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	02/06/2025

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 - Minimal harm or potential for 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** 47858 Based on interview and record review, the facility failed to notify the physician for one out of three sampled residents having a change of condition (Resident 2) by failing to: 1) Ensure the physician was made aware of Resident 2's wandering (aimlessly going from one location to another) behaviors on 12/30/2024, 1/1/2025, and 1/4/2025. 2) Ensure the Interdisciplinary Team (IDT) meeting assessed Resident 2's risk for wandering after resident 2 exhibited a change of condition, as indicated in the facility's Elopement Wandering policy. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities) with other behavioral disturbances, lack of coordination, difficulty in walking, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 required substantial or maximal assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene, and was entirely dependent (helper does all the effort) on staff when walking ten feet (ft- a unit of measurement). During a concurrent interview and record review 2/6/2025 at 3:24p.m. with Licensed Vocational Nurse (LVN) 3, Resident 2's Nursing Progress Notes, dated 12/30/2024, 1/1/2025, and 1/4/2025, were reviewed. The progress notes indicated Resident 2 wandered at night. LVN 3 stated she wrote the note and did not make the physician aware of Resident 2's wandering behaviors because she forgot. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/2025 at 3:33 p.m. with the Minimum Data Set Nurse Coordinator (MDSNC), all of Resident 2's IDT Meeting Notes, dated 2024 to 2025 were reviewed. There was no documentation to indicate Resident 2's risk for wandering was assessed by the IDT. The MDSNC stated the team should have assessed Resident 2's risk upon admission, upon every readmission, and when Resident 2 exhibited changes of condition. The MDSNC stated the IDT should have met to properly assess and address Resident 2's wandering behaviors to ensure proper interventions were in place. During a concurrent interview record review on 2/5/2025 at 4:45 p.m. with the Director of Nursing (DON), Resident 2's IDT Meeting Notes, dated 2025, were reviewed. The DON stated IDT meetings were important because different disciplines within the facility were able to meet with the resident to formulate a plan of care and ensure [the resident's] psychosocial needs were met. The DON stated there should have been an IDT meeting to modify Resident 2's plan of care for wandering. During a review of the facility's Policy and Procedure (P&P), titled, Change in Resident's Condition or Status, revised 11/2015, the P&P indicated the charge nurse would notify the attending physician when the following has occurred: 1. There has been an incident involving the resident. 2. A significant change in the resident's physical, emotional, and mental condition. 3. A need to alter the resident's medical treatment significantly. The P&P also indicated a significant change of condition is a decline or improvement in the resident's status that requires an interdisciplinary review (IDT). During a review of the facility's P&P, titled, Wandering and Elopement, revised 11/2018, the P&P indicated the facility was to assess the resident upon, admission, readmission, and upon identification of significant change of condition.

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47858

Based on interview and record review, the facility failed to prevent physical abuse for two out of three sampled residents (Resident 2 and Resident 3) when the facility failed to:

1) Ensure Resident 1 ' s physicians ' order on 12/3/2024 to send out to the General Acute Center Hospital (GACH) for a psychiatric evaluation (the diagnosis, treatment, and prevention of mental health conditions) if Resident 1 displayed any further behaviors of physical aggression was written and carried out.

2) Ensure the physician was notified after Resident 1 displayed episodes of physical aggression on 12/4/2024 and 12/5/2024 with staff.

These failures resulted in Resident 1 pushing Resident 3 down in the hallway, unprovoked, on 1/21/2025, Resident 1 hitting Resident 2 on the head multiple times in Resident 1 ' s room on 1/23/2025 which led to a delay in care for Resident 1 and placed other residents at risk of further abuse by Resident 1.

Findings:

a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Human Immunodeficiency Virus disease (HIV - a virus that attacks the body's immune system), anxiety disorder (feelings of uneasiness), unspecific psychosis (a mental health condition characterized by a loss of contact with reality).

During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 11/26/2024, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 1 required substantial or maximal assistance (helper provides more than half of the effort) for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene.

During a review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/21/2025, the SBAR indicated Resident 1 shoved Resident 3 in front of a medication cart, in the hallway.

During a review of Resident 1 ' s SBAR, dated 1/23/2025, the SBAR indicated Resident 2 wandered into Resident 1 ' s room, and Resident 1struck Resident 2 in the head multiple times. The SBAR indicated Resident 2 sustained a scratch on the left arm and thumb.

