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	01/02/2025

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Change in a Resident's Condition, which indicated the facility will notify a resident's physician when there was a significant change (major decline or improvement in the resident's status that could not normally resolve itself without intervention by the staff) in the resident's condition by failing to notify a physician timely, for one of seven sampled residents (Resident 2) when: a. Resident 2 had a change of condition of a decreased oxygen saturation (the percentage [%] of oxygen in a person's blood, normal oxygen saturation level between 95 and 100 %] rate oxygen of 84 %. Resident 2's oxygen saturation did not reach the normal oxygen saturation level of 95 to 100% after administering 5 liters per minute (LPM, unit of measurement) of oxygen, 10 LPM, and 15 LPM of oxygen via an oxygen mask (device used to deliver supplemental oxygen [treatment in which a storage tank of oxygen or a machine called a compressor is used to give oxygen to people with breathing problems]). b. Resident 2 refused the 72-Hour Neurological check (series of tests over a 72-hour period to assess for changes in neurological function [the ability of the nervous system to send and receive signals throughout the body, allowing for movement, sensation, and other bodily functions]) and Body Check Assessment after an unwitnessed fall on [DATE]. c. Resident 2 refused Skin Check Assessments during activities of daily living ([ADLs], activities such as bathing, dressing, and toileting a person performs daily). These failures resulted in Resident 2 being hypoxic (absence of oxygen in the tissues to sustain bodily functions) with labored breathing (breathing that requires more effort than normal, or an increased amount of energy) and only responsive to tactile stimuli (any form or touch or physical contact perceived by the skin), and a one hour delay in transferring the resident to a general acute care hospital (GACH) for timely evaluation and treatment. These failures also had the potential to result in the ability of Resident 2's nervous system (a complex network of nerve tissue that sends signals between the brain and the body) to send and receive signals throughout the body, allowing for movement, sensation, and other bodily functions. These failures resulted in Resident 2's covered skin area (back and buttocks) not being assessed for skin breakdown and impaired skin integrity. Findings: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Actual harm Residents Affected - Few	a. During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb (leg), acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of the left calf muscular vein (part of the deep vein system that drains blood from the calf muscles back to the heart), and peripheral vascular disease ([PVD], a slow progressive narrowing of the blood flow to the arm and legs). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 2's cognition (process of thinking) was severely impaired. The MDS indicated Resident 2 required moderate assistance with oral hygiene, toileting, bathing, and dressing. The MDS indicated Resident 2 had four venous ulcers (an open sore on the leg that occurs when blood does not circulate properly in the leg veins) and an infection of the foot. During a review of Resident 2's Change in Condition (COC), dated [DATE], the COC indicated on [DATE] at 3:08 a.m., Resident 2 was observed with discoloration and swelling of his right first toe and bleeding from the right, lower extremity (leg). The COC indicated Resident 2 had abnormal vital signs (measurements of the body's most basic functions) and altered mental status (a change in how well your brain is working). The COC indicated [DATE] was called at 4:09 a.m., and Resident 2 was transferred to the GACH at 4:40 a.m., 92 minutes after Resident 2's initial change of condition. During a review of Resident 2's Progress Notes, dated [DATE], the Progress Notes indicated on [DATE] at 3:08 a.m., Licensed Vocational Nurse (LVN) 1 assessed Resident 2's discoloration and swelling on his right first toe. The Progress Notes indicated Resident 2 appeared confused. The Progress Notes indicated the following vital signs and assessments: 1. At 3:10 a.m., Resident 2's vital signs were the following: Blood pressure (BP, force of blood used to get through the vessels of the body) was ,d+[DATE] (normal range of ,d+[DATE] [top number] and ,d+[DATE] [bottom number) millimeters of mercury ([mm Hg], unit of measurement), respiratory rate (RR, breathing) of 21 breaths per minute (normal RR 12 to 20 bpm), heart rate (HR) was 66 beats per minute ([BPM], normal range 60 to 100 BPM), temperature of 98.8 degrees Fahrenheit ([F], a unit of measurement, normal temperature range 97 to 99 F), and oxygen saturation of 84% on room air. The Progress Note indicated supplemental oxygen was initiated at 5 LPM via an oxygen mask. 2. At 3:40 a.m., the Progress Note indicated Resident 2 had no changes from the assessment done at 3:10 a.m. The Progress Note indicated Resident 2 was making noises. Resident 2's vital signs were the following: BP was ,d+[DATE] mmHg, RR was 21 bmp, HR was 87 BPM, temperature was 98.9 F, and oxygen saturation was 87% while receiving 10 LPM of oxygen via an oxygen mask. 3. At 3:55 a.m., Resident 2's vital signs were the following: BP was ,d+[DATE] mmHg, RR was 22 bpm, HR was 87 BPM, temperature was 98.9 F, and oxygen saturation was 84% while receiving 15 LPM via an oxygen mask. