STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	06/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Registered Nurse (RN) 1, RN 2, and Licensed Vocational Nurse (LVN) 4 practiced the necessary competencies when providing care and services when the following occurred: 1. RN 1 did not correctly interpret or carry out Resident 115's physician order to change the resident's urinary catheter (thin tube inserted into the bladder) drainage bag (a medical device used to collect urine that is drained from the bladder). 2. RN 2 and LVN 4 did not know the facility policy and procedure (P&P) for replacing a resident's humidifier bottle (a device that adds moisture to the oxygen being delivered). These deficient practices placed the residents at risk for infection and illness. Findings: 1. During a review of Resident 115's admission Record, the admission Record indicated Resident 115 was originally admitted on [DATE] and most recently readmitted on [DATE]. Resident 115's admitting diagnoses included urinary retention (the inability to fully or partially empty the bladder, leaving urine trapped inside), acute kidney failure (a sudden and significant loss of kidney function), and benign prostatic hyperplasia (BPH, a condition in which the prostate gland grows larger than normal) with lower urinary tract (bladder and urethra in both males and females, and the prostate in males) symptoms. During a review of Resident 115's Minimum Data Set (MDS, a resident assessment tool), dated 4/19/2025, the MDS indicated Resident 115 had moderate cognitive impairments (a stage of cognitive decline where individuals experience more noticeable problems with thinking, learning, and memory compared to normal aging). The MDS indicated Resident 115 was dependent on staff for toileting hygiene (a set of practices that are necessary to prevent the spread of disease and preserve health related to urination and defecation). During a review of Resident 115's physician order, dated 1/11/2025, the order indicated staff were to change Resident 115's urinary catheter drainage bag every two (2) weeks and as needed every day shift every 14 day(s). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 115's care plan titled Risk for infection related to indwelling catheter, dated 1/12/2025, the care plan indicated the goal of care was that Resident 115 would not have signs or symptoms of a urinary tract infection. The care plan indicated staff were to change Resident 115's catheter drainage bag as ordered. During a concurrent interview and record review, on 6/3/2025 at 3:30 p.m., with RN 1, Resident 115's physician order dated 1/11/2025 was reviewed. RN 1 stated the physician order indicated staff were to change Resident 115's urinary catheter drainage bag every two weeks if needed. RN 1 stated the order did not indicate staff were to change the urinary catheter drainage bag every two weeks and as needed. During an interview on 6/4/2025 at 10:59 a.m., with RN 1, RN 1 stated she spoke with the Director of Nursing (DON) and clarified Resident 115's physician order, dated 1/11/2025. RN 1 stated she now understood staff were to change Resident 115's urinary catheter drainage bag every two weeks and as needed. RN 1 stated she was not previously following the order to change the urinary catheter drainage bag every two weeks. RN 1 stated the purpose of changing the drainage bag at least every two weeks was to prevent infection. During a concurrent interview and record review, on 6/4/2025 at 1:41 p.m., with the Director of Nursing (DON), Resident 115's physician order, dated 1/11/2025, was reviewed. The DON stated the order indicated the drainage bag was to be changed every two weeks and as needed. The DON stated the order was written clearly and licensed nursing staff, including RNs and licensed vocational nurses (LVNs) should have the competency to interpret and carry out the order. The DON stated it was a competency issue if licensed nursing staff could not interpret the order as it was written. During an interview on 6/5/2025 at 1:38 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated unchanged drainage bags could harbor bacteria and lead to infection. The IPN stated this was why it was important to ensure the urinary catheter drainage bags were changed the frequency ordered. During a review of the facility's job description for Registered Nurse Supervisor, undated, the job description indicated RNs were to be able to demonstrate knowledge of and ability to apply basic principles of nursing care. During a review of the facility's P&P titled Catheter - Care Of, revised 5/2018, the P&P indicated staff were to ensure residents with a catheter received appropriate care and services to prevent infections to the extent possible. 2. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 76's admitting diagnoses included dementia (a progressive state of decline in mental abilities). During a review of Resident 76's MDS, dated , the MDS indicated Resident 76 had severely impaired cognition (a significant decline in a person's ability to think, remember, learn, and use judgment). The MDS indicated Resident 76 was dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76's physician order, dated , the physician order indicated Resident 76 was to receive oxygen therapy (a medical treatment that involves administering supplemental oxygen to individuals who have difficulty getting enough oxygen through normal breathing). During an observation on 6/3/2025 at 11:05 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed receiving oxygen therapy via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 76's nasal cannula was connected to a humidifier bottle dated 5/2/2025. During an observation on 6/4/2025 at 8:48 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed receiving oxygen therapy via nasal cannula. Resident 76's nasal cannula was connected to the same humidifier bottle. The date read 6/2/2025, and the previous month of 5 (May), had been written over. During an interview on 6/4/2025 at 8:50 a.m., with Registered Nurse (RN) 1, RN 1 stated humidifier bottles were to be changed every week. During a concurrent interview and record review, on 6/4/2025 at 8:53 a.m., with RN 1, a photo of Resident 76's humidifier bottle, taken on 6/3/2025 at 11:05 a.m., was reviewed. RN 1 stated the humidifier bottle was dated 5/2/2025. RN 1 stated the humidifier bottle should have been changed multiple times since 5/2/2025. RN 1 stated the purpose of replacing the humidifier bottle weekly was to prevent infection. During a concurrent interview and record review, on 6/4/2025 at 9:14 a.m., with LVN 4, a photo taken of Resident 76's humidifier bottle taken on 6/3/2025 at 11:05 a.m. was reviewed. LVN 4 stated the initials on the humidifier bottle were hers, and stated the date on the humidifier bottle was 5/2/2025. When asked how frequently the humidifier bottle was to be changed, LVN 4 stated she was not sure. During a concurrent interview and record review, on 6/4/2025 at 9:16 a.m., with LVN 4, a photo taken of Resident 76's humidifier bottle taken on 6/4/2025 at 8:49 a.m., was reviewed. LVN 4 stated the initials on the humidifier bottle were hers and stated the date on the humidifier now read 6/2/2025. LVN 4 stated she wrote over the previous month of 5 (May) and made it a 6 (June). During an interview on 6/4/2025 at 9:44 a.m., with LVN 4, LVN 4 stated the facility policy was to change humidifier bottles as needed. LVN 4 stated this meant the bottles would be changed once nearly empty or empty. LVN 4 stated she received this guidance from RN 2. During an interview on 6/4/2025 at 12:56 p.m., with the IPN, the IPN stated that weekly replacement of humidifier bottles was for infection control. The IPN stated that failure to change the humidifier bottle in accordance with the facility policy created the potential for respiratory infections. During an interview on 6/5/2025 at 10:16 a.m., with the DON, the DON stated staff were trained on facility policies and procedures. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/5/2025 at 10:17 a.m., with the DON, RN 2's and LVN 4's signed job descriptions dated 3/30/2023 and 12/2/2024, were reviewed. The DON stated RN 2's job description indicated she should be able to remember and recall facility policies and procedures. The DON stated LVN 4's job description indicated she should be able to remember, recall, and implement facility policies and procedures. During a concurrent interview and record review, on 6/5/2025 at 10:19 a.m., with the DON, the facility's P&P titled Oxygen Administration, revised 2018, was reviewed. The DON stated the P&P indicated humidifier bottles were to be to be changed weekly and as needed. The DON stated the purpose of this practice was for infection control. The DON stated failure to implement this policy created the potential for respiratory infection.