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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555106	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Lodge	5053 Peck Rd. El Monte, CA 91732

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow through (follow up) on one of four sampled resident's (Resident 1), who was at risk for falls, fall that occurred on 1/9/2026, in accordance with the facility's policy and procedure (P&P) titled, Change of Condition. The facility failed to assess Resident 1 after the fall, report the fall to Resident 1's physician (Medical Doctor [MD] 1), and complete a change in condition (COC, an alteration in a resident's physical health that differs from their previous baseline) for Resident 1.This deficient practice had the potential to result in Resident 1 not receiving the necessary care and services affecting Resident 1's physical well-being.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including other abnormalities of gait (the pattern of walking) and mobility (ability to move freely), unspecified dementia (a progressive state of decline in mental abilities), and history of falling.During a review of Resident 1's Fall Risk Evaluation (FRE), dated 12/17/2025, timed at 6:40 PM, the FRE indicated Resident 1 was a risk for falls and to alert MD 1 if a fall occurred.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL).During a review of Resident 1's Progress Notes (PN), dated 1/9/2026, timed at 3:07 AM, the PN indicated, at approximately 3 AM, LVN 2 heard an alarm noise from the back hallway and entered Resident 1's room. LVN 2 noted Resident 1 to be on the floor, sitting on Resident 1's bottom in front of Resident 1's roommate's bed. LVN 2 asked Resident 1 what had happened and Resident 1 responded, I do not know, I just fell. The PN indicated Resident 1 had an abrasion (a superficial injury where the skin is scraped or rubbed off) on Resident 1's mid-back on the right side and LVN 2 notified Resident 1's primary nurse (LVN 3) who stated LVN 2 would resume follow-up. During a concurrent observation and interview on 2/5/2026 at 6:14 AM with Resident 1 and Certified Nursing Assistant (CNA) 1 in Resident 1's room. CNA 1 was monitoring Resident 1 at Resident 1's bedside. Resident 1 was lying in bed, confused (unable to answer most questions), and trying to get out of bed. Resident 1 had a pinkish colored linear scarring on the right forehead above the eyebrow. Resident 1 stated, Resident 1 had fallen a couple of times at the facility. CNA 1 stated, Resident 1 was a fall risk. CNA 1 stated, CNA 1 believed Resident 1 had fallen once in January 2026 during the evening shift (3 PM - 11 PM) and Resident 1 required stitches (special threads that doctors use to close a wound or cut).During an interview on 2/5/2026 at 10:01 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had advanced dementia with, a lot of confusion, and was a fall risk. LVN 1 stated Resident 1 had a fall (no date recollection) and Resident 1 had (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Lodge	5053 Peck Rd. El Monte, CA 91732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a laceration (cut, tear, or rip on the skin) on the forehead that was fully healed. LVN 1 stated a fall was [considered] a COC and it was important to notify the family and physician immediately [after the fall] to obtain physician orders if the resident (in general) needed to be transferred out to the hospital. During a concurrent interview and record review on 2/5/2026 at 10:31 AM with the DON, Resident 1's medical records were reviewed. Resident 1's Progress Notes (PN), dated 1/9/2026, timed at 3:07 AM, the DON stated, it sounded like [Resident 1 had a fall on 1/9/2026]. The DON stated LVN 2 was the charge nurse and was responsible for completing a COC for Resident 1's fall dated 1/9/2026. The DON stated there was no documented evidence indicating MD 1 was notified of Resident 1's fall dated 1/9/2026. The DON stated there was no COC or assessment [in Resident 1's medical record] for Resident 1's fall dated 1/9/2026. The DON stated, completing a COC immediately, as soon as it [a fall] occurs was important to ensure MD 1 was notified, [assisted with] communication amongst staff, [assisted with] reevaluating Resident 1 for rehabilitation [services], [assisted with] adjusting care plans, and [implementing interventions like] could have moved Resident 1 closer to the nursing station sooner.During an interview on 2/6/2026 at 7:47 AM, LVN 3 stated Resident 1 had a fall (no date recollection) and was transferred to the hospital where Resident 1 got stitches. LVN 3 stated LVN 2 reported early morning last month to LVN 3 that LVN 2 found Resident 1 sitting on the floor while LVN 3 was on lunch break. LVN 3 stated LVN 3 did not assess Resident 1 after Resident 1's fall dated 1/9/2026. LVN 3 stated, LVN 2 told LVN 3 LVN 2 would take care of the incident. LVN 3 stated, a fall was a COC, and it was important to assess the resident (in general), notify the physician for the overall wellbeing of the resident.During a review of the facility's undated P&P titled, Change of Condition, the P&P indicated, the facility ensured proper assessment and follow-through for any resident with a change of condition. The P&P indicated a change of condition is a sudden or marked difference in the resident like bruises, lacerations, blisters, rashes, or skin tears. The P&P indicated all changes of condition in a resident should be handled promptly, documentation of change in condition should be performed by the Licensed Nurse accordingly, and a COC would be completed as indicated. The P&P indicated upon the COC, staff members were to take the following actions: the physician shall be called [notified] promptly and daily assessments.