STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2026
NAME OF PROVIDER OR SUPPLIER: Santa Fe Heights Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its readmission process to obtain and review clinical documents (medical records, consisted of patient's medical history, treatments, and discharge, which are reviewed prior to approving or denying an admission) for the determination to readmit one of two sampled residents (Resident 1) from the general acute care hospital (GACH) after being cleared by the GACH to return to the facility on 1/27/2026.This deficient practice resulted in the denial of Resident 1's right to return to the facility and resulted in Resident 1's unnecessary stay at the GACH for nine days.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 had modified independence (some difficulty in new situations only) with cognitive skills (process of thinking) for daily decision making. The MDS indicated Resident 1 did not exhibit any physical or verbal behavioral symptoms directed towards others. The MDS indicated Resident 1 required moderate assistance (helper does less than half of the effort) with toileting, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 1 was discharged to the GACH with his return anticipated.During a review of Resident 1's History and Physical (H&P), dated 10/9/2025, the H&P indicated Resident 1 had the capacity to understand and make 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), dated 1/5/2026, the SBAR indicated Resident 1 was lethargic (state of severe drowsiness) and had altered level of consciousness (ALOC- a state where the individual is not functioning at their normal mental baseline). The SBAR indicated Resident 1 was transferred to the general acute care hospital (GACH).During a telephone interview on 2/3/2026 at 2:40 p.m., with GACH Case Manager (CM 2), GACH CM 2 stated Resident 1 was medically cleared to return to the facility on 1/27/2026 but the facility refused to readmit him. GACH CM 2 stated the facility denied Resident 1's readmission before receiving the resident's clinical documents. GACH CM 2 stated Resident 1's clinical documents were not provided to the facility due to their refusal. GACH CM 2 stated the facility denied Resident 1's readmission because of his aggressive behaviors, however, Resident 1 was now calm and had appropriate behavior. During an interview on 2/2/2026 at 1:49 p.m., with Registered Nurse (RN) 1, RN 1 stated the process of readmitting a resident back to the facility began with receiving a phone call from the GACH informing them of the resident's medical clearance for discharge. RN 1 stated after the facility (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was informed of the resident's discharge from the GACH, the GACH would send the clinical documents for the Director of Nursing (DON) or designee to review. RN 1 stated the clinical documents were reviewed to determine if the resident was safe to discharge to the level of care the facility provided. RN 1 stated reviewing the clinical documents allowed the facility to determine if the resident required any specific treatments or an isolation room (specialized room designed to contain the spread of infections or protect vulnerable residents). RN 1 stated if a resident was within their bed hold agreement (the facility keeps the resident's bed vacant and available during a seven-day period, ensuring the resident could return to the same bed), the resident would return to their same room. RN 1 stated if a resident was gone beyond their bed hold agreement, the resident would return to the first available bed in the facility. RN 1 stated there were not many reasons to decline a resident's readmission to the facility. RN 1 stated declining a resident's readmission could include the facility being at full capacity (operating at the maximum level with no available room for new residents) and did not have an open bed to accommodate the resident or if the resident required services the facility did not provide. RN 1 stated aggressive behavior was never a reason to decline a resident's readmission to the facility. RN 1 stated he was temporarily responsible for reviewing resident's clinical documents who were ready to admit or readmit to the facility. RN 1 stated the facility did not have any clinical documents to review for Resident 1's readmission to the facility. During a telephone interview on 2/2/2026 at 2:35 p.m., with Receptionist 1, Receptionist 1 stated she assisted with the resident's admissions to the facility. Receptionist 1 stated once the facility received clinical documents from the GACH case manager, an inquiry form was created and both were given to the DON to review. Receptionist 1 stated the DON was responsible for approving or denying a resident's readmission after reviewing the clinical documents. Receptionist 1 stated, on an unknown date, she received a call from the GACH regarding Resident 1's potential readmission and transferred the call to the Marketing Director (MD) who temporarily took over the admission tasks of the facility. Receptionist 1 stated after transferring the phone call to the MD, she did not have any other communication with the GACH's case managers regarding Resident 1's readmission. During an interview on 2/2/2026 at 3:28 p.m., with the MD, the MD stated when a resident was ready for discharge