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	05/29/2025

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 0600 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to protect resident's right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1), who was subjected to Resident 2's physical attack, who had diagnosis of schizophrenia (a serious mental disorder in which people interpret reality abnormally, may result in delusions and behavior that impairs daily functioning, may have grandiose delusions [strong beliefs of things that are untrue]). The facility failed to: - Implement the facility's policy and procedure (P&P) titled, Abuse Prevention/Prohibition, dated 11/2018, which indicated the facility would understand behavioral symptoms of residents that may increase the risk of abuse including aggressive and/or catastrophic reactions of residents, outbursts, or yelling out. - Develop a resident specific Schizophrenia care plan for Resident 2, with interventions to monitor behavior and re-evaluate for effectiveness. -Implement the Psychosocial Well-Being Care Plan dated 3/17/2025 to listen attentively and address concerns of Resident 2, when Resident 2 had erratic mood swings for eight days and auditory hallucinations (a perception of having seen or heard something that was not there) for five days from 5/1 - 5/13/2025. This deficient practice resulted in Resident 2 punching Resident 1 in the right eye causing bruising (traumatic injury to the skin that results in discoloration, inflammation, and pain), and swelling to the right eye. Resident 1 received pain medication, had emotional distress, stated she did not feel safe in the facility, and did not want to be alone. Findings: A review of Resident 2's admission Record indicated the resident was re-admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mental health condition characterized by a persistent low mood), alcoholic liver disease (a range of liver injuries caused by excessive alcohol consumption), and heart failure (when the heart cannot pump enough blood to meet the body's needs). Further review of the admission Record indicated there was no diagnosis included regarding Schizophrenia. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's care plan titled, Psychosocial Well-Being (encompasses mental, emotional, social, and spiritual well-being, and its impact on overall health and functioning) dated 3/17/2025 indicated Resident 2 had the potential for alteration in psychosocial well-being related to feeling down depressed or hopeless. The care plan goal indicated to minimize episodes of behavioral symptoms for three months and the interventions indicated to listen attentively to Resident 2 and address concerns. A review of the Residents 2's care plan titled, Mood Pattern with depression manifested by inability to sleep dated 3/17/2025, indicated interventions to monitor for increase or decrease behavior and notify medical doctor, to evaluate effectiveness of or response to medication and report to medical doctor. A review of Resident 2's History and Physical (H&P), dated 3/18/2025 indicated the resident did not have the capacity to understand and make decisions. A review of the Medication Administration Record (MAR) dated 3/31/2025 indicated Resident 2 was to receive Trazadone (an antidepressant medication used to treat depression and anxiety) 50 milligrams (mg, unit of measurement) at bedtime for Schizophrenia spectrum disorder (a group of mental health conditions characterized by psychosis, hallucinations, delusions and disorganized thinking). A review of the Minimum Data Set (MDS, a resident assessment tool) dated 4/3/2025, indicated Resident 2's cognition (the ability to think, understand, and reason) was mildly impaired and the resident felt down, depressed or hopeless with a frequency of 7 - 11 days. The MDS indicated Resident 2 had an active diagnosis of a psychiatric mood disorder (depression) and was taking an antidepressant medication (used to treat mental health conditions like depression and anxiety). The MDS did not indicate Resident 2 had any behaviors of hallucinations or delusions (misconceptions or beliefs that were firmly held or contrary to reality), did not indicate Resident 2 had a diagnosis of Schizophrenia, nor received any antipsychotic medications (a class of medicines used to treat psychosis [a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality] and other mental and emotional conditions. According to a review of the Psychiatric Evaluation Notes dated 4/12/2025, from Resident 2's Primary Physician's Office, Resident 2 had diagnoses including Schizophrenia and Mood Disorder (a mental health condition that affects a person's emotional state, causing long periods of sadness, depression, mania, or elation). The Psychiatric Evaluation Note indicated Resident 2 had episodes of being irritable, yelling and talking to herself. A review of the Physician's Order Summary Report dated 4/14/2025, indicated Resident 2 received Depakote (a mood stabilizer medication) 250 mg three times a day for mood disorder manifested by erratic mood swings (rapid and intense moment to moment emotional changes) and