STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555732	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Heights Healthcare Center, LLC	2309 N Santa Fe Ave Compton, CA 90222

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to ensure the Minimal Data Set ([MDS]- a resident assessment tool), was coded correctly for one of four sampled residents (Resident 1). This deficient practice resulted in incorrect data transmitted to the Center for Medicare and Medicaid Services (CMS) regarding Resident 1 ' s behavior (how person ' s mental health affects their actions), hallucinations (perceptual experiences in the absence of real external sensory stimuli), and verbal behavioral (e.g., screaming) (yelling) directed toward others. Findings: During a review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (feeling of fear, dread, and uneasiness) , and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s quarterly (cycle once every three months) Minimum Data Set ([MDS] - a resident assessment tool), dated 9/24/2024, the MDS section C (cognitive patterns) indicated Resident 1 ' s cognitive skills (the ability to think and process information) for daily decisions making was intact. During a review of Resident 1 ' s physician order, dated 7/1/2024, the order indicated monitor for schizoaffective disorder manifested by (m/b) auditory hallucinations every shift. During a concurrent interview and record review on 11/18/2024 at 1:45 p.m., with Minimum Data Set Nurse (MDSN 1), Resident 1 ' s care plan titled Behavior problem, initiated 9/19/2024 and revised 10/17/2024 was reviewed. MDSN 1 stated Resident 1 ' s care plan indicated Resident 1 had a behavior problem auditory hallucination related to (r/t) schizoaffective disorder. MDSN 1 stated Resident 1 ' s care titled problems/needs date initiated 9/12/2024, indicated Resident 1 was yelling at the staff. MDSN 1 stated Resident 1 ' s behavior should have been coded on Resident 1 ' s MDS under section E (behavior). (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/18/2024 at 1:56 p.m., with MDSN 1, Resident 1 ' s MDS, dated [DATE] section E (behavior) was reviewed. MDSN 1 stated Resident 1 ' s MDS section E behavior hallucinations were coded as None of the Above, and verbal behavioral directed toward others was encoded 0 (behavior not exhibited). MDSN 1 stated Resident 1 ' s behaviors it should have been coded. MDSN 1 stated she does not know how she missed that. During a review of the facility ' s policy and procedure (P&P) tilted Resident Assessment, revised 3/2022, the P&P indicated resident assessment coordinator was responsible for ensuring appropriate resident assessments. The P&P indicated person who have completed MDS resident assessment form would sign the document attesting to the accuracy of such information.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to initiate and implement a comprehensive care plan for two of four sampled residents (Resident 1 and 3) by failing to: 1. Initiate a care plan with individualized approaches addressing Resident 1 ' s behavior (how person ' s mental health affects their actions) pacing (walking back and forth) in the hallway. 2. Initiate a care plan to address Resident 1 ' s medication administration and side effects of buspirone (medication to treat anxiety disorder). 3. Initiate a care plan to address Resident 3 ' s Restorative Nurse Aide (RNA) services. Findings: a)During a review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (feeling of fear, dread, and uneasiness) , and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS] - a resident assessment tool), dated 9/24/2024, the MDS indicated Resident 1 ' s cognitive skills (the ability to think and process information) for daily decisions making was intact. During a review of Resident 1 ' s progress note, dated 10/9/2024, the progress note indicated Resident 1 was observed pacing down the hallway multiple times. The progress note indicated Resident 1 ignored staff and refused care. During a concurrent interview and record review on 11/18/2024 at 1:26 p.m., with Registered Nurse (RN 1), Resident 1 ' s, situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/2/2024 was reviewed. RN 1 stated the SBAR, indicated Resident 1 was pacing in the hallway and was aggressive towards other residents. RN 1 stated Resident 1 ' s behavior pacing in the hallway should have a care plan. During a concurrent interview and record review on 11/18/2024 at 1:40 p.m., with RN 1, Resident 1 ' s active care plans were reviewed. RN 1 stated Resident 1 did not have a care plan addressing her (Resident 1) behavior pacing in the hallway. RN 1 stated care plan should be completed upon admission, readmission, and when there was change on condition. RN 1 stated the licensed nurses were responsible for creating a care plan. RN 1 stated care plan would ensure staff providing care