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	11/13/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, document and communicate changes in condition for a resident following an unwitnessed fall for one out of three sampled residents (Resident 1) when the following occurred: 1. Certified Nursing Assistants (CNA) 1 and 2 observed new onset of shoulder pain and limited range of motion while assisting Resident 1 put on a sweater (on 11/3/2025 and 11/6/2025) but did not effectively communicate the change to the Licensed Vocational Nurse (LVN) and did not complete a Stop and Watch form (the facility CNA to LVN communication tool). 2. LVN 1 noted new skin redness to Resident 1's right shoulder on 11/6/2025 (three days after Resident 1's fall) but failed to document the finding, failed to assess for range of motion changes and failed to notify the physician or RN Supervisor. These failures resulted in a delay of physician notification and had the potential to result in missed opportunities to identify Resident 1's clavicle fracture (broken collarbone) and significant bruising to the shoulder, which was not discovered until 11/10/2025 (seven days after her fall), placing Resident 1 at risk for increased pain, functional decline and delayed treatment.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included history of falling, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following a stroke (loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), dementia (a progressive state of decline in mental abilities), and mild intellectual disabilities. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 11/30/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering, lower and upper body dressing putting on footwear, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make medical decisions. During a review of Resident 1's Pain Care Plan, dated 10/30/2025, the Care Plan indicated the nurses were to call the physician for any significant change of condition, find out the reason for pain and intervene, provide nursing measures that will promote comfort, and assess for nonverbal signs and symptoms of pain. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 11/3/2025, the SBAR indicated, on 11/3/2025 at 11:00 a.m., Resident 1 was observed lying a supine position in the hallway, and stated she fell. The SBAR indicated Resident 1 sustained a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) on the back of Resident 1's head. The SBAR indicated the physician was made aware and an x-ray (a type of medical imaging) of the skull (bony enclosure around the brain) was ordered. During a review of Resident 1's SBAR, dated 11/10/2025, the SBAR indicated Resident 1 complained of pain to her right shoulder when raising her right arm and had discoloration to her right shoulder. The SBAR indicated the physician was made aware and an x-ray of the right arm and shoulder was ordered. During a review of Resident 1's X-ray Report, dated 11/10/2025, the report indicated a displaced, acute communicated fracture (a severe type of bone fracture where the bone is broken into multiple pieces) of Resident 1's right clavicle (collarbone). During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells), diabetes (poor blood sugar control) and chronic pain. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact. During a concurrent observation and interview on 11/12/2025 at 1:40 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed with two round, yellow, purple bruises on the back of her shoulder. Resident 1 stated she fell and could not recall how she developed her shoulder injury. 1. During an interview on 11/12/2025 at 2:21 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 recalled, on 11/6/2025, Resident 1 cried and complained of right arm pain while CNA 1 assisted Resident 1 with putting on a sweater. CNA 1 stated when a resident complained of a new onset of pain, the process was to immediately notify the charge nurse and complete a Stop and Watch form. CNA 1 stated she made Licensed Vocational Nurse (LVN) 1 aware but did not complete a Stop and Watch form. CNA 1 stated she should have completed the form to document that she

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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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a registered nurse (RN) supervisor completed the post-fall incident report per facility Policy and Procedure (P&P), titled, Assessing Falls and Their Causes, for a resident who suffered an unwitnessed fall that resulted in the identification of right shoulder bruising and a clavicle fracture (broken collar bone) seven days after the fall for one of three sampled residents (Resident 1). This failure had the potential to result in a delay in an RN- level, thorough post-fall assessment of Resident 1's condition and had the potential to lead to missed opportunities to identify a developing injury. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included history of falling, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following a stroke (loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), dementia (a progressive state of decline in mental abilities), and mild intellectual disabilities. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 11/30/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering, lower and upper body dressing putting on footwear, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make medical decisions. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 11/3/2025, the SBAR indicated, on 11/3/2025 at 11:00 a.m., Resident 1 was observed lying a supine position in the hallway, and stated she fell. The SBAR indicated Resident 1 sustained a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) on the back of Resident 1's head. The SBAR indicated the physician was made aware and an x-ray (a type of medical imaging) of the skull (bony enclosure around the brain) was ordered. During a review of Resident 1's Fall Incident Report (undated), the report indicated Licensed Vocational Nurse (LVN) 1 prepared the report. The Fall Incident Report indicated, on 11/3/2025, a skin check was completed, a hematoma was observed (on the back of Resident 1's head) and no visible skin cuts or abrasions were observed. During a review of Resident 1's SBAR, dated 11/10/2025, the SBAR indicated Resident 1 complained of pain to her right shoulder when raising her right arm and had discoloration to her right shoulder. The SBAR indicated the physician was made aware and an x-ray of the right arm and shoulder was ordered. During a review of Resident 1's X-ray Report, dated 11/10/2025, the report indicated a displaced, acute communicated fracture (a severe type of bone fracture where the bone is broken into multiple pieces) of Resident 1's right clavicle (collarbone). During a concurrent interview and record review on 11/13/2025 at 11:01 a.m. with Quality Assurance Nurse (QAN), the facility's P&P, titled, Assessing Falls and Their Causes, revised 3/2018, and Resident 1's Fall Incident Report (undated) were reviewed. The P&P indicated the nurse supervisor on duty was to complete the Fall Incident Report within 24 hours after the fall occurred. The Fall Incident report indicated LVN 1 completed the report. QAN stated, according to the policy, the registered nurse (RN) supervisor on duty during the time of the fall (RN 1) was supposed to complete the Fall Incident Report. QAN stated the facility did not follow their own policy and had the licensed staff followed the policy, RN 1 would have been prompted to complete RN 1's own physical, post-fall assessment or re-verify LVN 1's post-fall assessment. QAN stated Resident 1 would have benefited from an RN- level post-fall assessment to ensure there were no range of motion issues, injuries, neurological deficits (injury to the brain), and skin issues missed during LVN 1's assessment. During an interview on 11/13/2025 at 11:46 a.m. with RN 1, RN 1 stated he was the assigned RN supervisor during Resident 1's fall on 11/3/2025. RN 1 stated the fall occurred during his lunch break and he was unable to conduct Resident 1's initial post-fall assessment. RN 1 stated he should have completed Resident 1's Fall Incident Report and did not do so because he was unaware of the facility's policy. RN 1 stated if he had been aware, he would have completed the incident report by conducting his own partial post-fall assessment in conjunction with LVN 1's documented assessment. During an interview on 11/13/2025 at 12:59 p.m. with the Director of Nursing (DON), DON stated it was the expectation of the RN Supervisor to conduct a thorough musculoskeletal, neurological, mobility assessment