was not sufficient to use unofficial hand gestures to communicate with Resident 107.</p> <p>During an interview on 6/12/2024 at 12:12 p.m., with FM 1, FM 1 stated she was Resident 107's responsible party. FM 1 stated the facility contacted her through video calls whenever they need to and twice a month, if that. FM 1 stated Resident 107's preferred communication method was ASL, and stated the facility informed her they were using a relay service to communicate with Resident 107 during daily provision of care. FM 1 stated Resident 107 could not read small text and wore glasses. FM 1 stated Resident 107's vision was very bad. FM 1 stated Resident 107 had the physical capability to write but could not write or spell well. FM 1 stated she recommended the use of a TRS to the facility as a method for communicating with Resident 107. FM 1 stated that during her video calls with Resident 107, Resident 107 used ASL to express to FM 1 that facility staff did not understand what she was saying to them when she tried to explain her needs. FM 1 stated she could tell Resident 107 was frustrated based on her facial expressions. FM 1 stated Resident 107 asked her multiple times if she could go home. FM 1 stated Resident 107 appeared to be in distress during the conversations and FM 1 felt bad.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>During an interview and record review, on 6/12/2024 at 12:35 p.m., with the MDSN, Resident 107's MDS dated [DATE], and care plan titled The resident has a communication problem related to expressive aphasia, and hearing deficit, dated 4/13/2024 and revised 5/23/2024, were reviewed. The MDSN stated she conducted the MDS assessment dated [DATE]. The MDSN stated the assessment indicated Resident 107 was sometimes understood, sometimes understood others, and had moderate visual impairment. When asked how the assessment was conducted, the MDSN stated she wrote questions on a piece of paper and asked Resident 107 to provide her responses in writing. The MDSN stated she did not verify Resident 107 if could read or understand the written questions to provide an accurate response. The MDSN stated Resident 107's degree of visual impairment was moderate and determined using her own judgment and not through a formal assessment. The MDSN stated, It was kind of hard to assess her vision. The MDSN stated the purpose of the MDS was to indicate the level of care and services required for the resident. The MDSN stated the MDS assessment also guided the care plan and should be as accurate as possible. The MDSN stated Resident 107's care plan included utilization of a communication board (a sheet of symbols, pictures, or photos that someone can point to, to communicate with those around them) and a writing tablet as needed. The MDSN stated she could not explain why the care plan had not been revised when it became apparent that the intervention was not effective. The MDSN stated there was no documentation in the record to indicate what had been done to address the communication challenges with Resident 107 when the communication board and writing tablet were determined to be ineffective. The MDSN stated not only was it frustrating for Resident 107 to be unable to express herself or understand others but it was also a safety concern.</p> <p>During an interview on 6/12/2024 at 1:29 p.m., with the DSS and the Social Services Assistant (SSA), the SSA stated on 6/6/2024, she attempted to use a phone application for interpretation which allowed Resident 107 to video chat with a live interpreter, for the first time. The SSA stated the phone application was not currently available for staff's use. The SSA stated the facility had a portable computer tablet to use but she had to look for its charger. The DSS stated video calls with FM 1 were the most effective method to communicate with Resident 107. The DSS stated an inability to communicate could cause Resident 107 to experience anxiety and frustration.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lighthouse Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Santa Ana Blvd. Los Angeles, CA 90059	
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on 6/13/2024 at 12:12 p.m., with the DON, Resident 107's Admission Record, and nursing progress notes dated 4/12/2024 to 6/13/2024, the medical record titled Change in Condition Evaluation (COC), dated 4/18/2024, the facility's P&P titled Communication Barriers, dated 4/5/2023, the P&P titled Translation or Interpretation Services, dated 6/1/2021, and Resident 107's GACH 1 H&P, dated 4/8/2024, were reviewed. The DON stated the progress notes indicated staff were aware of Resident 107's preference to communicate using ASL, and Resident 107 displayed signs of frustration, agitation, and restlessness due to her inability to communicate with the staff. The DON stated the COC, dated 4/18/2024, indicated Resident 107 attempted to leave the facility and that attempts to redirect Resident 107 were less effective due to communication barriers. The DON stated staff should have been able to communicate with Resident 107. The DON stated she was aware since Resident 107's admission to the facility, that staff had difficulty communicating with the resident. The DON stated it was reasonable that Resident 107 wanted to elope due to an inability to communicate or understand others. The DON stated clear communication was important for staff to identify and address Resident 107's needs. The DON stated it was a safety concern if Resident 107 could not communicate her needs with the staff. The DON also stated lack of clear communication could lead to inaccurate assessments of Resident 107's clinical condition, and negatively impact the plan of care. The DON stated Resident 107's psychosocial well-being could also be negatively affected, and Resident 107 could suffer anxiety and frustration. The DON stated the facility's P&P, dated 4/5/2023, indicated interpreter services should have been available to Resident 107. The DON stated the facility did not provide interpreter services and did not have access to any interpreter services. The DON stated she assumed Resident 107 could communicate by writing but she did not verify with GACH 1. The DON stated the facility's P&P dated 6/1/2021 indicated staff should not rely on family members for translation services.</p> <p>A review of the facility's policy and procedure (P&P) titled RAI Process - MDS Assessments, Processing and Documentation, dated 1/1/2012, indicated the purpose of the policy was to provide residents assessment that accurately depict and identify resident-specific issues and objectives. The P&P indicated the MDS was a part of the Resident Assessment Instrument (RAI) and indicated the RAI included an accurate reflection of the resident's status.</p> <p>A review of the facility's policy and procedure (P&P) titled Behavior - Management, dated 1/1/2012, indicated staff will perform an appropriate assessment of the resident's behavioral symptoms and implemented appropriate interventions. The P&P indicated when a resident displayed new behavioral symptoms, staff would implement non-pharmacologic interventions to alleviate possible causative factors and use effective verbal and non-verbal communication techniques to manage the behavior problems, prior to initiating psychotropic medications. The P&P indicated possible interventions included addressing psychosocial stressors and medical conditions.</p> <p>A review of the facility's P&P titled Admission of Patients, undated, indicated the facility was supposed to accept and retain only those patients for whom the facility can provide adequate care.</p> <p>A review of the facility's policy and procedure titled Care Planning, dated 5/1/2018, indicated it was the facility policy to ensure that a comprehensive, person-centered care plan was developed for each resident based on their individually assessed needs, and changes made to the care plan on an ongoing basis as needed. The P&P indicated the care plans should describe the services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's P&P titled Translation or Interpretation Services, dated 6/1/2021, indicated the purpose of the P&P was to ensure residents who have hearing deficiencies have the same access to Facility services as other residents. The P&P indicated family members and friends were not to be relied upon to provide interpretation services for the resident.</p> <p>A review of the facility's P&P titled Communication Barriers, dated 4/5/2023, indicated the facility was responsible for providing effective interpretation or arranging for a qualified interpreter when needed. The P&P indicated if an interpreter was needed the facility was responsible for maintaining a list of qualified interpreters and coordinating services with the qualified interpreter. The P&P indicated the facility was supposed to provide language assistance and auxiliary aids, as appropriate, to residents who had a hearing, visual, or speech disability. The P&P indicated that upon hire and at least annually, facility staff were supposed to be trained to provide access to interpreter services by referring residents to social services.</p> <p>A review of the facility's P&P titled Resident Rights - Accommodation of Needs, dated 5/1/2023, indicated it was the facility's policy to ensure that the facility provided an environment and services that met the resident's individual needs. The P&P further indicated facility staff were supposed to interact with the resident in a way that accommodated the physical or sensory limitations of the residents, promoted communication, and maintained the resident's dignity.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092</p> <p>Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer (a wound that develops from prolonged pressure depriving the tissue from receiving oxygen) for one out of three residents (Resident 58).</p> <p>The deficient practice had the potential to cause serious infection, tissue injury, and extreme discomfort to Resident 58.