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	4. At 4:07 a.m., Resident 2 was observed with his eyes closed, with labored breathing, and with his (unspecified) upper extremity cold to the touch. Resident 2 was unable to respond verbally but would awake to tactile stimuli (any form or touch or physical contact perceived by the skin). Resident 2's vital signs were the following: BP was ,d+[DATE] mmHg, RR was 22 bpm, HR was 116 BPM, temperature was 99.1 F, and oxygen saturation was 87% while receiving 15 LPM of oxygen via a non-rebreather mask (oxygen mask that delivers high concentrations of oxygen). The Progress Notes dated [DATE], indicated [DATE] was called at 4:09 a.m. and the emergency medical services (EMS) arrived at the facility at 4:13 a.m. The Progress Notes indicated on [DATE], Resident 2 was transferred to the GACH at 4:40 a.m., 92 minutes after Resident 2's initial change of condition. During a review of Resident 2's GACH Emergency Department (ED) Note, dated [DATE] and timed at 5:10 a.m., the GACH ED Note indicated upon arrival to the ED, Resident 2's vital signs were the following: BP was , d+[DATE] mmHg, RR was 22 bpm, HR was 98 BPM, temperature was 104.9 F, and oxygen saturation was 87% on 15 LMP of oxygen via an oxygen mask. The GACH ED Note indicated Resident 2 was brought to the GACH via ambulance for worsening cellulitis to the bilateral (affecting both sides) lower extremities. The GACH ED Note indicated Resident 2's legs were initially wrapped in gauze and plastic bags and when removed the legs were noted to be extremely pungent malodorous (a strong, sharp, unpleasant odor). The GACH ED Note indicated Resident 2's lactic acid level (a blood test used to help diagnose sepsis [a life-threatening blood infection]) was elevated at 3.46 millimoles per liter ([mmol/L, unit of measurement], normal value of 0.7 to 1.9 mmol/L). The GACH ED Note indicated Resident 2's white blood cell count ([WBC], a blood test that indicate the presence of inflammation or infection) was elevated at 16 microliters ([X10^3/Ul]- a unit of measurement, normal WBC count 4.5 to 11). The GACH ED Note indicated Resident 2 was diagnosed with septic shock (a life-threatening condition that occurs when an infection causes a dangerously low blood pressure and organ failure), acute renal failure (condition where kidneys suddenly lose their function), and cellulitis. During a review of Resident 2's GACH History and Physical (H&P), dated [DATE] and timed at 7:57 a.m., the H&P indicated Resident 2 had worsening right, lower extremity cellulitis. The GACH H&P indicated Resident 2 remained hypotensive (low blood pressure) despite fluid resuscitation (a medical procedure that involves replacing fluids lost by the body) and received norepinephrine (a vasopressor [drug used to make blood vessels constrict or become narrow to raise blood pressure]), vasopressin (a vasopressor), and phenylephrine (vasopressor). The H&P indicated the general surgeon was consulted and a decision was made for Resident 2 to have an emergent right, below the knee amputation. During a review of Resident 2's GACH Nursing Progress Notes, dated [DATE] and timed at 10 a.m., Resident 2 arrived in the Intensive Care Unit (ICU, a hospital ward that provides specialized care for patients who are very ill or injured) at 9:00 a.m. and was intubated (a procedure that involves the insertion of a tube to facilitate breathing) at 10:30 a.m. The notes indicated Resident 2 underwent right and left below the knee amputations (removal of a limb) and was required to be placed on maximum continuous doses of norepinephrine (a vasopressor), vasopressin, and phenylephrine. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's GACH Clinical Notes, dated [DATE] and timed at 6:21 p.m., the Clinical Note indicated Resident 2 continued to receive Levophed (used to treat life-threatening low blood pressure) and phenylephrine despite the right, lower extremity amputation and continued fluid resuscitation. The Clinical Note indicated Resident 2's left lower extremity appeared worse than at admission ([DATE]), with new ischemic changes (when the part of the body does not get enough blood or oxygen) to the soft tissue (the body's supporting tissues such as fat, skin, and muscle). The Clinical Note indicated the care team will proceed with an emergent left below the knee amputation. During a review of Resident 2's GACH Amputation Below Knee Procedure Notes, dated [DATE], the notes indicated Resident 2 underwent bilateral below the knee amputations. During a review of Resident 2's GACH Rapid Response Note, dated [DATE] and timed at 11:54 a.m., the note indicated Resident 2 became pulseless (no heartbeat), required chest compressions, and expired at 11:57 a.m. from cardiac arrest (occurs when the heart suddenly stops beating). During an interview on [DATE] at 12:52 p.m., with LVN 1, LVN 1 stated on [DATE], at approximately 3 a.m., he noticed Resident 2 looked off. LVN 1 stated Resident 2 had blood on his right lower extremity and his right toe had a dark purple discoloration. LVN 1 stated at the beginning of the shift at 11 p.m., Resident 2 did not have any bleeding or dark purple discoloration on his right toe. LVN 1 stated he began to check Resident 2's vital signs and observed the resident's oxygen saturation was low, at 84%. LVN 1 stated he initiated supplemental oxygen