During an interview on 2/5/2025 at 1:30p.m. with Registered Nurse (RN) 1, RN 1 stated the licensed nurses should have notified the physician on 12/4/2024 and 12/5/2024 when Resident 1 displayed episodes of aggression. RN 1 stated this should have been done to prevent any abuse and minimize the chance of another altercation.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/2025 at 1:19 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s SBAR, dated 12/3/2024, was reviewed. The SBAR indicated Resident 1 hit CNA ' s arm as she attempted to make Resident 1 ' s bed. The SBAR indicated the physician ordered to send out Resident 1 to the GACH for further psychiatric evaluation if Resident 1 displayed another episode of physical aggression. LVN 1 stated it was important to write and carry out physician orders because the orders provided guidance on how to provide care for a resident. LVN 1 stated she should have written and carried out the physician ' s order and placed the order into the Electronic Medical Record (EMR). LVN 1 stated she did not transcribe the order or relay the information to the oncoming shift LVN. During a concurrent interview and record review on 2/5/2025 at 1:19 p.m. with LVN 1, Resident 1 ' s Nursing Progress Note dated 12/4/2024 was reviewed. The Nursing Progress Note indicated Resident 1 had become physically aggressive towards a CNA after the CNA attempted to assist Resident 1 to pull up his pants. The Nursing Progress Note indicated Resident 1 threw a lunch tray out of his room. LVN 1 stated there was no documentation to indicate the physician was made aware. LVN 1 stated it was important to notify the physician of any changes of condition and altercations, especially when residents became physically aggressive. LVN 1 stated she should have notified the physician when Resident 1 had displayed the episode of aggression on 12/4/2024. LVN 1 stated she assumed that the physician had already been made aware and that she was a new nurse. During a concurrent interview and record review on 2/5/2025 at 4:45 p.m. with the Director of Nursing (DON), Resident 1 ' s SBAR Note dated 12/3/2024 and Nursing Progress Notes, dated 12/3/2024 and 12/5/2024, were reviewed. The DON stated she expected the licensed nurses to write and carry out orders once the orders were received from the physician. The DON stated LVN 1 should have written the physician ' s order to send Resident 1 out to the GACH if he displayed another act of aggression. The DON stated Resident 1 should have been sent out to the GACH on 12/4/2024 or 12/5/2024 to prevent further instances of physical aggression, physical altercations, or physical abuse. During a concurrent interview and record review on 2/6/2025 at 3:55 p.m. with LVN 2, Resident 1 ' s Nursing Progress Note, dated 12/5/2024 was reviewed. The Nursing Progress Note indicated Resident 1 had become physically aggressive after staff had attempted to transfer Resident 1 to another room. There was no documentation to indicate the physician was made aware. LVN 2 stated Resident 1 started to lunge towards staff and attempted to attack them. LVN 2 stated she should have called the physician, but did not think of doing so at the time. LVN 2 stated she was not made aware of the physician ' s previous order to send out Resident 1 if he (Resident 1) displayed continued acts of aggression. LVN 1 stated if she had known, she would have sent Resident 1 to the GACH to receive the care he needed. b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included dementia (a progressive state of decline in mental abilities) with other behavioral disturbances, lack of coordination, difficulty in walking, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 required substantial or maximal assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene, and was entirely dependent (helper does all the effort) on staff when walking ten feet (ft- a unit of measurement). c. During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 ' s diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and difficulty in walking. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 required partial or moderate assistance (helper provides less than half of the effort) for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. During an interview on 2/5/2025 at 4:45 p.m. with the DON, the DON stated the licensed nurses should have sent Resident 1 out to the GACH for a psychiatric evaluation on 12/4/2024. The DON stated, This led to repeated episodes of altercations, further acts of aggression towards staff, and residents. The DON stated this could have led to the physical abuse incidents on 1/21/2025 and 1/23/2025 to Resident 2 and Resident 3 by Resident 1. During a review of the facility ' s Policy and Procedure (P&P), titled, Abuse Prevention and Prohibition, revised 11/2018, the policy indicated the facility was to understand behavioral symptoms of residents that would increase the risk of abuse. The P&P indicated aggressive and, or catastrophic reactions of residents and wandering behaviors were symptoms that would increase the risk of abuse. The P&P indicated the facility involved qualified psychiatrists and other mental health professionals to help facility staff manage difficult of aggressive residents. During a review of the facility ' s P&P, titled, Medication and Treatment Orders, revised 4/2014, the P&P indicated the licensed nurses were to record verbal orders immediately in the resident ' s chart by the person receiving the order.

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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** 47858 Based on interview and record review, the facility failed to ensure a care plan was initiated and implemented to address a resident's known wandering behaviors before the resident wandered into Resident 1's room and caused a physical altercation (on 1/23/2025) for one out of three sampled residents (Resident 2). Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities) with other behavioral disturbances, lack of coordination, difficulty in walking, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 required substantial or maximal assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene, and was entirely dependent (helper does all the effort) on staff when walking ten feet (ft- a unit of measurement). During a concurrent interview and record review 2/6/2025 at 3:24p.m. with Licensed Vocational Nurse (LVN) 3, Resident 2's Nursing Progress Notes, dated 12/30/2024, 1/1/2025, and 1/4/2025, and all of Resident 2's care plans, dated 2024 to 2025, were reviewed. The progress notes indicated Resident 2 wandered at night. LVN 3 stated there was no care plan initiated to address Resident 2's wandering behaviors. LVN 3 stated she wrote the note and forgot to initiate a care plan. LVN 3 stated she should have immediately created a care plan for Resident 2's wandering behaviors so that interventions could have been in place to keep Resident 2 safe, to prevent physical altercations, physical abuse, and injury. During an interview on 2/5/2025 at 4:45 p.m. with the Director of Nursing (DON), the DON stated if there had been a care plan in place (for Resident 2), interventions would have been put into place. b. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Human Immunodeficiency Virus disease (HIV - a virus that attacks the body's immune system), anxiety disorder (feelings of uneasiness), unspecific psychosis (a mental health condition characterized by a loss of contact with reality). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 11/26/2024, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 1 required substantial or maximal assistance (helper provides more than half of the effort) for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. (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 Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/23/2025, the SBAR indicated Resident 2 wandered into Resident 1's room, and Resident 1struck Resident 2 in the head multiple times. The SBAR indicated Resident 2 sustained a scratch on the left arm and thumb. During a review of the facility's P&P, titled, Care Plans Comprehensive, revised 9/2010, the P&P indicated the facility was to develop and maintain a comprehensive care plan for the resident that identifies the highest level of functioning the resident may be expected to attain. During a review of the facility's P&P, titled, Safety and Supervision of Residents, revised 7/2070, the P&P indicated the facility was to address safety and accident hazards and implement interventions to reduce accident risks and hazards.