</p> <p>Findings:</p> <p>A review of Resident 58's Admission Record indicated the facility originally admitted Resident 58 on 2/11/2021, and most recently readmitted Resident 58 on 4/12/2024. Resident 58's admitting diagnoses included carcinoma (cancer) of the anus (the opening at the far end of the digestive tract through which stool leaves the body) and anal canal (a channel connecting the rectum to the anus), chronic ulcerative proctitis (an inflammatory disease involving only the rectum), and adult failure to thrive (a weight syndrome with decreased appetite, poor nutrition, and inactivity).</p> <p>A review of Resident 58's History and Physical (H&P), dated 4/12/2024, indicated Resident 58 had the capacity to understand and make decisions.</p> <p>A review of Resident 58's baseline (a minimum starting point used for comparison) assessment titled Light Comprehensive Assessment, dated 4/12/2024, indicated Resident 58 had no skin break down (opening of the skin) or pressure ulcers upon admission.</p> <p>A review of Resident 58's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/24/2024, indicated Resident 58 required total assistance with all activities of daily living (self care activities performed daily) such as eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene.</p> <p>A review of Resident 58's Light Wound Weekly Observation Tool, dated 5/11/2024, indicated Resident 58 developed a wound on the sacrum (lower back) which measured 3 centimeters (cm, unit of measurement) (in length) by (x) 3 cm (in width) x 0.1 cm (in depth) in size.</p> <p>A review of Resident 58's Light Wound Weekly Observation Tool, dated 5/15/2024, indicated Resident 58 wound on the sacrum had increased in width and the new measurements were 2.4 cm x 4.5 cm.</p> <p>A review of Resident 58's Light Wound Weekly Observation Tool, dated 6/5/2024, indicated Resident 58 wound on the sacrum had increased in overall size, measuring 5.4 cm x 6.4 cm x 1.2 cm.</p> <p>A review of Resident 58's care plan for Pressure Ulcers, dated 5/15/2024, indicated Resident 58 had an unstageable (unable to determine the depth, degree, and severity of the wound) pressure ulcer to the sacrum. The care plan indicated Resident 58's health goal was to heal the wound and remain free from infection by turning and repositioning Resident 58 at least once every two (2) hours and more often as needed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 58's Physicians Orders, dated 6/5/2024, indicated Resident 58's unstageable pressure ulcer was to be treated with Santyl ointment (a topical wound care treatment that breaks down unhealthy tissue that prevents wound healing) daily. The order further indicated to clean Resident 58's wound with normal saline, and to cover with a dry dressing. The physician orders for Resident 58 did not include a skin barrier or protectant cream for incontinence related moisture of urine and feces.</p> <p>A review of Resident 58's care plan titled Stage 4 (a wound so deep it reaches the bone) Pressure Ulcer of the Sacrum dated 6/6/2024, indicated for staff to monitor for effectiveness of treatments and to inform the physician for wound improvements and declines.</p> <p>A review of Resident 58's care plan titled Poor Healing of Stage 2 (a pressure ulcer that exceeds the dermis with partial thickness loss) dated 6/11/2024, indicated Resident 58's health goal was to show signs of healing on the sacral (sacrum) wound. There were no staff interventions/approaches indicated on the care plan.</p> <p>During an observation on 6/10/2024 at 10:12 a.m., Resident 58 was observed bedbound and asleep on an air mattress (a mattress used to relieve pressure for bedbound residents).</p> <p>During an interview on 6/12/2024 at 9:52 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 58 was last admitted to the facility on [DATE] without wounds. RNS 1 stated a wound was discovered on Resident 58 on 5/11/2024 while under the facility's care. RNS 1 stated Resident 58 constantly had feces coming out of her anus which made it hard to keep the resident skin clean and dry. RNS 1 stated Resident 58's care plan did not indicate any interventions for increased frequency of incontinence care or any moisture barrier creams. RNS 1 stated due to Resident 58's situation more frequent skin checks and cleaning was warranted.</p> <p>During an interview on 6/12/2024 at 2:10 p.m., with the Director of Nursing (DON), the DON stated Resident 58 developed a wound under the facility's care. The DON stated due to Resident 58's situation the resident should be turned and skin checked more frequently, however it was not part of their plan of care. The DON was not able to determine what stage Resident 58's wound was due to care plan discrepancies (one care plan indicated a Stage 4 and another indicated a Stage 2).</p> <p>During an interview on 6/12/2024 at 2:36 p.m., with the Treatment Nurse (TXN), the TXN stated Resident 58's sacral wound was currently a Stage 3 (full thickness loss with a depth that can reach the fat tissue layer) because she was able to see subcutaneous (fat) tissue.</p> <p>During an interview on 6/13/2024, at 8:51 a.m., with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 58 had a small amount of blood and liquid feces constantly coming out of her anus. CNA 7 stated as soon as she changed and repositioned Resident 58, the resident would become wet from a combination of blood and feces. CNA 7 stated she changed and repositioned Resident 58 every 2 hours.</p> <p>A review of the facility's policy and procedure (P&P) titled Pressure Ulcer Management Protocol, dated 3/2010, indicated to primarily prevent ulcers by:</p> <ul style="list-style-type: none"> a. Risk Assessment b. Relieve Pressure <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Good Skin Care</p> <p>d. Nutritional Assessment</p> <p>e. Incontinence Assessment</p> <p>d. Resident Mobility</p> <p>F. Resident & Family Education.</p> <p>The P&P indicated for pressure ulcers that are a Stage II (2), Stage III (3), and Stage IV (4) interventions should include:</p> <p>a. Repositioning in bed every 1-2 hours and chair every 30 minutes to 2 hours.</p> <p>b. Hydrotherapy (a method that uses water to treat a variety of conditions) and/or showers up to 3 times a week unless contraindicated.</p> <p>c. Lubrication of the skin with body lotions to enhance pliability of skin and minimize risk.</p> <p>d. Dietary interventions with particular attention to protein, vitamin C, fluid intake, and nutritional supplements as indicated.</p> <p>The P&P further indicated a bowel and bladder management regime, good perineal (private region) care, and use of protective moisture barrier creams as indicated are part of the interventions.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092</p> <p>Based on observation, interview, and record review, the facility failed to keep the environment free from hazardous maintenance tools and nails in the room for two out of eight residents (Resident 10 and Resident 51).</p> <p>The deficient practice had the potential to cause injury to Resident 10 and 51 by coming into direct contact with sharp objects.</p> <p>Findings:</p> <p>a. A review of Resident 10's Admission Record indicated the facility originally admitted Resident 10 on 7/22/2016, and most recently readmitted Resident 10 on 12/21/2022. Resident 10's admitting diagnoses included dementia (a brain disease that effects memory and cognitive function, interfering with daily life), schizophrenia (a mental disorder characterized by disorganized and delusional thinking, and auditory or visual hallucinations), and bipolar disorder (a mood disorder with manic and depressive episodes).</p> <p>A review of Resident 10's History and Physical (H&P), dated 12/19/2022, indicated Resident 10 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 10's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/1/2024, indicated Resident 10 was mildly cognitively impaired (ability to think and reason). The MDS indicated Resident 10 required total assistance with toileting hygiene, showering/bathing, and personal hygiene.</p> <p>b. A review of Resident 51's Admission Record indicated the facility originally admitted Resident 51 on 11/07/2017, and most recently readmitted Resident 51 on 5/23/2024. Resident 51's admitting diagnoses included multiple sclerosis (a progressive disease in which the immune system eats away at the protective covering of nerves causing weakness and immobility).</p> <p>A review of Resident 51's H&P, dated 5/24/2024, indicated Resident 51 had the capacity to understand and make decisions.</p> <p>A review of Resident 51's MDS, dated [DATE], indicated Resident 51 was cognitively intact. The MDS indicated Resident 51 had required total assistance with all activities of daily living such as eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene.</p> <p>During an observation on 6/10/2024, at 10:49 a.m., inside Resident 51 and Resident 10's shared room, Resident 51 and Resident 10 were observed asleep. There was a rolling cart with used nails, screws, a wood [NAME], and other unidentifiable sharp objects exposed and within reach.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2024 at 10:55 a.m., with Maintenance Assistant (MA) 1, MA 1 stated his tools were in Resident 10 and Resident 51's room because the floor needed to be fixed, but he had to step away for 5 minutes. MA 1 stated leaving unattended tools and sharp objects was a safety concern for the residents.</p> <p>During an interview on 6/12/2024 at 10:26 a.m., with Registered Nurse (RN) 1, RN 1 stated when maintenance staff performed work in a resident room, they must remove their tools and not leave them in the room unattended, even for short periods because it was unsafe for residents. RN 1 stated a resident could take the instrument and use it on themselves, hide or, or use it on others.</p> <p>During an interview on 6/12/2024 at 10:32 a.m., with the Maintenance Supervisor (MS), the MS stated when maintenance staff worked in resident areas or in resident rooms, they must take their tools with them, and put it somewhere safe and inaccessible to residents to prevent possible resident injury.</p> <p>During an interview on 6/12/2024 at 1:55 p.m., with the Director of Nursing (DON), the DON stated when maintenance staff performed work inside a resident room they could not leave tools in the room because it could cause an injury to residents.