and had to increase the amount of oxygen to Resident 2, however, the Resident 2's oxygen saturation did not improve and fluctuated between 84 to 87%. LVN 1 stated due to Resident 2's condition, wound care was not provided to Resident 2's legs and instead was wrapped with additional gauze and a plastic bag. LVN 1 stated he attempted to notify Resident 2's physician towards the end of his shift at approximately 7 a.m., (four hours after Resident 2's initial change of condition). LVN 1 stated Resident 2's physician was not notified when Resident 2's initial change of condition was noted at 3:10 a.m. LVN 1 stated he went with his nursing judgement and acted to treat Resident 2's desaturation (decrease in oxygen saturation) instead of calling Resident 2's physician and waiting for orders. LVN 1 stated he should have notified Resident 2's physician of the resident's status and initial desaturation of 84% for guidance on how to proceed with Resident 2's care. LVN 1 stated if he notified Resident 2's physician sooner, he may have been directed to call [DATE] sooner. During an interview on [DATE] at 2:20 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 2 did not have any respiratory issues and never required supplemental oxygen. RN 1 stated if a resident required 10 LPM of oxygen, regardless of improvement, he would have to immediately call [DATE]. RN 1 stated Resident 2 requiring supplemental oxygen was a change of condition and his physician should have been notified immediately. RN 1 stated notifying the physician would provide a line of communication where the physician may give orders on how to proceed with treatment. RN 1 stated the physician may request to call [DATE] due to the need of a higher level of care for prompt assessment and treatment. RN 1 stated Resident 2 was hypoxic (having too little oxygen) for over an hour and could have been hypoxic long before LVN 1 assessed him. RN 1 stated the lack of physician notification resulted in a delay in care. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:56 p.m., with the Director of Nursing (DON), the DON stated Resident 2 should have been sent to the GACH sooner. The DON stated Resident 2 had a change in oxygenation and mental status. The DON stated Resident 2's physician should have been notified of Resident 2's initial change of condition. The DON stated Resident 2 should not have been allowed to decline to the degree of being responsive only to tactile stimuli. The DON stated Resident 2 was hypoxic for over an hour, which meant he was not getting oxygen to his vital organs. The DON stated Resident 2 suffered a delay in care. During a review of the facility's Policy and Procedure (P&P) titled, Transfer or Discharge, Emergency, revised ,d+[DATE], the P&P indicated when it was necessary to make an emergency transfer to the hospital, the facility would notify the resident's physician. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised ,d+[DATE], the P&P indicated the nurse would notify the resident's physician when there was a significant change (major decline or improvement in the resident's status that could not normally resolve itself without intervention by the staff) in the resident's condition and the resident needed to be transferred to the GACH. b. During a review of Resident 2's COC, dated [DATE], the COC indicated on [DATE] at 9:20 a.m., Resident 2 had an unwitnessed fall and was found in a sitting position on the floor by his bed. The COC indicated Resident 2's 72-Hour Neurological Check (series of tests over a 72-hour period to assess for changes in neurological function [the ability of the nervous system to send and receive signals throughout the body, allowing for movement, sensation, and other bodily functions]) was initiated. During a concurrent interview and record review on [DATE], with RN 1, Resident 2's 72-Hours Neuro Checklist, dated [DATE], was reviewed. RN 1 stated the 72-Hour Neuro Checklist indicated Resident 1's neurological assessment was initiated on [DATE] at 9:30 a.m. RN 1 stated the 72-Hour Neuro Checklist indicated assessment was to be completed twice every 30 minutes, then three times every hour, then two times every two hours, then four times every four hours, and finally six times every eight hours. RN 1 stated the 72-Hours Neuro Checklist dated [DATE], indicated: a. At 9:30 a.m., BP of ,d+[DATE] mmHg, temperature 97.8 F, HR of 80 BPM, RR of 18 bpm, alert, pupils equal and responsive, and left- and right-hand grip firm. b. At 10 a.m., Resident 2 refused assessment. c. At 1 p.m., Resident 2 refused assessment. d. At 4 p.m., Resident 2 refused assessment. e. At 7 p.m., Resident 2 refused assessment. f. At 10 p.m., Resident 2 refused assessment. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	RN 1 stated Resident 2 refused the neurological assessments on [DATE]. RN 1 stated the licensed nurses did not complete the 72-Hours Neuro Checklist for the full 72 hours. RN 1 stated the 72-Hours Neuro Checklist was only completed for 12 hours. RN 1 stated although Resident 2 refused the neurological assessments; the licensed nurse should have continued to try to assess Resident 2 for neurological deficits. RN 1 stated conducting the neurological assessments would help detect any changes in Resident 2's mental status and ensure his brain was functioning at its baseline. RN 1 stated not attempting to complete Resident 2's 72-Hours Neuro Checklist put the resident at risk for undetected symptoms from a brain bleed. RN 1 stated Resident 2's physician should have been notified of his refusal of the neurological assessments. RN 1 stated notifying Resident 2's physician would allow the physician to be aware of Resident 2's status, and further treatment. During a review of the facility's P&P titled, Neurological Assessment, revised ,d+[DATE], the P&P indicated, The purpose of this procedure is to provide guidelines for a neurological assessment upon physician order, when following an unwitnessed fall, subsequent to a fall with a suspected head injury, or when indicated by resident condition. The P&P indicated, Notify the physician of any changes in a resident's neurological status. Notify the supervisor if the resident refuses the procedure. Report other information accordance with facility policy and professional standards of practice. c. During a review of Resident 2's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Fall Management Follow-Up, dated [DATE], the IDT Fall Management Follow-Up indicated Resident 2 was placed on Neuro Checks and Post-Fall Monitoring. The IDT Fall Management Follow-Up indicated other interventions implemented for Resident 2 included to check the resident's vital signs, pain assessment, and body/skin check. The IDT Fall Management Follow-Up indicated an X-ray (procedure to take pictures of the inside of the body) of Resident 2's hips were ordered. The IDT Fall Management Follow-Up indicated Resident 2 did not want the licensed nurse to perform any assessments and to leave him alone. During an interview on [DATE] at 1:10 p.m., with the Quality Assurance (QA) Nurse, the QA Nurse stated after a fall, Resident 2's vital signs and exposed skin, such as arms, legs, and head were assessed. The QA Nurse stated when Resident 2 had an unwitnessed fall on [DATE] but refused to have a full body and skin assessment done. The QA Nurse stated Resident 2 was found on his buttocks and it was important to assess the area for any redness or bruising. The QA Nurse stated Resident 2's physician was not notified the resident refused the skin assessment after the fall. The QA Nurse stated she was unsure why Resident 2's physician was not notified of his refusal for a skin assessment. The QA Nurse stated Resident 2's physician should have been notified for orders to monitor Resident 2 for skin changes and any treatment, if needed. d. During a review of Resident 2's Skin Observation document, dated [DATE] through [DATE], the Skin Observation document indicated Resident 2 refused the skin observation on [DATE], [DATE], [DATE], and [DATE]. During a review of Resident 2's Wound Scan Photos, dated [DATE] and timed at 8:44 a.m., the Wound Scan Photos indicated Resident 2 had redness to the bilateral buttocks, a dark brown spot on his lower back, and a red/brown spot on his left lower back. During a review of Resident 2's GACH Nursing Note, dated [DATE] and timed at 10 a.m., the Nursing Note indicated Resident 2 had many wounds on his back and hip area indicating that he is unable to turn on his own. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:26 a.m., with the Treatment Nurse (TN), the TN stated the CNAs see the residents' skin more often than the licensed nurses. The TN stated the licensed nurses depended on the CNAs to report any skin changes immediately. The TN stated if a resident refused a shower or skin assessment, the CNA would have to inform the licensed nurse. The TN stated he was unaware of any wounds on Resident 2's buttocks and backside. The TN stated a facility-wide skin sweep would be conducted monthly and Resident 2 was set to have a full body skin assessment if he was not sent to the GACH. During an interview on [DATE] at 11:13 a.m., with CNA 7, CNA 7 stated she was assigned to Resident 2 and was familiar with the resident. CNA 7 stated Resident 2 would not allow her to touch him or allow her to assist with his ADLs or other parts of his care. CNA 7 stated Resident 2 would ask for towels and take wet wipes into the restroom to wipe himself down. CNA 7 stated Resident 2 would close the door on her and would not allow CNA 7 to observe his back side and buttocks. CNA 7 stated Resident 2 was very independent and ambulatory (ability to walk). CNA 7 stated she informed the licensed nurse of Resident 2's skin check refusals. During an interview on [DATE] at 11:44 a.m., with the DON, the DON stated the licensed nurses conduct a monthly skin sweep for each resident, and CNAs would perform a daily skin observation when providing care to a resident. The DON stated the CNAs would note any skin changes and inform the licensed nurses. The DON stated Resident 2 did not allow the CNAs or licensed nurses to assist with his care and demanded they leave his room. The DON stated Resident 2's physician was not notified the resident refused his skin assessments. The DON stated the physician should have been notified for interventions to better care for Resident 2 and prevent the resident's condition from getting worse. The DON stated notifying Resident 2's physician could have allowed for better assessment of Resident 2's skin and to identify any changes in his skin and treat accordingly. During a review of the facility's P&P titled, Refusal of Care and Treatment, revised 2017, the P&P indicated, The Attending Physician must be notified of refusal or treatment, in a time frame determined by the resident's condition and potential serious consequences of the refusal.

