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	05/17/2025

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 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** Based on interview and record review, the facility failed to ensure adequate resident supervision (oversight), and monitoring was implemented for one of three sampled residents (Residents 1), who was at high risk for elopement (leaving the facility without permission and supervision). This failure resulted in resident eloping the facility on 5/16/2025 and placed the resident at risk for missing scheduled medications, exposure to hot weather, accidents and other complications that can lead to severe injuries, hospitalization and death. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a chronic mental illness where individuals experience symptoms of both schizophrenia and a mood disorder), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (excessive and persistent fear or worry.) During a review of Resident 1 ' s History and Physical (H&P) dated 4/21/2025, the H&P indicated Resident 1 does not have the mental capacity to understand and make medical decisions. During a review of Residents 1 ' s Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 4/7/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required partial to moderate assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene. The MDS indicates Resident 1 required supervision or touching assistance with transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side.) During a review of Resident 1 ' s Elopement Evaluation, dated 4/7/2025 the evaluation indicated Resident 1 had history of elopement or had attempted to leave the facility without informing staff. The evaluation indicated Resident 1 had verbally expressed the desire to go home. The evaluation indicated Resident 1 wanders. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s progress notes, dated 4/17/2025 the progress notes indicated Resident 1 ' s wander guard bracelet (a bracelet monitor) was checked and Resident 1 stated, I took it out, it ' s heavy and I don't like it. Resident 1 stated, I've learned my lesson, I will not leave without telling anyone. The progress notes indicated the Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care), asked the resident if she has plan of exiting the facility and resident stated, No, I've learned my lesson. The progress notes indicated the IDT will continue with frequent visual check with the resident every shift. During a review of Resident 1 ' s care plan titled Resident 1 ' s Wander guard applied on 4/14/2025 was removed by the resident. The resident requested not to put it back. It's heavy and the resident doesn't like it, dated 4/17/2025, one of the care plan interventions indicated frequent visual check of Resident 1 ' s whereabouts within the facility. During an interview on 5/17/2025 at 10:31 a.m. with Resident 1, Resident 1 stated, I went to shop for fresh fruits and vegetables, went to different stores and I had lunch at Ihop restaurant. Resident 1 stated I spent the entire day shopping. Resident 1 stated I put the chair and sneaked out from the window. Resident 1 stated, I have no injuries. I am okay. Resident 1 stated, I did not tell anybody. Resident 1 stated, I called my sister to tell her about my shopping, then I came back to the facility. During an interview on 5/17/2025 at 3:30 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the frequent visual checks described in Resident 1 ' s care plan meant that Resident 1 needed to be checked every two hours. LVN 2 stated the care plan needs to be precise with every how many hours Resident 1 need to be visually checked. LVN 2 stated the visual check should be documented in the resident ' s clinical record. LVN 2 stated Resident 1 should always be monitored because she is at risk forelopement and injuries while outside the facility. During a concurrent interview and record review on 5/17/2025 at 3:55 p.m. with the Director of Nursing (DON), Resident 1 ' s care plan titled Resident 1 ' s Wander guard applied on 4/14/2025 was removed by the resident. The resident requested not to put it back. It's heavy and the resident doesn't like it, dated 4/17/2025, was reviewed. The DON stated Resident 1 refused to wear the wander guard. The DON stated the care plan indicated frequent visual monitors which means Certified Nursing Assistants (CNA) and charge nurses should be monitoring Resident 1 to know where she is always at. The DON stated the care plan was not clear. The DON stated frequent visual checks should specify how often Resident 1 needed to be monitored for Resident 1 ' s safety, and to deliver high quality care. The DON stated the risk of not being specific with monitoring isResident 1 will not get the supervision she needs and can lead to another episode of elopement. During a review of the facility ' s P&P titled Care Plans- Comprehensive, dated 9/2010, the P&P indicated an individualized care plan 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) titled, Safety and Supervision of Residents, dated 2007, the P&P indicated resident safety, supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated when accident hazards are identified, the QA&A/Safety Committee shall evaluate and analyze the cause and develop strategies to mitigate or remove the hazards to the extent possible.