</p> <p>A review of the facility's policy and procedure (P&P) titled Safety Committee - Composition and Duties, dated 5/1/2018, indicated the purpose of the policy was to promote the quality of resident care and safety by monitoring safe practices. The P&P indicated that staff are to:</p> <ol style="list-style-type: none"> a. Maintain facility grounds in a manner to allow for the safety of residents and facility risks. b. Identify hazardous areas and unsafe work practices and recommend corrective action. 		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>47286</p> <p>Based on observation, interview, and record review, the facility failed to implement the Registered Dietician's (RD, a health professional who has special training in diet and nutrition) recommendations for one of 25 sampled residents (Resident 66), when staff were unaware of recommendations for Resident 66 to be initiated on a Restorative Nursing Aid (RNA, a certified nursing assistant primarily assigned to perform therapeutic exercises and activities to maintain or re- establish a resident's optimum physical function and abilities) feeding program (a medical and nutritional treatment regimen to aid those with nutritional concerns).</p> <p>This deficient practice increased the risk for Resident 66 to sustain further weight loss and not meet his nutritional needs.</p> <p>Findings:</p> <p>A review of Resident 66's Admission Record indicated the facility originally admitted Resident 66 on 7/9/2021, and most recently readmitted the Resident 66 on 1/27/2023. Resident 66's admitting diagnoses included generalized muscle weakness and dysphagia (difficulty swallowing).</p> <p>A review of Resident 66's History and Physical (H&P), dated 2/5/2024, indicated Resident 66 had the capacity to understand and make decisions.</p> <p>A review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 5/26/2024, indicated Resident 66 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 66 required set-up or clean-up assistance from staff to eat.</p> <p>A review of Resident 66's care plan, dated 4/5/2024 and revised 5/31/2024, indicated Resident 66 was at risk for complications in health status due to his history of weight loss and fluctuating weight. The care plan indicated the goals of care included minimization of repeat significant weight loss. The staff interventions indicated dietary consultations as needed, assessment of Resident 66's need for further nutritional support, and to assist with meals to encourage increased meal intake.</p> <p>A review of Resident 66's Dietary Progress Note, dated 6/10/2024, indicated Resident 66 sustained a 39 pound (lb.) weight loss in the last six months due to variable oral intake (nutrition consumed by mouth). The progress note indicated the Registered Dietician (RD) recommended Resident 66 be initiated on a RNA feeding program for breakfast and lunch to promote increased oral intake and weight stabilization.</p> <p>A review of Resident 66's active physician orders did not indicate any orders for RNA feeding program.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/2024 at 8:54 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 66 was receiving a pureed diet (a diet where the food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) and fed himself. CNA 4 stated she set-up Resident 66's breakfast tray in the morning and did not assist with or supervise Resident 66 for breakfast.</p> <p>During a concurrent observation and interview, on 6/11/2024 at 1:02 p.m., in Resident 66's room, Resident 66 was observed sitting up in bed, with his lunch tray on his bedside table, placed directly in front of him. Resident 66 stated he was feeding himself. No staff were observed at the bedside to assist Resident 66 to eat, or to supervise the resident while eating.</p> <p>During an interview on 6/11/2024 at 1:04 p.m. with CNA 4, CNA 4 stated Resident 66 was not on a feeding program and stated Resident 66 fed himself.</p> <p>During a concurrent interview and record review on 6/11/2024 at 1:13 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 66's dietary progress note dated 6/10/2024 was reviewed. RNS 1 stated the progress note indicated Resident 66 was supposed to be on a RNA feeding program. RNS 1 stated she was not aware of this progress note, or the RD's recommendations. RNS 1 stated that if Resident 66 was not on an RNA feeding program as recommended by the RD, Resident 66 was at risk for further weight loss.</p> <p>During an interview on 6/11/2024 at 1:19 p.m., CNA 1, CNA 1 stated she worked as a RNA in the facility and was responsible for implementing the RNA feeding program for any residents that required it. CNA 1 stated Resident 66 was not included in the residents seen for the RNA feeding program for breakfast or lunch.</p> <p>During a concurrent interview and record review, on 6/11/2024 at 2:18 p.m., with the Director of Nursing (DON), Resident 66's dietary progress note, dated 6/10/2024, and the current physician orders were reviewed. The DON stated that when the RD recommended to start a resident on a RNA feeding program, the recommendation was entered as an order to be carried out by the staff. The DON stated she was unaware of the recommendations made by the RD and stated there were no orders for Resident 66 to be started on an RNA feeding program. The DON stated the RNA feeding program was an intervention utilized when a resident had experienced weight loss and poor oral intake. The DON stated the RNA feeding program required RNAs to provide supervision to the residents during meals, encourage oral intake, and/or feed the residents if needed. The DON stated the RNA program was to aid in the prevention of further weight loss.</p> <p>During an interview on 6/12/2024 at 11:00 a.m., with the RD, the RD stated that timeliness in following up on the dietary recommendations made for the facility residents could make a difference in the residents' outcomes, including their nutritional status.</p> <p>A review of the facility's job description titled Job Descriptions Job Title: [Registered Nurse] Supervisor, dated 12/14/1998, indicated the RNS was responsible for monitoring all documentation necessary for quality patient care.</p>		

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 06/13/2024
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the facility failed to assess the medical need, obtain a physician order, and informed consent for the use of bed side rails for nine of nine sampled residents (Resident 93, Resident 40, Resident 13, Resident 36, Resident 112, Resident 66, Resident 71, Resident 88, and Resident 16).</p> <p>These deficient practices had the potential to place Residents 93, 40, 13, 36, 112, 66, 71, 88, and 16 at risk for accidents, injury, and hazards such as entrapment and falls.</p> <p>Findings:</p> <p>a. During an observation on 6/10/2024 at 10:36 a.m., in Resident 93's room Resident 93's bed was observed with the bilateral (pertaining to both sides) siderails up.</p> <p>A review of Resident 93's Admission Record indicated Resident 93 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 93's diagnoses included chronic obstructive pulmonary disease ([COPD] a chronic lung disease that causes obstructed airflow from the lungs) and chronic kidney disease (loss of kidney function).</p> <p>A review of Resident 93's Minimum Data Set ([MDS] a standardized assessment and care planning tool), dated 3/14/2024, indicated Resident 93's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 93 required moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower, and personal hygiene.</p> <p>b. During an observation on 6/10/2024 at 10:47 a.m., in Resident 40's room, Resident 40 was observed lying in bed. Resident 40's bed had bilateral siderails in the up position.</p> <p>A review of Resident 40's Admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included COPD, epilepsy (abnormal electrical brain activity), muscle weakness (loss of muscle strength), schizophrenia (serious mental illness that effects how a person thinks, feels, and behaves), and anxiety (feeling of fear, restlessness, and excessive worry).</p> <p>A review of Resident 40's MDS, dated [DATE], indicated Resident 40's cognitive skills for daily decision making was impaired. The MDS indicated Resident 40 required moderate assistance (helper does less than half the effort) from staff for toileting hygiene, and shower. The MDS indicated Resident 40 required supervision (the helper provides verbal cues, touching contact as resident completes activity) for oral hygiene, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/11/2024 at 12:00 p.m., in Resident 40's room, Resident 40 was observed sitting on the bed and watching television. Resident 40's bilateral siderails were in the up position. Resident 40 stated he would like to have more space around the bed and be able to sit by the window and enjoy the view on the outside patio. Resident 40 stated he was not aware why his bed had siderails and stated he did not need siderails.</p> <p>c. During an observation on 6/10/2024 at 11:21 a.m., in Resident 13's room, observed Resident 13's bed with the bilateral (pertaining to both sides) siderails up.</p> <p>A review of Resident 13's Admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included dementia (a loss of brain function such as memory, language, thinking), dysphagia (difficulty swallowing), Parkinson's disease (a brain disorder that cause uncontrollable movements, such as shaking, and difficulty with balance), and schizophrenia.</p> <p>A review of Resident 13's MDS, dated [DATE], indicated Resident 13 had moderate impairment in cognitive skills for daily decision making. The MDS indicated Resident 13 required assistance from staff for activities of daily living (ADLs, self care activities performed daily such as dressing, toileting, personal hygiene, and bathing).</p> <p>d. During an observation on 6/10/2024 at 12:06 a.m., in Resident 36's room, Resident 36's bed was observed with the bilateral siderails up.</p> <p>A review of Resident 36's Admission Record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 36's diagnoses included dementia, anxiety, epilepsy, and diabetes (high blood sugar).