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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** 47679 Based on interview and record review, the facility failed to revise the person-centered care plan (document that helps nurses and other team care members organize aspect of resident care) for one of seven sampled residents (Resident 2), who refused skin check assessments during activities of daily living ([ADLs], activities such as bathing, dressing, and toileting a person performs daily). This failure had the potential to result in the mismanagement of Resident 2 ' s care by not having a guideline to follow for assessing and managing Resident 2 ' s skin integrity. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb, acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of the left calf muscular vein, and peripheral vascular disease ([PVD], a slow progressive narrowing of the blood flow to the arm and legs). During a review of Resident 2 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 11/27/2024, the MDS indicated Resident 2 ' s cognition (process of thinking) was severely impaired. The MDS indicated Resident 2 required moderate assistance with oral hygiene, toileting, bathing, and dressing. The MDS indicated Resident 2 had four venous ulcers (an open sore on the leg that occurs when blood does not circulate properly in the leg veins) present. The MDS indicated Resident 2 had an infection of the foot. During a review of Resident 2 ' s Skin Observation record, dated 11/24/2024 through 11/28/2024, the Skin Observation record indicated Resident 2 refused the skin observation on 11/28/2024, 12/2/2024, 12/4/2024, and 12/11/2024. During an interview on 1/2/2025 at 11:11 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated when the residents were showered, the CNAs would do a skin inspection and report any out of the ordinary findings to the licensed nurse. CNA 3 stated if a resident refused a shower or refused the skin inspection, the licensed nurse would be notified. During an interview on 1/3/2025 at 11:13 a.m., with CNA 7, CNA 7 stated she was assigned to Resident 2 and was familiar with the resident. CNA 7 stated Resident 2 would not allow her to touch him (Resident 2) or allow her (CNA 7) to assist with his ADLs or other parts of his care. CNA 7 stated Resident 2 would ask for towels and take wet wipes into the restroom to wipe himself down. CNA 7 stated Resident 2 would close the door on her and would not allow her to see his back side and buttocks. CNA 7 stated Resident 2 was very independent and ambulatory (ability to walk). CNA 7 stated she would inform the licensed nurse of Resident 2 ' s skin check refusals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/2025 at 11:44 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses conduct a monthly skin sweep for each resident, however, the CNAs would do a skin observation daily when they provided care to a resident. The DON stated the CNAs would note any skin changes and inform the licensed nurses. The DON stated Resident 2 did not allow the CNAs or licensed nurses to assist with his care and would demand them to leave his room. The DON stated Resident 2 ' s care plan of refusing skin assessments should have been revised. The DON stated Resident 2 refused a skin assessment upon admission, however, the care plan should have been revised to communicate the ongoing problem. The DON stated revising the care plan would ensure the nurses and the physician were aware of the ongoing problem and to develop and implement further interventions to prevent skin breakdown and to promote skin healing. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans- Comprehensive, revised 9/2010, the P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the resident and the resident ' s condition change.

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Santa Fe Heights Healthcare Center, LLC	2309 N Santa Fe Ave Compton, CA 90222

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to provide ordered wound care treatments on 12/7/2024 and 12/28/2024, for one of seven sampled residents (Resident 2). This failure had the potential to result in the development of an infection and the potential for Resident 2 ' s wounds to worsen. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb, acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of the left calf muscular vein, and peripheral vascular disease ([PVD], a slow progressive narrowing of the blood flow to the arm and legs). During a review of Resident 2 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 11/27/2024, the MDS indicated Resident 2 ' s cognition (process of thinking) was severely impaired. The MDS indicated Resident 2 required moderate assistance with oral hygiene, toileting, bathing, and dressing. The MDS indicated Resident 2 had four venous ulcers (an open sore on the leg that occurs when blood does not circulate properly in the leg veins) present. The MDS indicated Resident 2 had an infection of the left foot. During a review of Resident 2 ' s Order Recap Report, dated 11/1/2024 through 1/31/2025, the Order Recap Report indicated the following orders: a. Cleanse Resident 2 ' s left, dorsal (top side) foot venous wound with normal saline (solution of water and salt used to clean wounds) and pat dry. Apply silvadene cream (medicated cream used to prevent and treat wound infections) and zinc oxide cream (cream used to treat and prevent skin irritation). Cover with absorbent dressing and wrap with kerlix (dressing used to secure and prevent movement of primary dressing), once a day. b. Cleanse Resident 2 ' s left, lower extremity (leg) venous wound with normal saline and pat dry. Apply Silvadene cream and zinc oxide cream. Cover with absorbent dressing and wrap with kerlix, once a day. c. Cleanse Resident 2 ' s right, dorsal foot venous wound with normal saline and pat