to Resident 1 were aware of the Resident 1 ' s behavior, and the necessary interventions to know the resident ' s needs, what specific could staff assist Resident 1 and to provide quality care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/18/2024 at 1:50 p.m., with RN 1, Resident 1 ' s active physician order as of 11/1/2024 was reviewed, the RN 1 stated the order indicated buspirone HCL 10 milligram ([mg]- a unit of measurement) oral tablet, give one (1) tablet two times a day for anxiety manifested by (m/b) continuous pacing in the hallway. RN 1 stated the order indicated monitor Resident 1 for anxiety m/b continuous pacing in the hallway every shift. RN 1 stated buspirone was a new medication for Resident 1 and should have a care plan. RN 1 stated it could be a potential delay to necessary interventions without a care plan addressing the usage of buspirone. b) During a review of Resident 3 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (feeling of fear, dread, and uneasiness), and abnormalities of gait (a manner of walking) and mobility. During a review of Resident 3 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/2/2024, the MDS indicated Resident 3 ' s cognitive skills (the ability to think and process information) for daily decisions making was intact. The MDS indicated Resident 3 required supervision or touch assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3 ' s order summary report, dated 10/22/2024, the order summary report indicated RNA would ambulate (walk) Resident 3 five times per week. During a concurrent interview and record review on 11/19/2024 at 4:40 p.m., with Physical Therapist 1(PT -licensed professional who work with patient to restore, maintain, and improve ability to move), Resident 3 ' s Physical Therapy Discharge Summary (PTDS), dated 10/22/2024 was reviewed. PT 1 stated Resident 3 was discharged from PT services on 10/22/2024 with a physician order for RNA services for ambulation five times per week. PT 1 stated Resident 3 RNA services should have a care plan. During a concurrent interview and record review on 11/19/2024 at 4:55 p.m., with Director of Nursing (DON), Resident 3 ' s active care plans were reviewed. The DON was not able to provide documentation that Resident 3 ' s RNA services care plan was initiated. The DON stated services and treatments provided for residents at the facility should have a care plan. The DON stated without care plan addressing Resident 3 ' s RNA services placed Resident 3 at risk not receiving necessary care, treatment, and service. During a review of the facility ' s Policy and Procedure (P&P) titled Care Plan- Comprehensive, revised 9/2010, the P&P indicated individualized comprehensive care plan would be developed for each resident and should include measurable objectives and timetables to meet the resident ' s medical, nursing, mental and psychological needs. During a review of the facility ' s policy and procedure (P&P) tilted Resident Mobility and Range of Motion, revised 7/2017 the P&P indicated a care plan would be developed and would include specific interventions, exercises, and therapy to maintain, and/or improve mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Restorative Nursing Assistant (RNA) Job Description, undated, the P&P the RNA would perform services in compliance with written care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to revise a behavior care plan one of four sampled residents (Resident 1) to reflect resident ' s behavior (-how person ' s mental health affects their actions) pacing (walking back and forth) in the hallway, verbal, and physical aggressing toward other residents in the facility. This deficient practice resulted to Resident 1 not having an individualized care plan that addresses specific interventions to establish effective behavior management and had the potential to affect the provision of necessary care and services for Resident 1. Findings: During a review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (feeling of fear, dread, and uneasiness) , and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS] - a resident assessment tool), dated 9/24/2024, the MDS indicated Resident 1 ' s cognitive skills (the ability to think and process information) for daily decisions making was intact. During a concurrent interview and record review on 11/18/2024 at 11:37 a.m., with Licensed Vocational Nurse (LVN 1), Resident 1 ' s progress notes dated 10/1/2024-11/10/2024 were reviewed. LVN 1 stated the progress note, dated 10/1/2024 indicated Resident 1 was monitored for aggressive behavior towards staff. LVN 1 stated the progress note dated 11/9/2024, indicated Resident 1 observed pacing down the hallway multiple times. LVN 1 stated progress note, dated 11/10/2024 indicated Resident 1 was agitated toward staff, roommate, and visitor. LVN 1 stated Resident 1 ' s behavior