</p> <p>A review of Resident 36's MDS, dated [DATE], indicated Resident 36 cognitive skills for daily decision making was impaired. The MDS indicated Resident 36 required moderate assistance from staff for toileting hygiene, shower, and personal hygiene.</p> <p>e. During a concurrent observation and interview on 6/10/2024 at 12:58 p.m., in Resident 112's room, Resident 112 was observed sitting on the bed. Resident 112's bed was had bilateral siderails in the up position. Resident 112 stated she did not need siderails and was not aware why her bed had siderails.</p> <p>A review of Resident 112's Admission Record indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses included schizophrenia and seizures (a medical condition caused by abnormal electric activity in the brain).</p> <p>A review of Resident 112's MDS, dated [DATE], indicated Resident 112's cognitive skills for daily decision making was intact. The MDS indicated Resident 112 required supervision (the helper provides verbal cues, touching contact as resident completes activity) for toileting hygiene, dressing, showering, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/12/2024 at 11:15 a.m., with Registered Nurse Supervisor (RNS) 1, Residents 93's, 40's, 13's, 36's, and 112's Electronic Medical Record (EMR) was reviewed. RNS 1 stated the facility implemented siderails for residents' safety and mobility. RNS 1 stated siderails use should have a physician order and informed consent. RNS 1 stated Residents 93, 40, 13, 36, and 112's EMR indicated there were no assessments of the medical need for the siderails prior to the use of the siderails. RNS 1 stated there were no physician order's or informed consent obtained for the use of siderails.</p> <p>47286</p> <p>f. A review of Resident 66's Admission Record indicated the facility originally admitted Resident 66 on 7/9/2021, and most recently readmitted the Resident 66 on 1/27/2023. Resident 66's admitting diagnoses included unspecified abnormalities of gait (manner of walking) and mobility, generalized muscle weakness, and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>A review of Resident 66's H&P, dated 2/5/2024, indicated Resident 66 had the capacity to understand and make decisions.</p> <p>A review of Resident 66's MDS, dated [DATE], indicated Resident 66 had moderate cognitive impairment. The MDS indicated Resident 66 required supervision or touching/steadying by staff to reposition himself in bed, transition from sitting to lying position and vice versa, transition from sitting to standing, and transfer from bed to chair and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 66's active physician orders did not indicate any orders for the use of bedrails.</p> <p>A review of Resident 66's care plans did not indicate a care plan had been developed for the use of bed rails.</p> <p>During an observation on 6/11/2024 at 8:39 a.m., at Resident 66's bedside, Resident 66's bed was observed with bed rails to the right and left side of Resident 66's bed.</p> <p>During a concurrent observation and interview on 6/11/2024 at 1:22 p.m., at Resident 66's bedside, with RNS 1, RNS 1 observed Resident 66's bed rails. RNS 1 verified Resident 66 had bed rails on both sides of the bed.</p> <p>During a concurrent interview and record review, on 6/13/2024 at 10:22 a.m., with RNS 1, Resident 66's assessments were reviewed. RNS 1 stated Resident 66 did not have a Bed Rail Entrapment Risk Assessment.</p> <p>g. A review of Resident 71's Admission Record indicated the facility originally admitted Resident 71 on 1/10/2013, and most recently readmitted the Resident 71 on 4/12/2024. Resident 71's admitting diagnoses included unspecified abnormalities of gait and mobility, generalized muscle weakness, and encephalopathy (a broad term for any brain disease that alters brain function or structure).</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 71's H&P, dated 4/17/2024, indicated Resident 71 had the capacity to understand and make decisions.</p> <p>A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had severe cognitive impairment. The MDS indicated Resident 71 required partial to moderate assistance from staff to roll left and right in bed, transition from a sitting to lying position and vice versa, transition from a sitting to standing position and vice versa, and transfer from a chair to bed and vice versa. The MDS did not indicate the use of bedrails.</p> <p>A review of Resident 71's active physician orders did not indicate any orders for the use of bedrails.</p> <p>A review of Resident 71's care plans did not indicate a care plan had been developed for the use of bedrails.</p> <p>During an observation on 6/11/2024 at 9:14 a.m., at Resident 71's bedside, Resident 71's bed was observed with bed rails to the right and left side of Resident 71's bed.</p> <p>During a concurrent interview and record review, on 6/13/2024 at 10:18 a.m., with RNS 1, Resident 71's assessments were reviewed. RNS 1 stated Resident 71 did not have a Bed Rail Entrapment Risk Assessment.</p> <p>During a concurrent interview and record review, on 6/13/2024 at 10:41 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Restraints, dated 5/1/2018 was reviewed. The DON stated the P&P indicated all residents were at risk for entrapment if bedrails were used and the residents should be assessed for risk of entrapment. The DON stated this assessment was not currently being done. The DON stated entrapment meant a resident was caught between the bed and the bedrail, and stated residents could sustain injuries if entrapment occurred.</p> <p>47679</p> <p>h. A review of Resident 88 Admission Record indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 88's diagnoses included encephalopathy, schizophrenia, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>A review of Resident 88's MDS, dated [DATE], indicated Resident 88 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 88's cognition was moderately impaired. The MDS indicated Resident 88 had impairments on both sides of his lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 88 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>A review of Resident 88's H&P, dated 7/4/2023, indicated Resident 88 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 88's Comprehensive Assessment, dated 10/13/2023, the Comprehensive Assessment indicated Resident 88 had left and right side rails which were indicated for safety and to promote independence with bed mobility. There was no indication that consent was received for bilateral (both sides) side rails.</p> <p>A review of Resident 88's active physician orders did not indicate any orders for the use of bedrails.</p> <p>During an observation on 6/10/2024 at 10:57 a.m. and on 6/11/2024 at 9:25 a.m., in Resident 88's room, Resident 88 was observed lying in bed, with the upper bilateral side rails up.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:22 p.m., with LVN 2, inside Resident 88's room, Resident 88 was lying in bed, with the upper bilateral side rails up. LVN 2 stated the use of side rails restricted Resident 88's movement and should not be used unless needed.</p> <p>i. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 16's diagnoses included encephalopathy, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and dementia.</p> <p>A review of Resident 16's MDS, dated [DATE], indicated Resident 16 was usually able to understand and be understood by others. The MDS indicated Resident 16's cognition was moderately impaired. The MDS indicated Resident 16 had impairments on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand) and on one side of the lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 16 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 16 used bed rails daily.</p> <p>A review of Resident 16's H&P, dated 1/16/2024, indicated Resident 16 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 16's Comprehensive Assessment, dated 2/8/2024, indicated Resident 16 had left and right-side rails. There was no indication for the use of the side rails nor indication that consent was received for bilateral side rails.</p> <p>During observations on 6/10/2024 at 10:23 a.m. and on 6/11/2024 at 9:27 a.m., in Resident 16's room, Resident 16 was observed lying in bed, with the upper bilateral side rails up.</p> <p>During a concurrent observation and interview on 6/11/2024 at 2:20 p.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 16's room, Resident 16 was observed lying in bed, with the upper bilateral side rails up. LVN 2 stated the use of side rails restricted Resident 16's movement and should not be used unless needed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2024 at 2:29 p.m., with LVN 2, LVN 2 stated Resident 16 and 88's use of bed rails was not appropriate because it restricted the resident's movements. LVN 2 stated these were mainly used for safety purposes, however, they should only be used as a last resort after utilizing less restrictive interventions such as closer monitoring. LVN 2 stated when a resident had side rails on their beds, they should be assessed for the appropriateness of the device and closely monitored to ensure their safety was upheld. LVN 2 stated if the bed rails were inappropriate for the resident and they were not closely monitored, the resident's were at risk of getting caught between the side rails and the bed which could cause injury or suffocation (death caused by not having enough oxygen).</p> <p>During an interview on 6/12/2024 at 10:46 a.m., with RNS 2, RNS 2 stated least restrictive methods should be utilized for residents, such as redirecting, assisting them with their needs, changing their surrounds, providing more supervision, or providing additional activities. RNS 2 stated when bed rails were utilized, the resident must be assessed that it was appropriate to use, and the residents must be monitored. RNS 2 stated if the residents were not properly monitored, complications, such as getting caught in the side rails and injury, could occur.