dry. Apply Silvadene cream and zinc oxide cream. Cover with absorbent dressing and wrap with kerlix, once a day d. Cleanse Resident 2 ' s right, lower extremity venous wound with normal saline and pat dry. Apply Silvadene cream and zinc oxide cream. Cover with absorbent dressing and wrap with kerlix, once a day. During a review of Resident 2 ' s Skin Observation Tool, dated 12/18/2024, the Skin Observation Tool indicated the following measurements for Resident 2 ' s venous wounds: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Right, dorsal foot venous wound measured 11 centimeters (cm, unit of measurement) in length, 4 cm in width, and 0.7 cm in depth. b. Right, lower leg venous wound measured 23 cm in length, 40 cm in width, and 3 cm in depth. c. Left, lower leg venous wound measured 35 cm in length, 30 cm in width, and 1.2 cm in depth. d. Left, dorsal foot venous wound measured 6 cm in length, 3 cm in width, and 0.3 cm in depth. The Skin Observation Tool indicated Resident 2 ' s wounds had heavy serous (clear or slightly yellow, thin, watery fluid that seeps from a wound during healing) drainage and edema (swelling). During an interview on 1/2/2025 at 11:29 a.m., with the Treatment Nurse (TN), the TN stated Resident 2 was admitted to the facility with venous ulcers to both lower legs and both dorsal feet. The TN stated there were times Resident 2 refused wound care treatment. The TN stated he would inform Resident 2 ' s physician of his refusal. The TN stated he was the only dedicated wound care nurse for the facility, however, the other licensed nurses could administer the treatment when he was not there. The TN stated Resident 2 ' s wound treatments was ordered once a day and unless Resident 2 refused the treatments, Resident 2 should have received the treatments even if he was not scheduled to work that day. During a concurrent interview and record review on 1/2/2024 at 11:35 a.m., with the TN, Resident 2 ' s Treatment Administration Record (TAR), dated 12/1/2024 through 12/31/2024 was reviewed. The TAR indicated Resident 2 did not receive the ordered wound care treatments for his left dorsal foot, left lower extremity, right dorsal foot, and right lower extremity on 12/7/2024 and 12/28/2024. The TN stated the empty boxes on Resident 2 ' s TAR signified that Resident 2 did not receive the ordered treatments on 12/7/2024 and 12/28/2024. The TN stated Resident 2 had extensive wounds on both his legs and feet and providing the wound care treatment everyday was important to heal those wounds. The TN stated Resident 2 ' s wounds had heavy drainage, which made it very important to change his wound dressings every day. The TN stated not providing the ordered wound care treatment and changing soiled dressings could cause Resident 2 ' s wounds to worsen. During an interview on 1/2/2025 at 2:17 p.m., with Registered Nurse (RN) 1, RN 1 stated the days the TN did not work, the residents ' wound care treatments would need to be completed by the licensed nurse assigned. RN 1 stated there was no reason for missed treatment unless the resident refused or was not in the facility. RN 1 stated providing wound care to Resident 2 was very important due to the size and nature of the wounds. RN 1 stated not providing wound treatments to Resident 2 had the potential to result in the wounds getting worse. During a review of the facility ' s policy and procedure (P&P) titled, Wound Care, revised 10/2010, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician ' s order. The P&P indicated after performing wound care to document on the resident ' s medical record the type of wound care given, the date and time the wound care was given, the name of the individual performing wound care, and if the resident refused the treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure residents were free of accidents and hazards for two of seven sampled residents (Residents 1 and 2) by failing to: 1. Ensure Certified Nursing Assistant (CNA) 1 reported Resident 1 ' s unwitnessed fall to the licensed nurses. 2. Ensure CNA 1 and CNA 2 followed the facility ' s procedure of not moving Resident 1, who fell , prior to being assessed by a licensed nurse. 3. Ensure Resident 1 did not experience a 2-hour delay in physical assessment, 72-Hour Neurological Check (serious of tests over a 72-hour period to assess for changes in neurological function) initiation, and care. 4. Complete Resident 1 ' s post-fall Fall Risk Evaluation. 5. Correctly complete Resident 2 ' s 72-Hour Neurological Check. These failures resulted in Resident 1 ' s licensed nurses being unaware of Resident 1 ' s fall, which resulted in a delay in assessment and interventions. These failures also resulted in Resident 2 not being assessed timely for neurological deficits. Findings: a. During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses the included ataxia (loss of muscle control and coordination) following nontraumatic subarachnoid hemorrhage (neurosurgical emergency that occurs when blood pools in the space that covers the brain), epilepsy (chronic brain condition that causes seizures, which are brief episodes of abnormal electrical activity in the brain), dementia (a progressive state of decline in mental abilities), and acute myocardial infarction (heart attack). During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 10/17/2024, the MDS indicated Resident 1 ' s cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 1 ' s History and Physical (H&P), dated 9/5/2024, the H&P indicated Resident 1 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 1 ' s Fall Risk Evaluation, dated 10/17/2024, the Fall Risk Evaluation indicated Resident 1 was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Change of Condition (COC), dated 12/15/2024, the COC indicated on 12/15/2024 at 4 p.m., Licensed Vocational Nurse (LVN) 2 noticed Resident 1 had red color in his spit