was a change in Resident 1 ' s care plan should be reviewed, and revised when Resident 1 had a change in condition. During a concurrent interview and record review on 11/18/2024 at 11:49 a.m., with LVN 1, Resident 1 ' s active care plans were reviewed. LVN 1 stated the care plan should have been reviewed and revised when there was change in condition. LVN 1 stated the licensed nurses were responsible for reviewing and revising a care plan. LVN 1 stated Resident 1 ' s care plan for pacing, verbal and physical aggression should have been revised to reflect the Resident 1 ' s behavior and would ensure staff providing care to Resident 1 were aware of the Resident 1 ' s behavior, and the necessary interventions address the Resident 1 ' s needs, and to provide quality care. During a review of the facility ' s Policy and Procedure (P&P) titled Care Plan- Comprehensive, revised 9/2010, the P&P indicated residents care plans would be revised when there has been a change in resident ' s condition.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to ensure a resident with or without limited range of motion (ROM-movement of the joints) receive appropriate treatment and services to increase, prevent, or maintain the ROM mobility (ability to move) for one of four sampled residents (Resident 3), by failing to: a. Implement the facility ' s policy on Resident Mobility and Range of Motion by not providing Restorative Nursing Assistant (RNA) to maintain and /or improve the resident ' s mobility and ROM. b. Ensure RNA services were provided as ordered by the physician for Resident 3. These deficient practices had the potential to place Resident 3 at a decline in physical function and at risk for decline in mobility. Findings: During a review of Resident 3 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and abnormalities of gait (a manner of walking) and mobility. During a review of Resident 3 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/2/2024, the MDS indicated Resident 3 ' s cognitive skills (the ability to think and process information) for daily decisions making was intact. The MDS indicated Resident 3 required supervision or touch assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 3 required supervision or touch assistance from staff for sit and stand (the ability to come to a standing position from seating) and walk 10 feet (a unit of measurement for length) once standing in a room, corridor (hallway), or similar space. During a review of Resident 3 ' s order summary report, dated 10/22/2024, the order summary report indicated RNA would ambulate (walk) Resident 3 five times per week. During a concurrent interview and record review on 11/19/2024 at 4:40 p.m., with Physical Therapist 1(PT -licensed professional who work with patient to restore, maintain, and improve ability to move), Resident 3 ' s Physical Therapy Discharge Summary (PTDS), dated 10/22/2024 was reviewed. PT 1 stated Resident 3 was discharged from PT services on 10/22/2024 with a physician order for RNA services ambulation five times per week. PT 1 stated was important for Resident 3 to receive RNA services as ordered by the physician to maintain and/or improve his mobility and ROM. PT 1 stated not receiving RNA services as ordered by the physician placed Resident 3 at risk for decline in physical function, and potential for fall and injury. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/20/2024 at 8:05 a.m., with RNA 1, Resident 3 ' s Restorative Care Flow Record ([RCFR]- a document used to keep track of a resident health) for 10/24/2024 to 11/20/2024 was reviewed. RNA 1 stated the RCFR indicated from 10/24/2024 to 11/ 20/2024 Resident 3 was to receive 18 RNA services with ambulation. RNA 1 stated RCFR indicated Resident 3 received only 10 RNA services. RNA 1 there was no documentation that Resident 3 refused and/or was unavailable to receive RNA services. RNA 1 stated Resident 3 not receiving RNA services as ordered placed Resident 3 at risk for decline in mobility, muscle weakness (a lack of muscle strength), and loss of the ability to perform everyday activities like walking, standing, and potentially impacting quality of life. During a review of the facility ' s policy and procedure (P&P) titled Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents with limited mobility would receive appropriate services to maintain or improve mobility. During a review of the facility ' s P&P titled Activity of Daily Living (ADL), revised 3/2018, the P&P indicated residents would be provided with services to ensure their ADLs do not decline. The P&P indicated facility would provide services to prevent functional decline. During a review of the facility ' s P&P titled Restorative Nursing Assistant (RNA) Job Description, undated, the P&P indicated RNA would provide ROM, exercises, ambulating to the residents as ordered by the physician.