from the GACH, the GACH would inform the facility with a phone call and send the clinical documents to the facility for the DON to review. The MD stated the facility would allow the resident back if the DON approved the readmission. The MD stated if the resident was within their bed hold agreement, the resident would come back to the same bed, however, if the resident was past the bed hold agreement, the resident would go to the first available bed. The MD stated, on an unknown date, he received a phone call from GACH CM 3 who informed him that Resident 1 was ready to discharge from the GACH. The MD stated he informed GACH CM 3 the facility would not accept Resident 1 back to the facility due to behavior. The MD stated Resident 1 would scream at the staff and may have hit a staff member before. The MD stated when he received the phone call, he informed the DON who made the decision to deny Resident 1's readmission based on his previous aggressive behavior in the facility. During an interview on 2/3/2026 at 1:01 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 1 was initially denied readmission to the facility because of his aggressive behavior which could be perceived as a danger to others. RN 1 stated Resident 1's denial of readmission was not appropriate because the facility did not have documentation to prove his aggressive behavior was an issue and a potential danger to others. During a concurrent interview and record review on 2/3/2026 at 1:09 p.m., with RN 1, the facility's Census, dated 1/27/2026, was reviewed. The Census indicated, on 1/27/2026, there was a total of 86 in-house residents with two residents on bed hold. The total in-house residents including bed holds was 88. RN 1 (continued on next page)

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	555732	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, on 1/27/2026, the facility had 11 empty beds and within those 11 empty beds, six beds were available for a male resident. RN 1 stated the facility could have accommodated Resident 1's readmission to the facility. During an interview on 2/3/2026 at 1:11 p.m. with RN 1, RN 1 stated the facility did not follow the appropriate readmission process by denying Resident 1's readmission without obtaining and reviewing his clinical documents. RN 1 stated because of this, Resident 1 remained in the GACH instead of being in the facility, which was considered his home. During a review of the facility's Policy and Procedure (P&P) titled, Bed-Holds and Returns, revised 3/2017, the P&P indicated, Residents may return and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. The P&P indicated, The resident will be permitted to return to an available bed in the location in the facility that he or she previously resided. If there is not an available bed in that part, the resident will be given the option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed becomes available.During a review of the facility's P&P titled, admission Criteria, revised 3/2019, the P&P indicated, The objectives of our admission criteria policy are to provide uniform criteria for admitting residents to the facility, admit residents who can be cared for adequately by the facility, . and assure that the facility receives appropriate medical and financial records prior to or upon the resident's admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise one of two sampled residents' (Resident 1) Care Plan based on the Interdisciplinary Team's (IDT- a group of individuals from different specialties who work together to create goals for better outcomes for the resident) recommendations to monitor the resident's aggressive behavior.This deficient practice resulted in the frequency Resident 1's aggressive behavior being unaccounted for and had the potential to result in Resident 1 not receiving the necessary care and services to treat his aggressive behavior.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 had modified independence (some difficulty in new situations only) with cognitive skills (process of thinking) for daily decision making. The MDS indicated Resident 1 required moderate assistance (helper does less than half of the effort) with toileting, upper/lower body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 10/9/2025, the H&P indicated Resident 1 had the capacity to understand and make 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), dated 11/27/2025, the SBAR indicated on 11/27/2025 Resident 1 exhibited behavioral symptoms such as agitation when Resident 1 was frustrated and believed he was being targeted by facility staff.During a review of Resident 1's Interdisciplinary Team (IDT- a group of individuals from different specialties who work together to create goals for better outcomes for the resident) Conference Record, dated 11/28/2025, the Record indicated the IDT met with Resident 1 to discuss issues related to his behavior of verbal aggression towards staff. The Record indicated interventions for Resident 1's plan of care was to continue to monitor Resident 1's behavior.During an interview on 2/3/2026 at 9:28 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1's verbal aggression was towards the staff as he would make rude comments or belittle and question their level of competency. LVN 1 stated Resident 1's behavior was consistent and should have been