and Resident 1 stated he fell on his face two hours prior. The COC indicated the 72-Hour Neurological Check was initiated and Resident 1 was assessed with slight swelling and discoloration to the left side of his face and under the eye. During a review of Resident 1 ' s Statement, dated 12/15/2024 at 4 p.m., the Statement indicated Resident 1 fell two hours prior and was assisted by two nurses who helped him into bed and then left the room. During a review of Resident 1 ' s 72 Hours Neuro Checklist, dated 12/15/2025 through 12/18/2024, the 72 Hours Neuro Checklist indicated Resident 1 ' s Neurological Assessment started on 12/15/2024 at 4 p.m. During an interview on 12/31/2024 at 9:50 a.m., with Resident 1, Resident 1 stated he fell when he tried to throw trash into the trashcan near his bed. Resident 1 stated the trash did not make it into the trashcan and when he tried to pick it up, he fell on to the floor. Resident 1 stated two CNAs helped him back into bed. Resident 1 stated he told the oncoming LVN he fell . During an interview on 12/31/2024 at 10:16 a.m., with CNA 1, CNA 1 stated towards the end of her shift on 12/15/2024, she did her rounds on residents and saw CNA 2 and CNA 5 waving her over to Resident 1 ' s room. CNA 1 stated when she entered Resident 1 ' s room, Resident 1 was on the floor. CNA 1 stated she and CNA 2 picked Resident 1 off the floor and assisted him back to his bed. CNA 1 stated she observed Resident 1 ' s face and did not see any bruising or visual bumps. CNA 1 stated once Resident 1 was back in bed, she changed his diaper and went to look for the LVN on duty. CNA 1 stated she could not locate the LVN assigned to Resident 1 and went to assist another resident. CNA 1 stated by the end of her shift, she forgot to report Resident 1 ' s fall to the assigned LVN. CNA 1 stated she could have reported Resident 1 ' s fall to the other licensed nurses on duty that day. CNA 1 stated there were two other CNAs assisting her and she could have delegated one to get the LVN. CNA 1 stated when a resident fell , she was supposed to get a licensed nurse to come to the room to assess the resident for any injuries. CNA 1 stated reporting to the licensed nurse immediately after Resident 1 ' s fall was important to ensure Resident 1 was assessed for injuries. During an interview on 12/31/2024 at 10:27 a.m., with CNA 2, CNA 2 stated she saw Resident 1 sitting on the floor and informed CNA 1 because she was the assigned CNA to Resident 1. CNA 2 stated she did not inform the licensed nurses about Resident 1 ' s unwitnessed fall because she was not assigned to Resident 1 and thought CNA 1 would report it. CNA 2 stated Resident 1 had an unwitnessed fall, she and CNA 1 should not have moved him before he was assessed by the licensed nurse. CNA 2 stated waiting for the licensed nurse to assess Resident 1 was essential just in case Resident 1 had a broken bone or other kind of injury. During an interview on 12/31/2024 at 11:27 a.m., with the Director of Staff Development (DSD), the DSD stated the expectations of the CNAs if they found a resident on the floor was to call the licensed nurse for assistance and to not move the resident. The DSD stated after a resident falls, the resident could sustain an unseen injury or could be injured when moved. The DSD stated informing the licensed nurse would allow them to conduct an assessment and to determine if the resident was safe to move. The DSD stated the licensed nurse would then report the fall to the physician who would give further orders on how to care for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11:53 a.m., with Registered Nurse (RN) 1, RN 1 stated he was not informed on 12/15/2024 that Resident 1 fell . RN 1 stated Resident 1 told LVN 2, who reported to the physician and began Resident 1 ' s assessments. RN 1 stated CNA 1 should have reported to the licensed nurse immediately after she found Resident 1 on the floor. RN 1 stated immediate reporting to the licensed nurse would allow for Resident 1 to be assessed for injury. RN 1 stated due to the delay in reporting, Resident 1 ' s 72-Hour Neurological Check initiated two hours after Resident 1 ' s fall. RN 1 stated the 72-Hour Neurological Check should have been initiated immediately after knowledge of Resident 1's fall to ensure Resident 1 ' s neurological status was assessed timely. RN 1 stated initiating the 72-Hour Neurological Check immediately was crucial to detect any changes in Resident 1 ' s mental status, which could mean injury to the brain. RN 1 stated if Resident 1 did not inform LVN 2 of his fall and neither CNA 1 nor CNA 2 notified a licensed nurse, Resident 1 may not have received the care and assessments needed. RN 1 stated CNA 1 should not have assisted Resident 1 back to bed before Resident 1 was assessed for injuries. RN 1 stated CNAs were not trained to assess for injuries or use the appropriate interventions. RN 1 stated after a fall, the resident would be assessed for visible injuries, changes in range of motion, any swelling, discoloration, or bleeding. During a concurrent interview and record review on 12/31/2024 at 12:01 p.m., with RN 1, Resident 1 ' s Fall Risk Evaluations were reviewed. RN 1 stated Resident 1 did not have a Fall Risk Evaluation completed after his fall on 12/15/2024. RN 1 stated the purpose of the Fall Risk Evaluation after a fall allowed the nurses to reevaluate and determine if the resident was at further risk for falls and what interventions to implement to prevent further falls. RN 1 stated because a Fall Risk Evaluation was not completed after Resident 1 fell , the nurses may not initiate and implement the appropriate interventions specific to prevent Resident 1 from falling in the future. During an interview on 12/31/2024 at 1:30 p.m., with the Director of Nursing (DON), the DON stated the CNAs were expected to report to the licensed nurse on