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	04/15/2026

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 - Minimal harm or potential for 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 interview and record review, the facility failed to ensure residents were free from sexual abuse for one of four sampled residents (Resident 2), when Resident 4 and Resident 2 were found in bed unclothed. This deficient practice resulted in Resident 2 being sexually abused by Resident 4 and had the potential for Resident 2 to experience physical harm, emotional trauma, fear, humiliation, and psychological distress. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re admitted on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's History and Physical (H&P), dated 10/8/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/25/2025, the MDS indicated Resident 2's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 4/15/2026 at 10:15 a.m., at Resident 2's bedside, with Resident 2, Resident 2 stated she did not want to engage in sexual activity and did not consent to sexual contact with Resident 4. b. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included dementia, schizoaffective disorder, and major depressive disorder. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was moderately impaired. The MDS indicated Resident 4 required moderate (helper does less than half the effort) assistance from staff for ADLs. During an interview on 4/15/2026 at 11:40 p.m., at Resident 4's bedside, with Resident 4, Resident 4 stated he liked women and liked to socialize with women. Resident 4 could not recall whether or not he engaged in sexual activity with Resident 2. During a concurrent interview and record review on 4/15/2026 at 12:00 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 2's progress note, authored by LVN 1, dated 11/16/2025 and timed at 11:02 a.m., was reviewed. The progress note indicated Resident 2 was observed unclothed in her bed with Resident 4. LVN 1 stated she observed both residents unclothed in Resident 2's bed. LVN 1 stated at the time of the incident, both residents verbally consented to sexual activity. LVN 1 stated she was not aware if an assessment was performed to determine either resident's capacity to consent to sexual activity. During an interview on 4/15/2026 at 12:30 p.m., with the Director of Nursing (DON), the DON stated the incident involving Resident 2 and Resident 4 was considered sexual abuse. The DON stated it was not the facility's practice to allow residents to engage in sexual activity without appropriate assessment. The DON stated that, if residents expressed a desire to engage in sexual activity, the facility was required to assess the residents' capacity to consent and, if appropriate, provide privacy. The DON stated the (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 - Minimal harm or potential for actual harm Residents Affected - Few	facility failed to ensure Resident 2 was protected from sexual abuse. During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2024, the P&P indicated all residents have the right to be free from any form of abuse including sexual abuse. The P&P indicated the facility was committed to ensuring that residents were protected from sexual abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report a sexual abuse allegation to the State Agency (California Department of Public Health [CDPH]), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement for two of four sampled residents (Residents 2 and 4), after Resident 4 was observed unclothed in Resident 2's bed, who was also unclothed. This deficient practice resulted in a delay of an onsite investigation by CDPH and had the potential to place all residents at risk for abuse.Findings: a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re admitted on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's History and Physical (H&P), dated 10/8/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/25/2025, the MDS indicated Resident 2's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 4/15/2026 at 10:15 a.m., at Resident 2's bedside, with Resident 2, Resident 2 stated she did not consent to sexual contact with Resident 4. b. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included dementia, schizoaffective disorder, and major depressive disorder. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was moderately impaired. The MDS indicated Resident 4 required moderate (helper does less than half the effort) assistance from staff for ADLs. During an interview on 4/15/2026 at 11:40 p.m., with Resident 4, Resident 4 stated he did not recall engaging in sexual activity with any residents. During a concurrent interview and record review on 4/15/2026 at 12:00 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 2's progress note, authored by LVN 1, dated 11/16/2025 and timed at 11:02 a.m., was reviewed. The progress note indicated on 11/16/2025, Resident 2 and Resident 4 were observed unclothed in Resident 2's bed. LVN 1 stated she observed Residents 2 and 4 unclothed in Resident 2's bed. LVN 1 stated such an incident was considered sexual abuse. LVN 1 stated the incident should have been reported immediately to the abuse coordinator and the appropriate state and federal agencies, including CDPH. LVN 1 stated she did not report the incident. During an interview on 4/15/2026 at 12:55 p.m., with the Administrator (ADM), the ADM stated she was the abuse coordinator and was responsible for reporting all abuse allegations to the CDPH, law enforcement, and Ombudsman. The ADM stated the staff had the ability to report to the three reporting agencies. The ADM stated staff were responsible for notifying her immediately of sexual abuse allegations so the allegation could be reported and investigated. The ADM stated immediate reporting was necessary to ensure a thorough investigation was conducted by both the facility and CDPH. During a review of the facility's policy and procedure (P&P) titled Abuse Reporting and Investigation, dated 5/2025, the P&P indicated all facility staff are required to report all allegations of abuse to the appropriate agencies within two (2) hours of becoming aware of the abuse. The P&P indicated that all staff were considered a mandated reporter and were responsible to notify appropriated authorities within 2 hours and to notify the facility Abuse Prevention Coordinator (APC) and their supervisor immediately.