</p> <p>During an interview on 6/13/2024 at 10:35 a.m., with the DON, the DON stated the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) would discuss the necessity of bed rails for the resident. The DON stated if the IDT approved the necessity for the use of bed rails, they would inform the resident's physician of the recommendation and discuss how the resident would benefit from the device. The DON stated prior to utilizing bed rails, the facility should be aware of the entrapment risk, and assess the space between the side rail and the bed to ensure there was no risk of the resident getting stuck in that space. The DON stated per their policy, an Entrapment Risk Assessment would be completed prior to the installation of bed rails. The DON stated this process was not done for Residents 16 and 88 for the utilization of bed rails which placed them at risk for injury.</p> <p>A review of the facility's policy and procedure (P&P) titled Siderails, revised 3/2010, indicated the facility was to use siderails based on the residents assessed medical needs. The P&P indicated a physician's order and signed release by resident is required. The P&P indicated the siderails were to be used for resident's mobility and /or transfer, and to protect the resident from falling out of bed.</p> <p>A review of the facility's P&P titled Restraints, revised 5/1/2018, indicated a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. This may include bed rails, beds against walls, restrictive clothing, etc. The P&P indicated residents shall be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measures shall be used. The P&P indicated informed consent will be obtained from the resident or responsible party if a restraint will be used. The P&P indicated if the facility is utilizing bed rails, a Bed Rail Entrapment Risk Assessment will be completed by a Licensed Nurse prior to the installation of bed rails. The P&P indicated the Interdisciplinary Care Team ([IDT] a group of healthcare professionals who work together to provide residents with the care they need) will discuss with the resident and/or resident representative the risk and benefits involved with bed rails and described alternatives that may be feasible prior to installing bed rails.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Behavior - Management, which indicated when a resident displayed new behavioral symptoms, staff would use effective verbal and non-verbal communication techniques to manage the behavior problems, prior to initiating psychotropic medications (medications used to treat anxiety) for one of one sampled residents (Resident 107), who was deaf and visually impaired. The facility failed to ensure:</p> <p>1. Resident 107's behavior was assessed using a communication board, writing pad, or American Sign Language (ASL, a language expressed by movements of the hands and face), to meet the resident's needs, prior to diagnosing Resident 107 with anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and administering lorazepam ([Ativan], a drug used to treat anxiety) to Resident 107 on 4/20/2024, 4/25/2024, and 5/3/2024.</p> <p>This deficient practice placed Resident 107 at risk for unnecessary medication and side effects associated with Ativan including headache, muscle weakness, sleep problems and loss of balance and coordination.</p> <p>Findings:</p> <p>A review of Resident 107's History and Physical (H&P) from a general acute care hospital (GACH) 1, dated 4/8/2024, indicated Resident 107 had a history of deafness, visual impairment/blindness, and dementia. The H&P did not indicate a diagnosis of anxiety disorder.</p> <p>A review of Resident 107's Admission Record indicated Resident 107 was admitted to the facility on [DATE]. Resident 107's admitting diagnoses included dementia (loss of memory, language, problem-solving and other thinking abilities), deaf, nonspeaking (lacking the power of hearing, or having impaired hearing), history of falling, and generalized muscle weakness. The Admission Record did not indicate a diagnosis of anxiety or anxiety disorder.</p> <p>A review of Resident 107's H&P, dated 4/17/2023, indicated Resident 107 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 107's Minimum Data Set (MDS, a standardized care-planning and care-screening tool), dated 4/19/2024, indicated Resident 107 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 107 had highly impaired hearing, did not speak, and had moderately impaired vision requiring the use of corrective lenses. The MDS indicated Resident 107 was unable to respond when asked how often she needed to have someone help her read instructions or written material. The MDS indicated Resident 107 exhibited rejection of care necessary to achieve goals for health and well-being for one (1) to three (3) days over a period of seven (7) days. The MDS indicated Resident 107 required partial to moderate assistance from staff for hygiene after toileting, dressing her upper body, personal hygiene activities, mobility while in bed, and transitioning between surfaces (bed to chair, getting on and off the toilet). The MDS indicated Resident 107 required verbal cues and/or touching/steadying assistance from staff when eating, brushing her teeth, dressing her lower body, putting on/taking off her shoes, and walking.</p> <p>A review of Resident 107's Progress Note, dated 4/12/2024 at 10:59 p.m., indicated Resident 107 had an episode of aggressive behavior due to frustration from inability to communicate her needs.</p> <p>A review of Resident 107's physician order, dated 4/12/2024, indicated to administer one (1) mg of lorazepam to be taken by mouth every four (4) hours as needed for anxiety for 14 days. This order was discontinued on 4/19/2024.</p> <p>A review of Resident 107's Admission Summary, dated 4/13/2024, indicated Resident 107 was admitted from GACH 1, was deaf and used American Sign Language (ASL, a language expressed by movements of the hands and face) to communicate. The Admission Summary dated 4/13/2024, indicated due to frustration from being unable to talk, Resident 107 spat water at the nursing staff who were attempting to assess her.</p> <p>A review of Resident 107's Progress Note, dated 4/14/2024, at 8:20 a.m., indicated Resident 107 was agitated (irritable, easily annoyed), displayed restlessness, walked up and down the hallway, and saying no one could understand her. The progress note did not indicate any attempts to assess Resident 107's preferred method of communication, or staff's attempts to communicate with the resident in her preferred method of communication.</p> <p>A review of Resident 107's Progress Note, dated 4/14/2024 at 9:59 p.m., indicated Resident 107 was observed with episodes of restlessness, wandering, and continuously trying to leave the facility. The progress notes further indicated Resident 107 was exhibiting increased frustration evidenced by her facial expressions. The progress note indicated Resident 107 was redirected to her room and placed under direct supervision. The progress note did not indicate any attempts to assess Resident 107's preferred method of communication, or staff's attempts to communicate with her in her preferred method of communication.</p> <p>A review of Resident 107's Progress Note, dated 4/15/2024 at 12:29 p.m., indicated Resident 107's family member (FM 1) notified staff that the effective way to communicate with Resident 107 was through ASL.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 107's Progress Note, dated 4/15/2024 9:29 p.m., indicated Resident 107 was agitated, restless, and communicating through hand gestures and no one could understand her. The progress note did not indicate any staff intervention to address Resident 107's agitation, restlessness, or any attempts to communicate with Resident 107 in her preferred method of communication, to meet her needs.</p> <p>A review of Resident 107's Progress Note, dated 4/17/2024 at 4:06 p.m., indicated Resident 107 wrote on pen and paper and indicated she wanted to go home.</p> <p>A review of Resident 107's Change in Condition Evaluation (COC), dated 4/18/2024 at 9:23 p.m., indicated Resident 107 was non-verbal and communicated in sign language. The COC indicated Resident 107 attempted to leave the facility. The COC indicated Resident 107 had episodes of restlessness and agitation. The COC indicated attempts to redirect the resident were less effective due to a communication barrier between Resident 107 and the staff. The COC indicated Resident 107 refused to go back to her room and continued to try to communicate in sign language and gestures. The COC did not indicate that attempts were made to communicate with Resident 107 in her preferred method of communication, or address Resident 107's restlessness and attempts to leave the facility.</p> <p>A review of Resident 107's physician order, dated 4/19/2024, indicated to administer one (1) mg of lorazepam to be taken by mouth every 14 hours as needed for anxiety for 14 days. This order was discontinued on 5/3/2024.</p> <p>A review of Resident 107's physician order, dated 4/13/2024 to 4/27/2024, indicated staff were to monitor Resident 107 for anxiety manifested by fidgeting or restlessness.</p> <p>A review of Resident 107's Progress Note, dated 5/2/2024 at 1:45 p.m., indicated Resident 107 was seen by Physician Assistant (PA) 1 on 4/18/2024. The progress note indicated Resident 107 presented as anxious and verbalized wanting to go home. The note further indicated PA 1's assessment indicated Resident 107 had anxiety disorder, and the plan of care included lorazepam (Ativan) 1 milligram (mg, a unit of measuring) every 12 hours as needed for anxiety for 14 days.</p> <p>A review of Resident 107's Progress Note, dated 5/5/2024 at 8:56 p.m., indicated Resident 107 was seen by PA 1 on 5/2/2024. The progress note indicated PA 1's assessment indicated Resident 107 had anxiety disorder and was to receive lorazepam 1 mg every 12 hours as needed for anxiety for 14 days.</p> <p>A review of Resident 107's Medication Administration Records (MAR), dated 4/1/2024 to 4/30/2024, and 5/1/2024 to 5/31/2024, indicated staff documented 16 episodes of anxiety manifested by fidgeting or restlessness, and administered four (4) doses of lorazepam to Resident 107 for anxiety on 4/20/2024, 4/25/2024, and twice on 5/3/2024.