monitored.During a concurrent interview and record review on 2/3/2026 at 9:31 a.m., with LVN 1, Resident 1's Care Plan titled Behavioral Symptoms, dated 11/28/2025, was reviewed. The care plan indicated Resident 1's behavioral symptoms were manifested by aggressive behavior, verbal abuse, and sudden angry outbursts. The interventions did not indicate monitoring for Resident 1's behavior symptoms of aggressive behavior, verbal abuse, and sudden angry outbursts. LVN 1 stated Resident 1's care plan should have been revised based on the IDT's recommendation to monitor Resident 1's behavior. During a concurrent interview and record review on 2/3/2026 at 9:33 a.m., with LVN 1, Resident 1's Orders, active on 2/3/2026, were reviewed. The Orders did not indicate to monitor for aggressive behavior, verbal abuse, and sudden angry outbursts. LVN 1 stated the order for behavior monitoring would prompt the licensed nurse to document the behavior frequency every shift. LVN 1 stated the purpose for behavior monitoring was for the licensed nurses to gather information and determine whether Resident 1's behavior became more frequent and to notify Resident 1's physician for further orders. During an interview on 2/3/2026 at 12:50 p.m., with Registered Nurse (RN) 1, RN 1 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 was known to have aggressive behavior and had a one-to-one sitter (1:1- person assigned to provide continuous, one-on-one observation to a specific resident) for Resident 1's and other resident's safety. RN 1 stated when the IDT met with Resident 1 to discuss his aggressive behavior, the IDT recommended to monitor Resident 1's behavior. RN 1 stated this recommendation should have been communicated to Resident 1's physician to receive an order to monitor every shift. RN 1 stated the IDT was responsible for updating Resident 1's care plan to ensure the licensed nurses were aware not only of Resident 1's aggressive behavior, but to also monitor and document the frequency. RN 1 stated without the necessary monitoring and documentation, Resident 1's aggressive behavior could go unnoticed and may not receive the necessary care and treatments. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans- Comprehensive, revised 9/2010, the P&P indicated, Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans.During a review of the facility's P&P titled, Behavioral Assessment, Intervention, and Monitoring, revised 3/3029, the P&P indicated, The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risks to the resident, and develop a plan of care accordingly.

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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 observation, interview, and record review, the facility failed to ensure fall risk interventions such as visual checks and monitoring were implemented and documented for one of three sampled residents (Resident 93) who was identified as a fall risk.This deficient practice resulted in Resident 93 sustaining an unwitnessed fall.Findings:During a review of Resident 93's admission Record, the admission Record indicated Resident 93 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 93's diagnoses included age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with pathological (caused by an underlying disease that has weakened the bone structure) fracture, history of falling, dementia (a progressive state of decline in mental abilities), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both hips.During a review of Resident 93's History and Physical (H&P), dated 1/30/2026, the H&P indicated Resident 93 had the capacity to understand and make decisions.During a review of Resident 93's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2026, the MDS indicated Resident 93's cognitive skills for daily decision making (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 93 had impairment on both sides of the lower extremities. The MDS indicated Resident 93 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toilet transfer and walking 10 feet and walking 50 feet. The MDS indicated Resident 93 required supervision (helper provides verbal cues and/or touching/steading) for transferring to and from a bed to a chair or wheelchair. The MDS indicated Resident 93 required the use of a wheelchair for mobility (ability to move from one place to another). During a review of Resident 93's care plan titled Osteoporosis related to the aging process, initiated on 9/17/2024 with a target date of 2/2/2026, the interventions indicated to monitor Resident 93 and document for risk of falls and educate the resident, family and caregivers on safety measures to reduce the risk of falls.During a review of Resident 93's care plan titled Resident had an actual fall with skin tear to the right upper arm and top of right hand due to poor balance, unwitnessed fall, initiated on 3/6/2024 and revised on 3/6/2025, the interventions indicated Resident 93 was to continue on the Falling Star Program.During a review of Resident 93's care plan titled Risk for falls, initiated 11/4/2025 and revised on 3/6/2025 with a target date of 2/2/2026, the care plan interventions indicated Resident 93 was placed on the falling star program.During a review of Resident 93's care plan addressing risk for falls, initiated on 8/8/2024, revised on 11/4/2025, with a target date of 