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	04/07/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure a resident ' s blood pressure (the pressure of the blood in the circulatory system), and pulse rate (the number of times the heart beats within a certain time period) was assessed and documented before the administration of hydralazine and lisinopril (medications that lower blood pressure by making blood vessels widen so blood gets through more easily) as ordered by the physician and indicated in the care plan for one out of six sampled residents (Resident 1). This failure had the potential to cause a decrease in Resident 1 ' s blood pressure and result in a medical emergency. Findings: 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 hypertensive heart disease (caused by unmanaged high blood pressure for a long time which could lead to heart failure or other health problems) chronic pulmonary edema (fluid accumulation in the lungs caused by heart problems), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1 ' s History and Physical (H&P), dated 4/3/2025, the H&P indicated Resident 1 was able to understand and make medical decisions. During a review of Resident 1 ' s Order Summary Report, dated 4/2025, the Order Summary Report indicated to administer hydralazine oral tablet 10 milligrams (mg- a unit of measurement) one tablet three times a day for hypertension (high blood pressure). The Order Summary Report indicated to hold the administration of hydralazine for a systolic blood pressure (SBP - top number of a blood pressure reading [normal range of 120-129]) of less than 110 millimeters of mercury ([MM HG]- unit of measurement that describes the amount of force blood uses to get through the vessels of the body) or a pulse less than 60 beats per minute (normal rate in an adult is between 60 and 100 beats per minute). The Order Summary Report indicated to administer lisinopril oral tablet 20 mg one tablet by mouth one time a day for hypertension. The Order Summary Report indicated to hold the administration of lisinopril for a SBP of less than 110 or a pulse of less than 60. During a review of Resident 1 ' s Cardiac Distress Care Plan, initiated 4/4/2025, the Cardiac Distress Care Plan indicated to administer medications as ordered and to monitor Resident 1 ' s pulse and blood pressure as ordered. (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/7/2025 at 12:28 p.m. with the Director of Nursing (DON), DON stated Resident 1 ' s Order Summary Report, dated 4/2025, and Electronic Medication Administration Record (eMAR), dated 4/4/2025 through 4/6/2025, and Vital Signs Summary, dated 4/4/2025 through 4/6/2025, were reviewed. The DON stated the Order Summary Report indicated there were specific parameters to hold Resident 1 ' s blood pressure medications. The DON stated Resident 1 ' s eMAR did not indicate Resident 1 ' s blood pressure or pulse were measured 30 minutes prior to the administration of the blood pressure medications on 4/4/2025 at 9 a.m., 1 p.m., and 5 p.m., 4/5/2025 at 1 p.m. and 5 p.m., and on 4/6/2025 at 1 p.m. and 5 p.m. Resident 1 ' s Vital Signs Summary indicated no vitals signs were recorded since Resident 1's admission to the facility. The DON stated it was important to ensure Resident 1 ' s vitals were assessed and documented to ensure the blood pressure medications were administered safely according to the physician ' s ordered parameters. The DON stated there was a possibility that Resident 1 could bottom out due to low blood pressure if the licensed nurses did not take the blood pressure or the pulse 30 minutes prior to the administration of Resident 1 ' s ordered doses of hydralazine and lisinopril. During an interview with Licensed Vocational Nurse (LVN) 2 on 4/7/2025 at 3:02 p.m., LVN 2 stated he was Resident 1 ' s assigned nurse and admitted Resident 1 to the facility on [DATE]. LVN 2 stated he performed the medication reconciliation and entered Resident 1 ' s blood pressure medications into the electronic medical record (EMR). LVN 2 stated he forgot to the input the supplemental documentation information to allow the licensed nurses to input Resident 1 ' s blood pressure and pulse measurements into the eMAR before the administration of each blood pressure medication. LVN 2 stated this led to the lack of documentation of vital signs taken prior to the administration of Resident 1 ' s hydralazine and lisinopril on the following shifts (4/2/2025 through 4/6/2025). LVN 2 stated if Resident 1 ' s blood pressure or pulse were not assessed 30 minutes prior to the administration of blood pressure medications, there was potential Resident 1 ' s blood pressure or pulse could have been significantly lowered, which could have led to a medical emergency. During a review of the facility ' s Policy and Procedure (P&P), titled, Care Plans, Comprehensive Person Centered, revised 12/2016, the P&P indicated the facility was to implement a comprehensive, person-centered care plan for each resident. During a review of the facility ' s Charge Nurse Job Description (undated), the Charge Nurse Job Description indicated to coordinate nursing care through an appropriate individualized care plan. The Job Description indicated the charge nurse was to administer and document medications and treatments in compliance with facility policy.