</p> <p>During an observation on 6/10/2024 at 10:10 a.m., in the doorway of Resident 107's room, Resident 107 was observed sitting up at the right edge of her bed with her back towards the door. Resident 107 did not respond to vocalized questions. Upon entering the room, Resident 107 vocalized unintelligible sounds, and pointed to her ears and her eyes. No communication board, writing pad, or other communication devices were observed readily available at Resident 107's bedside.</p> <p>During an observation on 6/10/2024 at 10:18 a.m., in Resident 107's room, Resident 107 was observed pacing at her bedside and pointing to her eyes and ears.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/12/2024 at 12:12 p.m., with FM 1, FM 1 stated she was Resident 107's responsible party. FM 1 stated the facility contacted her through video calls whenever they need to and maybe once or twice a month. FM 1 stated Resident 107's preferred communication method was ASL, and the facility informed her they were used a relay service to communicate with Resident 107 during daily provision of care. FM 1 stated Resident 107's vision was very bad, she could not read small print, and wore reading glasses. FM 1 stated Resident 107 could write but was unable to write or spell well. FM 1 stated she recommended the use of a Telecommunications Relay Service (a service that allows persons who are deaf, hard of hearing, deafblind, or with speech disabilities to communicate by telephone in a way equivalent to telephone services used by persons without such disabilities) to the facility as a method for communicating with Resident 107. FM 1 stated during her video calls with Resident 107, Resident 107 used ASL to notify FM 1 that the staff did not understand what she was saying to them each time she tried to explain her needs. FM 1 stated she could tell Resident 107 was frustrated based on her facial expressions. FM 1 stated Resident 107 asked her multiple times if she could go home, and FM 1 stated she had to change the subject because Resident 107 felt bad and appeared to be in distress during the conversations.</p> <p>During a telephone interview on 6/13/2024 at 8:41 a.m., with PA 1, PA 1 stated he was asked to assess Resident 107's behaviors and review and manage her psychotropic medications (medications that affect the mind, emotions, and behavior). PA 1 stated Resident 107 had dementia, deafness, and was non-verbal with periods of confusion. PA 1 stated Resident 107 attempted to leave the facility. PA 1 stated he was not trained or certified in ASL, and stated he assessed Resident 107 on 4/18/2024 and 5/2/2024. PA 1 stated on 4/18/2024 he was accompanied by an unspecified nursing staff who used an interpreter via video call to assist with interpreting Resident 107's responses. PA 1 stated he did not verify the identity or qualifications of the interpreter to ensure the assessment data collected was accurate. PA 1 stated he conducted the assessment on 5/2/2024 without the use of an interpreter. PA 1 stated he conducted the assessment by writing simple questions on a piece of paper, and asked Resident 107 to write yes or no in response to the questions. PA 1 stated he did not verify if Resident 107 could read or understand the questions. PA 1 stated his assessments were used to guide Resident 107's plan of care, and stated his assessments were supposed to be accurate, but he was unable to verify if the assessment data collected was accurate. PA 1 stated he should have used an interpreter, but he did not. PA 1 stated Resident 107 continued to receive Ativan to treat an anxiety disorder. PA 1 stated anxiety disorder can be an acute condition (a condition that is severe and sudden in onset) and likely caused by Resident 107's inability to communicate with others. PA 1 stated he was unsure if staff addressed the cause of Resident 107's anxiety prior to the administration of Ativan.</p> <p>During an interview on 6/13/2024 at 11:41 a.m., with the MDS Nurse (MDSN), the MDSN stated she was responsible for the admission process, including ensuring required services for each resident were readily available prior to admitting the resident to the facility. The MDSN stated prior to Resident 107's admission to the facility, staff were aware of Resident 107's hearing impairment, and the facility did not have interpreter services available. The MDSN stated the facility planned to rely on FM 1 as an interpreter, though it was not the facility's policy to rely on family members as interpreters. The MDSN stated interpreter services should have been available prior to accepting Resident 107 to the facility, and Resident 107 should not have been admitted without the necessary services available. The MDSN stated the facility was currently working on obtaining interpreter services, but there was still no service in place at the time of the interview.</p> <p>(continued on next page)</p>		

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<p>F 0758</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 6/13/2024 at 12:12 p.m., with the Director of Nursing (DON), Resident 107's Admission Record, undated, nursing progress notes dated 4/12/2024 to 6/13/2024, COC, dated 4/18/2024, and Resident 107's current and discontinued care plans, and Resident 107's discontinued physician orders for lorazepam, dated 4/12/2024 to 4/19/2024, and 4/19/2024 to 5/3/2024, were reviewed. The DON stated the Admission Record indicated Resident 107 was admitted on [DATE] and did not indicate a diagnosis of anxiety disorder. The DON stated the progress notes indicated staff were aware of Resident 107's preference to communicate using ASL, and Resident 107 displayed signs of frustration, agitation, and restlessness due to her inability to communicate with the staff. The DON stated there were no current or discontinued care plans to address Resident 107's anxiety. The DON stated there were no non-pharmacological (any type of healthcare intervention which is not primarily based on medication) interventions in place or previously attempted to address the cause of Resident 107's anxiety. The DON stated the COC, dated 4/18/2024, indicated Resident 107 attempted to leave the facility and attempts to redirect Resident 107 were less effective due to communication barriers. The DON stated she was aware when Resident 107 was admitted to the facility on [DATE], that staff had difficulty communicating with her (Resident 107). The DON stated it was reasonable that Resident 107 wanted to elope (when a person leaves unsupervised and undetected) due to an inability to communicate or understand others. The DON stated if Resident 107 could not communicate her needs, staff would not be able to meet the resident's needs. The DON also stated lack of clear communication could lead to inaccurate assessments of Resident 107's clinical condition, and negatively impact the plan of care. The DON stated Resident 107's psychosocial well-being could also be negatively affected, and Resident 107 could suffer anxiety and frustration.</p> <p>A review of the facility policy and procedure (P&P) titled Behavior - Management, dated 1/1/2012, indicated staff were supposed to perform an appropriate assessment of the resident's behavioral symptoms and implement appropriate interventions. The P&P indicated when a resident displayed new behavioral symptoms, staff would implement non-pharmacologic interventions to alleviate possible causative factors and use effective verbal and non-verbal communication techniques to manage the behavior problems, prior to initiating psychotropic medications. The P&P indicated possible interventions included addressing psychosocial stressors and medical conditions.</p> <p>A review of the facility P&P titled Psychotherapeutic Drug Management, dated 5/17/2024, indicated the purpose of the policy was to implement the most desirable and effective interventions to eliminate behaviors that were distressing to the resident, and/or decreasing or negatively impacting the resident's quality of life. The P&P indicated nursing staff's responsibilities included considering other factors that may be causing expressions or indications of distress before initiating psychotropic medications, such as an underlying medical condition, or psychosocial stressors.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994</p> <p>Based on observation, interview, and record review, the facility failed to ensure one bottle of Gabapentin (a medication used to treat nerve pain) 250 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) was stored in the refrigerator in one of three inspected medication carts (Station 2 Medication Cart 2) for Resident 62.</p> <p>The deficient practice of failing to store medications per the manufacturers' requirements increased the risk that Resident 62 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 1:45 p.m. of Station 2 Medication Cart 2, with Licensed Vocational Nurse (LVN 1), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications:</p> <ol style="list-style-type: none"> 1. One bottle of Gabapentin 250 mg per (l) 5 ml solution for Resident 62 was found stored at room temperature. <p>According to the manufacturer's product labeling, Gabapentin 250 mg/5 ml solution should be stored in the refrigerator.</p> <p>LVN 1 stated the Gabapentin solution for Resident 62 was stored at room temperature but was supposed to be stored in the refrigerator according to the pharmacy label. LVN 1 stated because the resident needed the medication multiple times per day, it was likely not returned to the refrigerator after each dose as it should be. LVN 1 stated if the medication was not stored properly, there was a risk that it may not be effective when used for the resident. LVN 1 stated Resident 62 used this medication to treat nerve pain and could experience increased pain if the Gabapentin was ineffective due to improper storage.</p> <p>A review of the facility's undated policy and procedure (P&P) titled Storage of Medications, indicated medications and biologicals are stored safely, securely, and properly, and following the manufacturer's recommendations or those of the supplier. The P&P indicated medications requiring refrigeration are kept in a refrigerator with a thermometer to allow temperature monitoring.