2/2/2026, the care plan indicated Resident 93 was at risk for falls related to a history of falls, hypoxia (low oxygen levels), impaired balance (difficulty maintaining balance), and a history of brain injury with risk for bleeding or fracture. The care plan indicated the goal for Resident 93 was to remain free of falls. The care plan interventions indicated Resident 93 was placed on the Falling Star Program (Yellow Star Program). The care plan interventions indicated to initiate fall risk precautions to reduce the risk of falls and injury. During a review of Resident 93's Quarterly Fall Risk Evaluation, dated 11/4/2025, the Fall Risk Evaluation indicated Resident 93 was at risk for falls.During a review of Resident 93's Nursing Progress Notes dated from 1/20/2026 through 1/23/2026, the Nursing Progress Notes did not indicate Resident 93 was monitored frequently or visual checks were performed prior to the fall on 1/23/2026.During a review of Resident 93's Change in Condition (CIC) Evaluation dated 1/23/2026 at 10:01 a.m., the CIC evaluation indicated on 1/23/2026 Resident 93 was found on her right side and was observed and evaluated for injuries. The CIC indicated a skin tear to the right upper extremity was noted, vital signs were within normal limits, and no change in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level of consciousness was identified. The CIC indicated Resident 93 stated, I rolled out of bed. The CIC indicated acetaminophen (a pain reliever used for mild to moderate pain) was administered, the physician and responsible party were made aware, and a new order for X-rays was noted and carried out.During a review of Resident 93's Post Fall Evaluation dated 1/23/2026 at 10:23 a.m., the Post Fall Evaluation indicated on 1/23/2026 at 7:30 a.m. Resident 93 experienced an unwitnessed fall in the resident's room. The Post Fall Evaluation indicated the fall occurred when the resident rolled out of bed and resulted in a right upper arm skin tear. The Post Fall Evaluation indicated no floor mat was present at the time of the fall. During a review of Resident 93's nursing progress note dated 1/23/2026 at 6:47 p.m., the nursing progress note indicated X-ray results were received with findings of an acute right pelvic fracture.During a review of Resident 93's nursing progress note dated 1/24/2026 at 8:37 a.m., the nursing progress note indicated Resident 93 was transferred to a general acute care hospital (GACH) for further evaluation and treatment related to a fall with an acute right pelvic fracture.During an interview on 2/2/2026 at 3:25 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was recently in-serviced on the Falling Star Program (also referred to by the facility as the Yellow Star Program). CNA 1 stated when residents were on fall precautions, a yellow star was placed next to the resident's name outside of the room. CNA 1 stated when a resident had a yellow star, staff provided closer monitoring to ensure the bed was in the lowest position and floor mats were placed on both sides of the bed. CNA 1 stated when caring for a resident identified as at risk for falls, she checked on the resident at least every 20 minutes. CNA 1 stated if a resident was a known fall risk and attempted to get out of bed, staff were expected to remain close to the resident's room.During a concurrent interview and record review on 2/3/2026 at 9:25 a.m., with the Quality Assurance Nurse (QAN), Resident 93's fall-related care plans, the facility's fall prevention program, and Resident 93's Activities of Daily Living task flowsheet (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) documentation for the month of January 2026 were reviewed. The QAN stated when a resident experienced a fall, staff completed a fall IDT review, conducted neurological checks, and implemented fall prevention interventions, including placement on the Falling Star Program. The QAN stated residents identified on fall precautions were expected to have certified nursing assistants (CNAs) remain close by to monitor the resident and offer toileting assistance as indicated in the care plan. The QAN stated CNAs were to document monitoring of residents on fall precautions on the ADLs task flowsheet. The QAN acknowledged the ADLs documentation indicated no documented monitoring by CNAs prior to Resident 93's fall on 1/23/2026, and the ADLs documentation indicated the last CNA entry for Resident 93 was completed on 1/22/2026 at 10:59 p.m. The QAN stated the resident fell at 7:30 and there was no way to determine whether fall risk monitoring or interventions were implemented in the absence of documentation. The QAN further stated documentation for monitoring falls required reinforcement with nursing staff.During an interview on 2/3/2026 at 12:59 p.m., with CNA 2, CNA 2 stated she identified residents at risk for falls by the presence of a star posted outside of the resident's room. CNA 2 stated staff provided increased attention and completed more frequent rounds when a star was present. CNA 2 stated she was assigned to Resident 93 and was aware Resident 93 was a fall risk. CNA 2 stated she made rounds on Resident 93 every 30 minutes and completed visual checks. CNA 2 stated she did not document the monitoring and only documented ADLs. CNA 2 stated prior to the fall on 1/23/2026, Resident 93 attempted to get