duty when a resident falls and to not move them. The DON stated based on the assessment and if the resident was stable, the resident would be assisted back into the bed or wheelchair. The DON stated a 72-Hour Neurological Check would be initiated if the resident stated or if there was suspicion that they hit their head. The DON stated immediate reporting of the CNA to the licensed nurse would allow the licensed nurse to address any acute issues present and to provide the appropriate care to the resident. The DON stated a delay in initiating Resident 1 ' s 72-Hour Neurological Check put him at risk for undetected neurological decline and potential for delay in interventions. The DON stated Fall Risk Evaluations were completed upon admission to the facility, quarterly, and after a fall. The DON stated completing the Fall Risk Evaluation after a fall would inform the nurses whether the resident was at a higher risk for falls and what measures to be put into place to prevent or decrease the chance of injury. During a review of the facility ' s policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. During a review of the facility ' s CNA Job Description, undated, the CNA Job Description indicated the duties and responsibilities of the CNA were to report all changes in the resident ' s condition to the Nurse Supervisor/Charge Nurse as soon as practical [and to] report all accidents and incidents you observe on the shift that they occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s In-Service Lesson Plan titled, Fall Risk & Prevention, undated, the In-Service Lesson Plan indicated not to move a resident who falls onto the floor and a head trauma is suspected. b. During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb, acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of left calf muscular vein, and peripheral vascular disease ([PVD], a slow progressive narrowing of the blood flow to the arm and legs). During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognition was severely impaired. The MDS indicated Resident 2 required moderate assistance with oral hygiene, toileting, bathing, and dressing. The MDS indicated Resident 2 had four venous ulcers (an open sore on the leg that occurs when blood does not circulate properly in the leg veins) present. The MDS indicated Resident 2 had an infection of the foot. During a review of Resident 2 ' s Fall Risk Evaluation, dated 11/25/2024, the Fall Risk Evaluation indicated Resident 2 was at risk for falls. During a review of Resident 2 ' s COC, dated 12/27/2024, the COC indicated on 12/27/2024 at 9:20 a.m., Resident 2 was found in a sitting position on the floor by his bed side. The COC indicated Resident 2 ' s 72-Hour Neurological Check was initiated. During a concurrent interview and record review on 1/2/2025, with RN 1, Resident 2 ' s 72 Hours Neuro Checklist, dated 12/27/2024, was reviewed. The 72 Hours Neuro Checklist indicated Resident 1 ' s neurological assessment was initiated on 12/27/2024 at 9:30 a.m. The 72 Hours Neuro Checklist indicated assessment was to be completed twice every 30 minutes, then three times every hour, then two times every two hours, then four times every four hours, and finally six times every eight hours. The 72 Hours Neuro Checklist indicated the following: a. 12/27/2024 at 9:30 a.m., Blood pressure of 108/64 millimeters of mercury ([mmHg], unit of measurement that describes the amount of force blood uses to get through the vessels of the body), Temperature 97.8 Fahrenheit ([F], a unit of measurement), Heart Rate of 80 beats per minute, Respiratory (breathing) Rate of 18 breaths per minute, alert, pupils were equal and responsive, and left- and right-hand grip were firm. b. 12/27/2024 at 10 a.m., Resident 2 refused assessment. c. 12/27/2024 at 1 p.m., Resident 2 refused assessment. d. 12/27/2024 at 4 p.m., Resident 2 refused assessment. e. 12/27/2024 at 7 p.m., Resident 2 refused assessment. f. 12/27/2024 at 10 p.m., Resident 2 refused assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 stated Resident 2 refused the neurological assessments. RN 1 stated the licensed nurse who attempted the neurological assessment on Resident 2 did not follow the timing. RN 1 stated instead of assessing Resident 2 every hour for three hours, the licensed nurse attempted the neurological assessment every three hours over a nine-hour period. RN 1 stated this was incorrect because the first few hours after a suspected head injury, neurological symptoms could present themselves and would only be detected with timely assessment. RN 1 stated the licensed nurses did not complete the 72 Hours Neuro Checklist for the full 72 hours and was only completed for 12 hours. RN 1 stated Resident 2 refused the neurological assessment; however, the licensed nurse should continue to try to assess Resident for neurological deficits. RN 1 stated conducting the neurological assessments would help detect any changes in Resident 2 ' s mental status and to ensure his brain was functioning at its baseline. RN 1 stated not attempting to complete Resident 2 ' s 72 Hours Neuro Checklist put him at risk of undetected symptoms from a brain bleed. During an interview on 1/2/2025 at 3:49 p.m., with the DON, the DON stated the 72 Hours Neurological Checks were done to identify any change in a resident ' s mental status and to allow for timely interventions. The DON stated the 72 Hours Neurological Checklist had to be completed, or at least attempted, so they could see a trend or pinpoint when a negative change in the resident ' s mental status occurred. During a review of the facility ' s P&P titled, Neurological Assessment, revised 10/2010, the P&P indicated, Neurological assessments are indicated upon physician order, following an unwitnessed fall, following a fall or other accident/injury involving head trauma, or when indicated by resident ' s condition.