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>38740</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff followed food production recipes and fortified diet (diet to increase caloric intake) guidelines during lunch service when:</p> <ol style="list-style-type: none"> Fortified diets (diet enriched to increase caloric content) were not prepared and served to 10 residents who were receiving a fortified diet. 17 residents who were prescribed a pureed diet (foods that do not require chewing and are easily swallowed in which all foods should be smooth and pureed to the consistency of pudding) received pureed vegetables (carrots and green beans) that were lumpy, not smooth, and had chunks which required chewing before swallowing. [NAME] 1 used a small scoop size to serve meatloaf for residents receiving a mechanical soft and finally chopped diet (includes moist foods in bit sized pieces for residents who have chewing and or swallowing difficulty). 29 residents prescribed a mechanical soft diet and four residents prescribed a finally chopped diet received 1/3 cup of meat loaf instead of 1/2 cup per the menu. <p>These deficient practices had the potential to result in meal dissatisfaction, decreased caloric intake, weight loss, and increased choking risk for residents requiring a pureed diet.</p> <p>Findings:</p> <ol style="list-style-type: none"> During the lunch service tray line observation on 6/10/2024 at 11:50 a.m., for residents who were prescribed a fortified diet, [NAME] 2 did not communicate to [NAME] 1 the fortified diet orders written on the meal tickets during tray line. [NAME] 1 did not add any additional food items per the fortified menu to the meal trays. <p>During a concurrent observation and interview with [NAME] 1 and [NAME] 2 on 6/10/2024 at 12:00 p.m., regarding the diet fortification process, [NAME] 1 stated when there was a fortified diet, butter was added to the vegetables during lunch. [NAME] 2 stated during lunch he reads and communicated the different diets based on the meal ticket indicated on the trays. Subsequently, [NAME] 2 did not read and communicate residents likes and dislikes or the fortified diet orders written on the meal tickets.</p> <p>During a concurrent interview on 6/10/2024 at 12:45 p.m., with [NAME] 2 and the Dietary Supervisor (DS), [NAME] 2 stated he did not read and communicate the fortified diets during lunch service. The DS stated fortified diets were for residents who were losing weight or not eating enough calories. The DS stated butter was added to vegetables during lunch service to increase calories. The DS stated residents receiving a fortified diet did not receive the fortified foods.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy and procedure (P&P) titled Therapeutic Diets, revised 5/1/2018, indicated, therapeutic diets are diets that deviate from the regular diet and require a physician order. The P&P indicated the dietary manager will observe meal preparation and serving to ensure that food portions served are equal to the written portion sizes. The P&P indicated the dietary manager will periodically review the residents tray card and the physicians' dietary orders to ensure that the information is consistent.</p> <p>A review of the facility's P&P titled Fortification of food: Increasing Calories and or protein in the Diet, dated 2023, indicated, the goal is to increase the calorie and or protein density of the foods commonly consumed by the resident to promote improvement in their nutrition status. The P&P indicated extra margarine may be added to one food item at breakfast, two food items at lunch, and one food item at dinner.</p> <p>2. During an observation on 6/10/2024 at 10:35 a.m., in the kitchen, [NAME] 1 was observed adding frozen mixed vegetables (carrots, green beans, cauliflower) inside a large pot. [NAME] 1 added water and stated after the vegetables boiled for 30 minutes he would remove some of the vegetables to blend for the pureed diet.</p> <p>During an observation of the lunch tray line service on 6/10/2024 at 11:50 a.m., the pureed vegetables were chunky and not smooth. During the serving of the pureed vegetables, observed pieces of vegetables on the plate.</p> <p>During a concurrent observation and interview with the DS and [NAME] 1 on 6/10/2024 at 1:00 p.m., [NAME] 1 stated pureed food should be the consistency of pudding, hold its shape and not require chewing so the residents could not easily swallow. [NAME] 1 stated the pureed vegetables he served had a chunky consistency. [NAME] 1 stated he was rushing for lunch service and did not blend the pureed vegetables well until smooth. [NAME] 1 stated it was important for pureed food to be soft and not chunky so there was no chewing before swallowing. The DS tasted the pureed food and stated there was some chewing needed before swallowing. The DS stated [NAME] 1 would need to blend the pureed food longer.</p> <p>A review of the facility's P&P titled Regular Pureed Diet, dated 2023, indicated, pureed diet is a regular diet that has been designed for residents who have difficulty chewing and or swallowing. The P&P indicated the texture of the food should be of a smooth and moist consistency.</p> <p>A review of the recipe for pureed vegetables indicated to puree the cooked vegetables to a paste consistency before adding liquids. The recipe indicated to gradually add warm liquid if needed. The recipe indicated the puree should reach the consistency of applesauce.</p> <p>A review of the International Dysphagia Diet (foods that are soft textured and moist, making them easy to swallow) Standardization Initiative guidelines for pureed diet (www.IDDSI.org) indicated, pureed food does not require chewing and have a smooth texture with no lumps.</p> <p>3. A review of the facility lunch menu for mechanical soft and finally chopped diet, dated 6/10/2024, indicated the following items would be served: Old fashioned meatloaf 4 ounces (oz., unit of measurement) or 1/2 cup mashable and moist with gravy; herb mashed potatoes 1/2 cup; seasoned fresh vegetables soft or chop 1/2 inch; pan biscuit; margarine; plain ice cream; and milk.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation of the lunch tray line service and interview with [NAME] 1 and the DS on 6/10/2024 at 11:50 a.m., for residents who were receiving a mechanical soft and finally chopped diet, [NAME] 1 served meatloaf using the #12 scoop yielding 2.5 oz. or 1/3 of cup instead of 1/2 cup per the menu. [NAME] 1 stated he used the smaller scoop to serve the mechanical soft meatloaf. [NAME] 1 stated he made a mistake and did not realize the scoop size. The DS stated the residents receiving a mechanical soft and finally chopped diet received less protein than the menu indicated.</p> <p>A review of the facility spreadsheet (portion and serving guide) dated 6/10/24, indicated old fashioned meatloaf regular portion for mechanical soft diet was 4 oz. or 1/2 cup.</p> <p>A review of the recipe for Old Fashioned Meatloaf indicated the portion size was 4 oz.</p> <p>A review of the facility's P&P titled Menu Planning, dated 2023, indicated, menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physicians' orders, and recommended dietary allowances. The P&P indicated standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the facility failed to provide food that accommodated residents' preferences and offer meal substitutes of the same nutritive values for one of six sampled residents (Resident 112).</p> <p>These deficient practices had the potential to alter Resident 112's nutritional status.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 6/10/2024 at 12:58 p.m., with Resident 112, in Resident 112's room, Resident 112's lunch meal tray was observed on top of the resident's bedside table. Resident 112's lunch meal tray included meatloaf, steamed vegetables, mashed potatoes, corn bread, and milk. Resident 112 was observed eating ice cream, and stated she was not going to eat her lunch because she did not like beef. Resident 112 stated that she was still being served beef even though she told the dietary staff that she did not like beef.</p> <p>A review Resident 112's meal tray ticket on 6/10/2024 at 1:05 p.m., indicated Resident 112 was receiving a regular, mechanical soft diet (texture-modified diet that restricts foods that are difficult to chew or swallow) with thin liquids. Resident 112's meal tray ticket indicated the resident disliked beef, coffee, pork, salad, and pasta.</p> <p>A review of Resident 112's Face Sheet, indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including schizophrenia (serious mental health condition which affects the way one thinks, behaves, and feels clearly) and seizures (abnormal electric activity in the brain).</p> <p>A review of Resident 112's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 5/16/2024, indicated Resident 112's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 112 required supervision (the helper provides verbal cues, touching contact as resident completes activity) for toileting hygiene, dressing, showering, and personal hygiene.</p> <p>During a concurrent observation and interview on 6/10/2024 at 1:15 p.m., with the Dietary Supervisor (DS), in Resident 112's room, the DS confirmed Resident 112's meal tray contained meatloaf. The DS stated he asked each individual resident about their food preferences. The DS stated there were three checks before the tray left the kitchen. The DS stated the tray line staff checked the menu cards with the tray. The DS stated he, himself, did a final check before the trays left the kitchen. The DS stated the third and final check was performed by the licensed nurse who helped pass out the trays to the residents.</p> <p>During an interview on 6/13/2024 at 9:57 a.m., with the Director of Nursing (DON), the DON stated it was important to honor residents' food preferences. The DON stated disliked food may affect the residents' intake and placed residents at risk for malnutrition (lack of proper nutrition).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lighthouse Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Santa Ana Blvd. Los Angeles, CA 90059	

