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	11/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 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 licensed nursing staff obtained informed consent for one of two sampled residents (Resident 1) prior to administering psychotropic medications (drugs that affect the brain and mind, altering a person's thoughts, emotions, feelings, awareness, and perceptions) for Resident 1. This deficient practice violated Resident 1's and/or Resident 1's responsible party's right to make an informed decision prior to the administration of a psychotropic medication and placed Resident 1 at risk for a medication error.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 paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 1's History and Physical (H&P) dated 10/3/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1's cognitive skills for daily decision making were moderately impaired (ability to think and reason). The MDS indicated Resident 1 required supervision from staff for eating, oral hygiene, toileting hygiene, dressing, shower/bathing and personal hygiene.During a review of Resident 1's Order Summary Report, dated 7/16/2025, the order indicated Resident 1 had an order for quetiapine fumarate (an antipsychotic medication) 50 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet three times a day for schizophrenia disorder manifested by visual hallucinations (visions that a person believes to be real but are not real), valproic acid (a medication used to treat seizures and bipolar disorder) 250 mg/5 milliliter ([ml] metric unit of measurement, used for mediation dosage and/or amount), give 10 ml by mouth every eight hours for bipolar disorder manifested by erratic mood swings ranging from calm to anger, and olanzapine (Zyprexa, an antipsychotic medication) 10 mg, give 10 mg by mouth three times a day for schizophrenia manifested by auditory hallucinations (sounds that a person believes to be real but are not real).During a review of Resident 1's Medication Administration Report (MAR), dated 7/1/2025 - 7/31/2025, the MAR indicated Resident 1 started receiving quetiapine fumarate 50mg, valproic acid 250mg/5ml, and Zyprexa 10mg on 7/17/2025.During a review of Resident 1's Verification of Informed Consent to Psychotropic Drug, Physical Restraint or Medical Device form, dated 7/22/2025, the form indicated the facility obtained consent for quetiapine fumarate 50mg, valproic acid 250mg/5ml, and Zyprexa 10mg on 7/22/2025.During a concurrent interview and record review on 10/15/2025 2:24 p.m. with Registered Nurse (RN) 1, Resident 1's Verification of Informed Consent form for quetiapine fumarate 50mg, valproic acid 250mg/5ml, and Zyprexa 10mg from, dated 7/22/2025, was reviewed. RN 1 stated Resident 1's Verification of Informed consent was obtained on 7/22/2025 and the form was used to verify if the medication's use, risks, and benefits were explained to the resident or responsible family. RN 1 stated licensed nurses must obtain the Verification of Informed Consent form before administering the medication.During a concurrent interview and record review on 10/15/2025 at 2:35 p.m. with RN 1, Resident 1's MAR, dated 7/1/2025 - 7/31/2025, was reviewed. The MAR indicated Resident 1 started receiving quetiapine fumarate 50mg, valproic acid 250mg/5ml, and Zyprexa 10mg on 7/17/2025. RN 1 stated Resident 1 received psychotropic medications before obtaining an informed consent and Resident 1 should not have received the medication until the informed consent had been obtained. RN 1 stated administering medication without a verification of Informed consent was an unsafe practice.During a review of facility's Policy and Procedure (P&P) titled Psychoactive Medication Informed Consent, dated 3/2024, the P&P indicated its purpose was to ensure an informed consent was obtained and verified prior to the initiation of psychoactive (a chemical substance that alters psychological functioning, such as mood, perception, and consciousness) medication use. The P&P indicated before initiating treatment with psychotherapeutic drugs, facility staff shall verify that residents' health records contain written informed consent with the required signatures.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nursing staff revised a fall care plan for one of two sampled residents (Resident 1) after Resident 1's fall on 1/4/2025, 7/28/2025, 4/30/2025, and 7/28/2025.These deficient practices resulted in Resident 1 not having effective interventions in place to minimize future falls and injuries, placing Resident 1 at risk for future falls. 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 paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 1's History and Physical (H&P), dated 10/3/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1's cognitive skills for daily decision making were moderately impaired (ability to think and reason). The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, oral hygiene, toileting hygiene, dressing, shower/bathing and personal hygiene.During a review of Resident 1's fall care plan, dated 12/3/2024, the care plan indicated Resident 1 fell on 1/4/2025, 1/10/2024, 4/30/2025, and 7/28/2025. The care plan indicated the interventions were not revised after Resident 1's falls.During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 7/28/2025, the SBAR form indicated Resident 1 had a witnessed fall on 7/28/2025.During a concurrent interview and record review on 10/15/2025 at 12:27 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's care plan for falls, dated 12/3/2024, was reviewed. The care plan indicated on 1/4/2025, 1/10/2025, and 4/30/2025, the care plan's interventions were not revised after Resident 1 had a fall. LVN 1 stated care plans must be revised after every fall and new interventions must be developed. LVN 1 stated if a care plan was not revised after a fall, there would be no additional interventions to minimize Resident 1's falls.During a concurrent interview and record review on 10/15/2025 at 1:10 p.m. with Registered Nurse (RN) 1, Resident 1's care plan for falls, dated 7/28/2025, was reviewed. The care plan indicated Resident 1 had a fall on 7/28/2025 and interventions were not developed. RN 1 stated the care plan was incomplete because interventions were not developed to minimize falls or injuries from a fall.During a concurrent interview and record review on 10/15/2025 at 3 p.m. with RN 1, Resident 1's care plan for falls, dated 12/3/2024, was reviewed. The care plan indicated on 1/4/2025, 1/10/2025 and 4/30/2025, Resident 1 had a fall, and the care plan interventions were not revised. RN 1 stated interventions had to be developed after every fall because the last intervention did not work. RN 1 stated this practice was unsafe for Resident 1 because the previous interventions did not work to prevent another fall and Resident 1 needed new interventions to minimize falls.During a review of facility's Policy and Procedure (P&P) titled Falls and Fall Risk, Managing, dated 4/2018, the P&P indicated if a fall reoccurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The P&P indicated staff would implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. The P&P indicated if the resident continues to fall, staff will re-evaluate the situation and determine if whether it is appropriate to continue or change current interventions.