up independently to go to the bathroom. CNA 2 stated Resident 93 continued to attempt to get up to do things independently. During a concurrent observation and interview on 2/3/2026 at 2:45 p.m., outside of Resident 93's room, with the QAN, Resident 93's name outside of the room was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed without a Falling Star symbol. The QAN stated the facility utilized standard fall precautions for residents identified as at risk for falls, which included frequent monitoring by nursing staff and communication of fall risks during shift huddles. The QAN stated nursing staff were expected to escalate fall interventions from frequent monitoring to visual checks when residents attempted to get out of bed without assistance and, if needed, bring residents closer to the nursing station for observation. The QAN stated Resident 93 had not been placed on visual checks following IDT review. The QAN stated visual checks required hourly documentation on a Visual Observation Log Check form and the form posted in the resident's room. The QAN acknowledged visual observations were not being documented on the Visual Observation Log Check form and were not posted in the resident's room. The QAN further stated Resident 93 was currently on the Falling Star Program following the recent fall on 1/23/2026 and had a low bed and floor mats in place. The QAN stated the Falling Star symbol should have been present prior to the fall on 1/23/2026. The QAN then placed a falling star symbol next to Resident 93's name outside of the room.During an interview on 2/3/2026 at 2:50 p.m., with the Director of Staff Development (DSD), the DSD stated the monitoring of resident's was not charted. The DSD stated frequent monitoring meant monitoring in addition to regular monitoring, and regular monitoring consisted of assisting residents with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. The DSD stated without documentation it was not possible to verify if the staff were monitoring Resident 63 for risk of falls.During an observation on 2/3/2026 at 3:18 p.m., in Resident 93's room, Resident 93 was observed awake and confused, sitting on the edge of the bed with her arms extended. Resident 93 was attempting to get out of bed. Resident 93's bed was in the lowest position with fall mats placed on both sides of the bed. Resident 93's name posted outside of the doorway did not have a star next to the name to indicate the resident was at risk for falls.During a telephone interview on 2/3/2026 at 4:25 p.m., with CNA 3, CNA 3 stated on 1/22/2026, she was Resident 93's assigned CNA during the night shift. CNA 3 stated during the night, Resident 93 remained in bed but attempted to sit up and get out of bed during the shift. CNA 3 stated she instructed Resident 93 to lie back down and return to sleep. CNA 3 stated Resident 93 had a known history of attempting to get out of bed. CNA 3 stated staff sat outside of Resident 93's room and checked on the resident because of the known risk of attempting to get out of bed. CNA 3 stated when a wheelchair was near the bed, Resident 93 attempted to get into the wheelchair and move into the hallway independently. CNA 3 stated during the night shift, staff attempted to keep residents in their rooms and in bed and redirected residents back to bed when they attempted to get up.During an interview on 2/3/2026 at 4:34 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 1/23/2026, she began her shift at 7 a.m. LVN 1 stated at 7:30 a.m., Resident 93's roommate alerted staff that Resident 93 was on the floor. LVN 1 stated she entered the room and observed Resident 93 on the floor. LVN 1 stated she observed Resident 93 lying in bed earlier that morning while completing rounds. LVN 1 stated she was not aware of Resident 93 having any prior falls and did not believe Resident 93 was a fall risk. LVN 1 stated the facility utilized a fall risk assessment; however, she did not know Resident 93 was a fall risk based on the medical record and relied on her observation that she had not previously seen Resident 93 fall. LVN 1 stated if she had known Resident 93 was a fall risk, she would have completed frequent visual checks and informed the CNAs. LVN 1 stated she checked on residents approximately every hour but did not document the visual checks. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, revised 4/2008, the P&P indicated all observations, medications administered, and services performed must be documented in the resident's clinical record. The P&P further indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2026