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Policy and Procedure (P&P) titled Food substitutions during tray line and alternate for food item resident does not like that is recorded on the tray card, undated, indicated the cook will provide a food substitute at each meal for food items that a resident may dislike, which has been noted on their tray card.</p> <p>A review of the facility's P&P titled Food preferences, undated, indicated, substitutes for all foods disliked will be given from the appropriate food group.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38740</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when:</p> <ol style="list-style-type: none"> 1. One package of ready to eat ham was stored in the walk-in refrigerator with no thaw date. One large tray of breaded fish, two large packages of diced pork and six logs of ground beef were thawing in the walk-in refrigerator with no pulled out of the freezer or thaw date. One plastic storage bag with a breaded food item stored in the reach in freezer had no label or date. 2. The ice machine was not maintained in a clean manner and the inside compartment of the ice machine was observed with black residue. 3. Dietary Aide 1 did not follow cleaning and sanitizing procedures when there was raw ground beef in the food preparation sink, and when [NAME] 1 used the same sink to drain ready to eat cooked vegetables. <p>These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 108 out of 114 residents who received food and ice from the kitchen.</p> <p>Findings:</p> <p>During an observation on 6/10/2024 at 8:45 a.m., in the kitchen, there was one large tray of breaded fish with no thaw date stored in the walk in refrigerator. There was one package of ready to eat previously frozen and thawed sliced ham stored in the walk-in refrigerator with no thaw date.</p> <p>During a subsequent concurrent observation and interview with the Dietary Supervisor (DS), there were two large packages of raw diced pork and six logs of ground beef thawing on the bottom shelf in the walk-in refrigerator with no thaw or pulled out of the freezer date. The DS stated the ground beef was going to be used that day (6/10/2024). The DS stated the meat was usually taken out of the freezer 3 days prior to preparation. The DS agreed that meat thawing in the refrigerator should be labeled to ensure the food items did not exceed the thawing and storing period.</p> <p>During a concurrent observation and interview with the DS on 6/10/2024 at 9:00 a.m., in the reach in refrigerator, there was one brown bag sack lunch with a ham sandwich and juice dated 6/7/2024. The DS stated the lunch bag included snacks for residents receiving dialysis treatment (process of filtering waste from the blood in place of kidneys that no longer function). The DS stated the sack lunch had been in the refrigerator for 3 days and must be discarded. The DS was observed removing the sack lunch from the refrigerator.</p> <p>During a subsequent concurrent observation and interview with the DS, in the reach in freezer, there was one plastic bag with a breaded food item. The bag was not labeled or dated. The DS stated everything that was out of the original box must be labeled and dated.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy and procedure (P&P) titled, Procedure for refrigerator storage, dated 2023, indicated, individual packages of refrigerated or frozen food taken from the original packing box needed to be labeled and dated.</p> <p>A review of the facility's P&P titled Meat Cookery and storage, revised 5/1/2018, indicated, meat to be defrosted will be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees Fahrenheit (F) or lower. The P&P indicated to date the meat when pulled for defrosting and date the meat for meal service.</p> <p>A review of the facility's P&P titled Thawing of meats, dated 2023 indicated, allow 2 to 3 days to defrost, depending on quantity and total weight of the meat. The P&P indicated to label defrosting meat with pull and use by date.</p> <p>2. During an observation of the facility's ice machine on 6/10/2024 at 9:15 a.m., located in the kitchen, a clean paper towel was used to swipe the ice storage bin ceiling and behind the plastic covering the ice dispensing area. A gray and black residue was observed on the paper towel. The residue was located under the baffle (plastic board that hold the ice from falling out of the ice storage bin). Observation of the ceiling of the ice machine and where the ice was dispensed was covered with the gray and black color residue.</p> <p>During a subsequent interview with the DS, the DS stated the maintenance staff was responsible for cleaning the ice machine's internal compartment.</p> <p>During a concurrent observation, interview, and review of the Ice Machine cleaning log, with Maintenance Supervisor (MS), on 6/10/2024 at 9:20 a.m., the MS stated he cleaned the ice machine every month and the last cleaning was on 5/4/2024. The MS stated during the cleaning process, the ice was removed and the internal storage bin and tubing was cleaned. The MS stated he did not remove the plastic (baffle) covering during the last cleaning. The MS agreed that there are some black residues and stated the ice machine was due for a cleaning. The MS stated the dirty ice machine compartment could contaminate the ice.</p> <p>A review of facility's P&P titled Ice Machine Cleaning Procedures, dated 2023, indicated, the ice machine needs to be cleaned and sanitized monthly. The P&P indicated to be sure special attention was paid to cleaning the door molding and the lid of the machine.</p> <p>A review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces and Utensils Code# 4-602.11, indicated, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent food preparation observation and interview with [NAME] 1, on 6/10/2024 at 10:00 a.m., [NAME] 1 finished mixing the raw ground beef with spoons and then placed the used spoons in the food preparation sink. [NAME] 1 stated the food preparation sink was for washing vegetables, fruits and that sometimes he placed the cooking pots and pans there until it was washed by the dishwasher. [NAME] 1 stated he did not use the sink to wash or thaw any raw meat products. [NAME] 1 stated DA 1 assisted with the cleaning and sanitizing of the counters and sinks during the cooking preparation. [NAME] 1 stated it was important to sanitize the food prep sink with sanitizer to prevent cross contamination of food.</p> <p>During an observation of the cleaning and sanitizing of the counters and sink on 6/10/2024 at 10:25 a.m., DA 1 picked up the spoons that was used to mix ground beef and placed them in the dishwashing machine. DA 1 then started to clean the food preparation sink. DA 1 filled a red bucket with a sanitizer solution and poured it out in and around the counters and sink. Then with her hands DA 1 was collecting the sanitizer solution from the counter and into the sink. DA 1 completed the cleaning with pouring water in the sink and dried it with a clean cloth. There were pieces of raw ground beef from the spoons at the bottom of the sink, near the drain and in the sieve (a strainer) that collects food waste.</p> <p>During a subsequent interview with DA 1, DA 1 stated she added a sanitizer and scrubbed the sink with the sanitizer, then rinsed it with water and dried it with a cloth stored in the sanitizer solution. When asked if the sink was clean with the raw ground beef at the bottom, DA 1 stated Yes, it's clean.</p> <p>During a food preparation observation on 6/10/2024 at 11:00 a.m., [NAME] 1 used the sink to drain the water from the cooked ready to eat vegetables.</p> <p>A review of the facility's P&P titled Shelves, Counters, and Other Surfaces Including Sinks (Handwashing, Food Preparation, Etc.), dated 2023, indicated, remove any large debris and wash surface with a warm detergent solution, and rinse with clear water using a clean sponge or cloth. The P&P indicated to wipe dry with a clean cloth and spray with a sanitizer. The P&P indicated to not rinse.</p> <p>A review of the facility's undated Dietary Aide Job Description indicated, responsibilities and duties included to wash and sanitize dishes, utensils and equipment as prescribed by standard procedure.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>47679</p> <p>Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP), who was responsible for the facility's Infection Prevention Control Program, completed ten hours of continuing education training on an annual basis.</p> <p>This deficient practice had the potential for the IP to be unaware and be unable to educate the facility's staff of updated information regarding Infection Prevention and Control.</p> <p>Findings:</p> <p>During an interview on 6/13/2024 at 7:40 a.m., with the Infection Preventionist (IP), the IP stated he was unable to find documentation that he completed ten hours of continuing education for the year of 2023. The IP stated he completed continuing education hours when he renewed his nursing license, however, those hours were not completed in the year of 2023. The IP stated he was responsible for completing ten hours of continuing education annually to ensure he was aware of any new guidelines or studies that were released and to be up to date with current infection prevention and control practices.</p> <p>During an interview on 6/13/2024 at 10 a.m., with the Director of Nursing (DON), the DON stated the IP was responsible for educating the staff on current infection prevention and control practices. The DON stated for the IP to educate others, he was responsible for being updated on current news and training sources. The DON stated if the IP did not complete the ten hours of continuing education annually, there was the potential that he could miss any changes that would need to be implemented and could possibly not be up to date on current infection control practices.</p> <p>A review of the California Department of Public Health All Facilities Letter (AFL), dated 11/4/2020, indicated, The IP should complete 10 hours of continuing education in the field of [Infection Prevention and Control] on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.</p>		