received Haloperidol (Haldol, antipsychotic medication used to treat Schizophrenia symptoms like hallucinations) 5 mg three times per day for Schizophrenia manifested by auditory hallucinations (when someone perceives sounds that are not there). A review of the Physician's Order Summary Report dated 4/14/2025, indicated Resident 2 was to be monitored for mood disorder manifested by erratic mood swings every shift and monitored for Schizophrenia manifested by hallucinations every shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's MAR dated 5/1/2025 indicated on 5/1, 5/4 - 5/6, 5/8, 5/9, 5/11 and 5/13/2025 (eight days) Resident 2 exhibited erratic mood swings but there was no description documented regarding the specific behavior or what was done about the behavior. A review of Resident 2's medical record indicated there was no documentation regarding listening attentively and addressing Resident 2's concerns, per the Psychosocial Well-Being care plan. According to a review of Resident 2's MAR, dated 5/1/2025 indicated that on dates 5/1, 5/2, 5/5, 5/9, and 5/11/2025 (five days) Resident 2 exhibited auditory hallucinations, but there was no description documented regarding the specific behavior Resident 2 exhibited or staff's interventions. A review of the Resident 2's medical record indicated there was no care plan for the diagnosis of Schizophrenia. A review of Resident 1's admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (mental health condition that's characterized by a persistent low mood), and osteoporosis (a chronic condition that causes bones to gradually lose density and mass, making them more fragile and prone to fractures). A review of the MDS dated [DATE], indicated Resident 1's cognition was moderately impaired, and the resident required substantial/maximal assistance (helper did most of the work) from staff for toileting hygiene, showers, and dressing. A review of the Situation Background Assessment Recommendation (SBAR) form dated 5/15/2025 indicated Resident 2 had become increasingly verbally confrontational with roommate (Resident 1) and struck Resident 1 with an open hand in the face. The SBAR indicated Resident 2's diagnoses included heart failure and alcoholic liver disease. The SBAR did not indicate Resident 2's diagnosis of Schizophrenia, nor any mental status changes observed. The SBAR indicated the Behavioral Evaluation was not clinically applicable to the change in condition being reported, including danger to self or others, verbal aggression, physical aggression, or personality change. The SBAR indicated to describe other behavioral changes noted or observed but this area remained blank. A review of Resident 1's Skin Observation Tool, dated 5/16/2025 indicated the resident had a right orbital eye swelling and discoloration. According to a review of the Mental and Behavioral Health Treatment Progress Note dated 5/19/2025, Resident 1 was in a low mood and stated she was struck by Resident 2 for no reason. The Progress Note indicated Resident 1 stated, I was punched in my eye. I don't want to see her or have anything to do with her. A review of the Faxed Document sent from the facility to the Department dated 5/20/2025 indicated there was a physical altercation between Resident 2 and Resident 1 that occurred at approximately 8:20 p.m. on 5/15/2025. The faxed document indicated Resident 2 hit Resident 1 in the face with an open hand, which was witnessed by a staff member (Certified Nursing Assistant, CNA 2) during a verbal argument. The faxed document indicated Resident 1 was moved to another room per her request and that the facility's Interdisciplinary Team determined, Resident 2 was physically aggressive causing to hit Resident 1 with an open hand. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the MAR dated 5/20/2025 and 5/22/2025 indicated Resident 1 received Tylenol 325 mg for pain. During an observation on 5/22/2025 at 9:47 a.m., in Resident 1's room, Resident 1 had bruising, discoloration to the right orbital eye and the top portion of the bridge of her nose. During a concurrent interview, Resident 1 stated she and Resident 2 were both in the room they shared. Resident 1 was sitting in her wheelchair, Resident 2 came towards her, and hit her in the eye three times. Resident 1 stated, I had asked her to stop, and she put her hand over my mouth when I started to yell for help. Resident 1 stated her face was hurting after being hit. Resident 1 stated she did not feel safe in the facility, did not want to be alone, and felt that Resident 2 would come into her room when she was alone. During an interview on 5/22/2025 at 2:10 p.m., CNA 2 stated that on 5/15/2025, Resident 1 was in her wheelchair trying to cover her face while Resident 2 was standing and hitting Resident 1. CNA 2 stated Resident 2 called her (CNA 2) a derogatory name when CNA 2 told Resident 2 to stop. Resident 1 kept saying, She hit me! She hit me! CNA 2 stated Resident 1 had redness to her nose and cheek, and that this was considered physical abuse. CNA 2 stated, Resident 2 is always cussing someone out. During an interview on 5/22/2025 at 4 p.m., the Director of Staff Development (DSD) stated recently she had to come out of her office to see what was going on due to Resident 2's loud shouting and cursing, as it had disturbed her and some of the residents. The DSD stated observed Resident 2's erratic mood swings of outbursts and talking to herself, the DSD did not report this behavior to the RN Charge Nurse. During an interview on 5/22/2025 at 4:33 p.m., with Registered Nurse (RN) 1 and Resident 1, in Resident 1's room, Resident 1 stated to RN 1 that she did not feel safe after being hit by Resident 2 and would feel safe if someone was in the room with her, especially at night. RN 1 stated since the incident, Resident 1 seemed sad, withdrawn, and remained in bed. On 5/23/2025 at 9:30 a.m., during an interview in Resident 2's room, Resident 2 stated Resident 1 was talking about her (Resident 2's) mother and that Resident 2's mother was dead. Resident 2 stated, So I hit her in the face. During an interview on 5/23/2025 at 12 p.m., the DON stated Resident 2 had a potty mouth, (using profanity or foul language) and rebelled against the structure of the facility. The DON stated Resident 2 displayed aggressive behavior towards another resident (Resident 1) and it was considered abuse. The DON stated the staff were to keep frequent visual checks on Resident 2, but there was no documentation in the medical record to confirm it was completed. The DON stated it was important to keep track and document Resident 2's whereabouts to prevent harm from reoccurring. The DON stated the physical altercation of Resident 2 hitting Resident 1 could affect Resident 1 and cause psychological harm, including being scared and withdrawn. The DON stated, We need to continue to check on Resident 1, so the psychological harm does not get worse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/23/2025 at 1:06 p.m., CNA 3 stated Resident 2 used profanity, would shout and say things such as Stupid, Shut up, and shout in the direction of residents when she walked down the hallway. CNA 3 stated Resident 2 would speak in Spanish, use derogatory language and say curse words. CNA 3 stated this behavior by Resident 2 could cause the other residents to feel badly and make the residents feel mad and disrespected. CNA 3 stated she did not report these recent behaviors from Resident 2 to a higher-level facility position. During a concurrent interview and record review on 5/23/2025 at 4:20 p.m. with RN 2, Resident 2's MAR was reviewed. The MAR indicated from 5/1 - 5/13/2025 Resident 2 was documented to have erratic mood swings on eight days, and from 5/2 - 5/11/2025 Resident 2 was documented to have auditory hallucinations on five days, but there was no description of Resident 2's behavior. When RN 2 was asked what the facility did regarding Resident 2 exhibiting erratic mood swings and auditory hallucinations, RN 2 stated she could not find documentation in the medical record of what was done for Resident 2. During an interview on 5/23/2025 at 4:30 p.m., RN 2 stated there was no care plan for Resident 2's diagnosis of Schizophrenia. RN 2 stated Resident 2's behaviors, such as thinking someone was speaking to her in a rude way, needed to be closely monitored for escalated behavior symptoms. RN 2 stated the Schizophrenia care plan interventions would include which non-pharmacological interventions to use and when to call the physician, so the physician could increase or decrease the resident's medications. RN 2 stated the care plan would assist the staff in identifying the aggressive behavior and knowing if the medication was working or not. On 5/28/2025 at 9:30 a.m., during an interview, Resident 1's Responsible Party (RP) stated that he was notified about Resident 1 being hit in the face by Resident 2. The RP stated, I visited on 5/16/2025 (the day after the physical altercation), and she (Resident 1) was scared and cried about being hit. The RP stated, Resident 1 was emotional and very upset about what happened. During a concurrent interview and record review on 5/29/2025 at 2:36 p.m., with RN 1, Resident 2's Psychiatric Evaluation Notes, dated 4/12/2025, from Resident 2's Primary Physician's Office were reviewed. RN 1 stated when Resident 2 used profanity it was not directed toward anyone in particular and it was a symptom of Resident 2's mood disorder and schizophrenia. RN 1 stated the facility should have managed Resident 2's mood behaviors with ongoing observations and document those behaviors as it was important to prevent physical abuse. A review of the facility's P&P titled, Abuse Prevention/Prohibition, dated 11/2018, indicated the facility would understand behavioral symptoms of residents that may increase the risk of abuse. The P&P indicated symptoms include, but are not limited to, aggressive and/or catastrophic reactions of residents, outbursts, or yelling out. A review of the facility's P&P titled, Care Planning- Interdisciplinary Team, dated 9/2013, indicated the facility's care planning/interdisciplinary team was responsible for the development of an individual comprehensive care plan for each resident. The P&P indicated the care plan was based on the resident's comprehensive assessment.