NAME OF PROVIDER OR SUPPLIER: Santa Fe Heights Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2309 N Santa Fe Ave Compton, CA 90222	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all incidents, accidents, or changes in the resident's condition must be recorded. During a review of the facility's P&P titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated staff were responsible for monitoring and documenting each resident's response to interventions intended to reduce falling or the risk of falling. The P&P further indicated if a resident continued to fall, staff were responsible for re-evaluating the resident's fall risk and the appropriateness of current interventions.During a review of the facility's P&P titled Assessing Falls and Their Causes, revised 3/2018, the P&P indicated staff were required to continue to collect and evaluate information to identify causes of falling, determine whether a pattern of falls existed, and document assessments and interventions intended to prevent falls.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to arrange a psychology consult (a form of therapy where a psychologist sees an individual for mental health or behavioral problems) for one of two sampled residents (Resident 1), after the resident exhibited behaviors.This deficient practice had the potential for Resident 1 to experience psychological distress, poor coping skills, and continuation of aggressive behavior.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 had modified independence (some difficulty in new situations only) with cognitive skills (process of thinking) for daily decision making. The MDS indicated Resident 1 required moderate assistance (helper does less than half of the effort) with toileting, upper/lower body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 10/9/2025, the H&P indicated Resident 1 had the capacity to understand and make 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), dated 11/27/2025, the SBAR indicated, on 11/27/2025, Resident 1 exhibited behavioral symptoms such as agitation when Resident 1 was frustrated and believed he was being targeted by staff.During a review of Resident 1's Care Plan titled, Aggressive Outbursts, dated 11/27/2025, the care plan indicated Resident 1 often offended, disrupted, or distracted other residents and could affect other's potential enjoyment. The interventions indicated for a psychological evaluation.During a review of Resident 1's Care Plan titled, Behavioral Symptoms, dated 11/28/2025, the care plan indicated Resident 1's behavioral symptoms were manifested by aggressive behavior, verbal abuse, and sudden angry outbursts. The interventions indicated for a psychological evaluation.During a concurrent interview and record review on 2/3/2026 at 9:56 a.m., with the Social Services Director (SSD), Resident 1's Interdisciplinary Team (IDT- a group of individuals from different specialties who work together to create goals for better outcomes for the resident) Conference Record, dated 11/28/2025, was reviewed. The record indicated the IDT met with Resident 1 to discuss issues related to his behavior of verbal aggression towards staff. The record indicated the IDT recommended referring Resident 1 to psychology for a consultation. The SSD stated when the IDT recommended a psychology referral, the referral should be made to ensure the psychologist (Psychologist 1) evaluated Resident 1 as soon as possible after displaying behavioral symptoms. During an interview on 2/3/2026 at 12:03 p.m., with the Medical Record Director (MRD), the MRD stated she was unable to find a psychology evaluation note in Resident 1's medical records after Resident 1's behavioral change in condition (COC) on 11/27/2025. The MRD stated Psychologist 1 would write a note and provide a copy to place into the resident's medical record chart after evaluating a resident. During an interview on 2/3/2026 at 12:16 p.m., with Psychologist 1, Psychologist 1 stated residents were referred to him when the residents displayed new or worsening behavioral symptoms. Psychologist 1 stated he did not recall being informed of Resident 1's behavioral change in condition on 11/27/2025. Psychologist 1 stated Resident 1 was difficult to sit down and talk with. Psychologist 1 stated if he were made aware of Resident 1's behavioral COC, he would have tried to sit down (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Resident 1 and see if Resident 1 would open up about his feelings. Psychologist 1 stated performing psychological evaluations were important because the time given to the resident could help find the reason behind the exhibited behavioral symptoms and find potential solutions. During an interview on 2/3/2026 at 12:41 p.m., with the SSD, the SSD stated the purpose of psychological evaluations was to allow the residents to express and talk about their feelings. The SSD stated referring Resident 1 for a psychological evaluation could have assisted in finding the root cause of Resident 1's aggressive behavior and to find potential solutions. The SSD stated without a psychological evaluation, Resident 1 was at risk of further aggressive behavior towards the staff and at risk of not receiving necessary treatments and services. During an interview on 2/3/2026 at 12:59 p.m., with Registered Nurse (RN) 1, RN 1 stated psychological evaluations were important for Resident 1 to express his feelings, have a better understanding of his emotions, and develop and implement better coping skills. RN 1 stated without the recommended psychological evaluation, Resident 1 was at risk for psychological distress, poor coping skills, and continuation of aggressive behavior. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, revised 3/2019, the P&P indicated, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. During a review of the facility's Social Services Designee Job Description, undated, the job description indicated the Social Services Designee's job function was to coordinate behavioral management with nursing and outside consulting psychology and psychiatric professionals.