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	06/10/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify informed consent for the administration and reˆordering of the psychoactive (a medication that affects mood, thoughts, behavior, or perception) medication, Ativan (an anti-anxiety medication), for one of three sampled residents (Resident 10), despite documented evidence that the resident lacked decisionˆmaking capacity. This deficient practice resulted in Resident 10 receiving psychoactive medication on multiple occasions without confirmation that the resident's responsible party (RP 1) had been informed of the risks, benefits, and alternatives, as required by facility policy. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE]. Resident 10's diagnoses included end stage renal disease (ESRD, irreversible kidney failure), anxiety disorder (an overwhelming feeling of uneasiness), and muscle wasting (thinning of the muscle). The admission record indicated Resident 10 had a responsible party (RP 1). During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 6/2/2026, the MDS indicated Resident 10's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 10 required maximal assistance (helper does more than half the effort) for toileting and showering. During a review of Resident 10's History and Physical (H&P), dated 3/3/2026, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Medication Administration Record (MAR), dated 5/2026 through 6/2026, the MAR indicated on 5/15/2026, Resident 10 received an intramuscular (IM, in the muscle) injection of Ativan 2 milligram (mg, metric unit of measurement, used for medication dosage and/or) per (/) milliliter (ml, metric unit of measurement, used for medication dosage and/or liquid amount) and an Ativan oral tablet 0.5 mg on 6/7/2026, 6/8/2026, and 6/9/2026. During a concurrent record review and interview on 6/10/2026 at 1:56 p.m. with Registered Nurse (RN) 1, Nursing Progress Notes, dated 5/2026, and Psychotropic Informed Consents, dated 5/2026 through 6/2026, were reviewed. The nursing notes did not indicate RP 1 was educated on the risks and the benefits of Ativan, nor verification of informed consent completed on 5/15/2026 (after the administration of the IM Ativan injection) and on 6/6/2026, when Resident 10 was reordered Ativan. RN 1 stated RP 1 should have been made aware of the risks and the benefits of Ativan on 5/15/2026 and again, on 6/6/2026. During an interview on 6/10/2026 at 2:08 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 6/6/2026, she transcribed Resident 10's order for Ativan. LVN 3 stated she should have verified informed consent from RP 1 but did not do so because she was unaware that Resident 10 was unable to make medical decisions. LVN 3 stated RP 1 had the right to be informed of the risks and benefits associated with the continued use of Ativan. During an interview on 6/10/2026 at 2:13 p.m. with LVN 2, LVN 2 stated on 5/15/2026, she should have verified informed consent from RP 1. During an interview on 6/10/2026 at 2:25 p.m. with RP 1, RP 1 stated she was not informed of the risks and benefits associated with the use of Ativan. RP 1 stated on 5/15/2026, she was not made aware of Resident 10's need for an Ativan injection. RP 1 also stated that she was not made aware Resident 10 was prescribed Ativan on 6/6/2026. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, revised 6/2019, the P&P indicated the Attending Physician was to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine the decisioning making capacity of the resident in the H&P. The P&P indicated the following: If the resident was determined to lack capacity to make informed decisions, a surrogate decision-maker was identified.When initiating a new order, the Attending Physician would obtain informed consent from the resident or the responsible party.The licensed nurse would verify with the resident or legal representative that informed consent had been obtained.In an emergency situation, orders for psychotropic drugs may be initiated upon a physician order without informed consent for a period of 48 hours.Disclosure of the risks of a proposed treatment may be withheld if there was documentation the resident or the RP specifically requested that he or she did not want to be information of the risks of the recommended treatment.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely responsible party (RP) notification for one of three sampled residents (Resident 10) when Resident 10 exhibited increased anxiety (an overwhelming feeling of uneasiness) on 5/15/2026 and required an administration of Ativan (a psychotropic medication, a medication that affects mood, thoughts, behavior, or perception) intramuscular injection (medication administered in the muscle). This deficient practice led to RP 1 being unaware of Resident 10's emergency administration of Ativan and episode of increased anxiety on 5/15/2026.Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE]. Resident 10's diagnoses included end stage renal disease (ESRD, irreversible kidney failure), anxiety (an overwhelming feeling of uneasiness) disorder, and muscle wasting (thinning of the muscle). The admission record indicated Resident 10 had a responsible party (RP 1). During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 6/2/2026, the MDS indicated Resident 's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 10 required maximal assistance (helper does more than half the effort) for toileting and showering. During a review of Resident 10's History and Physical (H&P), dated 3/3/2026, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Medication Administration Record (MAR), dated 5/2026 through 6/2026, the MAR Resident 10 received an Ativan (a psychotropic medication, a medication that affects mood, thoughts, behavior, or perception) Injection Solution two milligram per milliliter (mg/mL - a unit of measurement) on 5/15/2026 and an Ativan oral tablet 0.5 mg on 6/7/2026, 6/8/2026, and 6/9/2026. During a review of Resident 10's Physician Order, dated 6/6/2026, the order indicated to administer Ativan tablet 0.5 mg, one tablet by mouth every six hours as needed for panic attacks. During a concurrent interview and record review on 6/10/2026 at 12:48. p.m. with Licensed Vocational Nurse (LVN) 2, Resident 10's Progress Note, dated 5/15/2026, was reviewed. The note indicated Resident 10 exhibited increased anxiety and was ordered an Ativan Injection Solution two mg/ml to be administered intramuscularly (in the muscle). LVN 2 recalled that on 5/15/2026, Resident 10 repeatedly used her call light for help but refused to speak with staff when they responded. LVN 2 stated Resident 10 became increasingly verbally aggressive and called staff derogatory names. LVN 2 stated she notified the physician and obtained an order for an Ativan injection. LVN 2 stated she did not make RP 1 aware, nor did she create a change of condition note. LVN 2 stated that both actions were important to allow RP 1 to be aware of Resident 10's medical condition and to allow for further monitoring of Resident 10's change of condition and adjust Resident 10's plan of care. During a concurrent record review and interview on 6/10/2026 at 1:56 p.m. with Registered Nurse (RN) 1, all of Resident 10's H&P, dated 3/3/2026, and Nursing Progress Notes, dated 5/2026, were reviewed. There were no nursing notes to indicate Resident 10's responsible party was made aware of Resident 10's change of condition on 5/15/2026. RN 1 stated Resident 10's RP should have been made aware of the change of condition and the need for an IM dose of Ativan because RP 1 had the right to know the latest medical condition of Resident 10. RN 1 also stated a change of condition note should have been authored to guide ongoing monitoring for adverse reactions and behavioral changes. During an interview on 6/10/2026 at 2:25 p.m. with RP 1, RP 1 stated she was not made aware of Resident 10's episode of increased agitation and the need for an Ativan injection on 5/15/2026. RP 1 also stated that she was not made aware Resident 10 was prescribed Ativan on 6/6/2026. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the facility was to ensure the licensed nurse would notify the resident representative when the resident exhibited a significant change in the resident's mental or psychosocial status.