

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/09/2026
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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) and Restorative Nurse Aide (RNA) services were provided and performed as ordered for four out of four sampled residents (Resident 16, Resident 28, Resident 11, and Resident 69) when the facility did not ensure:1. Resident 11 received appropriate services to maintain functional ability and comfort related to activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).2. RNA orders were carried out as ordered for Resident 28.3. The charge nurse or the Rehabilitation Department was made aware Resident 28 could not tolerate RNA orders for the application of a right elbow splint (a medical device designed to treat a stiff elbow with limited range of motion by providing a prolonged, low-intensity stretch to tightened soft tissues) and bilateral hand rolls (devices used to maintain the hand in a functional position).4. RNA orders were carried out as ordered for Resident 16. 5. Notify the Rehabilitation Department of Resident 69's inability to complete ordered RNA sit-to-stand interventions. These deficient practices placed the residents at risk for further range of motion (ROM, the full, functional measurement of how far a specific joint or body part can move in various directions) decline, pain, and decreased ability to perform ADLs. Findings: a. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE]. Resident 11's diagnoses included palliative care (specialized medical care for individuals living with a serious, chronic, or life-threatening illness), cachexia (a complex syndrome associated with underlying illness and characterized by loss of muscle with or without loss of fat mass), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left hand, and unstageable pressure ulcer (full-thickness wound whose depth and severity cannot be determined) of the sacral region. During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 11's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 11 had functional impairments in range of motion to both sides of his upper and lower extremities. The MDS indicated Resident 11 required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 11's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Meeting Notes, dated 1/2/2026, the notes indicated Resident 11's restorative care needs were to maintain function. During a review of Resident 11's Joint Mobility Assessment, dated 1/6/2026, the Joint Mobility Assessment lacked recommendations and indicated Resident 11 was under hospice care. The Joint Mobility Assessment indicated Resident 11's had the following ROM limitations: - Severe limitations to his left and right shoulders. - Moderate limitations to his left and right elbows, fingers of the left hand, both hips, right knee and left and right ankle. - Moderate to severe limitations (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the left wrist.- Minimal limitations to his right wrist and fingers of the right hand.During a review of Resident 11's medical records, dated 1/2026 through 2/5/2026, the medical records did not indicate there were care plans to address Resident 11's ROM limitations.During an interview on 2/4/2026, at 1:11 p.m. with Resident 11's Representative Party (RP) 1, RP 1 stated Resident 11 was able to make his own decisions. RP 1 stated Resident 11 was available to consult him if he wished. RP 1 stated Resident 11 did not receive routine physical therapy and would like the resident to receive exercises.During an interview on 2/6/2026 at 8:37 a.m. with Resident 11, in the presence of Registered Nurse (RN) 1, Resident 11 stated he would like to receive RoM exercises.During an interview with 2/06/2026 at 10:46 a.m. with Physical Therapist (PT) 1, PT 1 stated he authored the Joint Mobility Assessment, dated 1/6/2026. PT 1 stated the normal process to have rehabilitation services ordered for a resident was to conduct a Joint Mobility Assessment and obtain an order for an evaluation for therapy. PT 1 stated Resident 11 had ROM limitations that would have warranted a proper evaluation for rehabilitation, but because Resident 11 was under hospice care, the evaluation was not performed. PT 1 stated it was the facility's practice to not provide RNA services to residents under hospice care. PT 1 stated Resident 11 could have at least benefitted from gentle passive ROM exercises in efforts to prevent decline and worsening contractures, which could lead to stiffness and pain. PT 1 stated this failure placed Resident 11 at risk of increased stiffness, worsening contractures, decreased comfort during end-of-life care.During a review of the facility's policy and procedure (P&P) titled, Hospice Program, revised 7/2017, the P&P indicated the coordinated care plan would reflect the resident's goals and wishes as stated in his advanced directives and during ongoing communication with the resident or representative including palliative goals and objectives, interventions, and medical treatment. The P&P indicated the coordinated care plan would be revised and updated as necessary to reflect the resident's current status including mobility and positioning.b. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 28's diagnoses included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dysphagia (difficulty swallowing), and hypertensive heart disease (high blood pressure).During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 28 had functional ROM limitations to his upper and lower extremities. The MDS indicated required substantial assistance (helper does more than half the effort) for ADLs.During a review of Resident 28's History and Physical (H&P), dated 2/2/2026, the H&P indicated Resident 28 had the capacity to understand and make decisions.During a review of Resident 28's care plan titled, Limited Physical Mobility Related to Impaired Bilateral Upper and Lower Extremities, revised on 8/20/2025, the care plan interventions indicated to carry out the RNA Program as ordered.During a review of Resident 28's care plan titled, At Risk for Further Functional Decline, initiated 2/21/2025, the care plan interventions were to ensure RNA documented weekly in the clinical record of the resident's progress and participation and notify the charge nurse should a decline in function is noted for possible rehabilitation intervention.During a review of Resident 28's Order Summary Report, dated 2/1/2026, the report indicated Resident 28 had the following RNA orders:1. RNA to splint (a medical device designed to treat a stiff elbow with limited range of motion by providing a prolonged, low-intensity stretch to tightened soft tissues) right elbow for two to three hours or as tolerated every day five times a week.2. RNA to provide bilateral lower extremity passive range of motion (PROM -an outside force moves the joint) exercises everyday five times a week, or as tolerated.3. RNA to monitor for pain before and applying the splint, and to notify the charge nurse for the presence of pain.4. RNA to provide bilateral upper extremity active assist range of motion (AAROM- a technique that involves a patient using their own muscles to move a joint while receiving help from a therapist), followed by the application of bilateral hand rolls (devices used to maintain the hand in a functional position) for four to five hours or as tolerated everyday five times per (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above or below the knee), and wedge compression fracture of T7-T8 vertebra (the front part of one or both of the mid-back bones have collapsed or broken).During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69's cognition was moderately impaired. The MDS indicated Resident 69 had impairment on both sides of his lower extremity (may include the hip, knee, ankle, and foot). The MDS indicated Resident 69 required substantial assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 69's H&P, dated 9/16/2025, the H&P indicated Resident 69 had fluctuating capacity to understand and make decisions. During a review of Resident 69's Order Summary Report, order dated 12/29/2025, the Order Summary Report indicated RNA to assist Resident 69 for sit-to-stand activity as tolerated, five times a week, with parallel bars using the left below the knee prosthetic device (device that replaces a missing body part) only. Resident 69's right above the knee prosthetic was sent out for modification.During a review of Resident 69's Multidisciplinary Care Conference, dated 12/19/2025, the Multidisciplinary Care Conference indicated Resident 69 had RNA therapy to stabilize his gait (the way a person walks).During a review of Resident 69's RNA Weekly Summary, dated 2/5/2026, the RNA Weekly Summary indicated Resident 69 was uncooperative and did not want to participate in RNA therapy. Resident 69 refused to participate two times. During a concurrent observation and interview on 2/5/2026 at 9:15 a.m., with Resident 69, in Resident 69's room, Resident 69 stored his left leg prosthetic in the closet. Resident 69 stated he was given a left and right leg prosthetic, but the right leg prosthetic had to be sent out because it did not fit him well. Resident 69 stated he was supposed to participate in RNA therapy with both of this leg prosthetics, however, since he was waiting for his right leg prosthetic to be modified, he did not want to participate. Resident 69 stated, it is a waste of time.During a concurrent interview and record review on 2/5/2026 at 12:44 p.m., with RNA 3, Resident 69's RNA Task Flow Sheet, dated 2/2/2026 through 2/5/2026, was reviewed. The RNA Task Flow Sheet indicated:- On 2/2/2026, Resident 69 refused RNA therapy.- On 2/3/2026, Resident 69 had 15 minutes of passive participation (received treatment without any active effort).- On 2/4/2026, Resident 69 had 15 minutes of RNA therapy with encouragement.- on 2/5/2026, Resident 69 refused RNA therapy. RNA 3 stated Resident 69 did not want to complete the full RNA order of sit-to-stand with his left leg on 2/3/2026 and 2/4/2026. RNA 3 stated Resident 69 allowed her to apply his left leg prosthetic; however, Resident 69 did not want to do the sit-to-stand activity. RNA 3 stated she approached Resident 69 multiple times on 2/2/2026 and 2/5/2026 and Resident 69 refused his therapy session. RNA 3 stated when a resident refused their RNA therapy or did not complete the ordered activity, the rehab and nursing departments should be notified. During an interview on 2/5/2026 at 2:42 p.m., with the (Director of Rehab) DOR, the DOR stated she was unaware of Resident 69's RNA therapy refusals and passive participation. The DOR stated prompt notification was important to allow the rehab department to speak with Resident 69 and uncover why he was refusing and passively participating in RNA therapy. The DOR stated the RNA orders may need to be changed to reflect Resident 69's level of participation and to encourage Resident 69 to become an active participant. The DOR stated due to Resident 69's passive participation and refusals and the lack of notification to the rehab department, Resident 69 was at risk of decline to his already limited mobility.During an interview on 2/9/2026 at 11:27 a.m., with the Director of Nursing (DON), the DON stated Resident 69's RNA therapy refusals and passive participation should have been reported to the rehab and nursing departments. The DON stated Resident 69 did not receive the full rehabilitation he required. The DON stated prompt notification would allow both departments to figure out why Resident 69 was not participating and to reevaluate his plan of care. The DON stated if Resident 69's refusal and passive participation continued to be unreported, Resident 69 was at risk of decline in his mobility. During a review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated the facility was to ensure residents with limited range of motion will receive (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. During a review of the facility's Restorative Nursing Assistant Job Description (undated), the RNA was to ensure the following: 1. Provide restorative nursing care (ROM, exercises, ambulating) to residents as ordered by the resident's physician 2. Perform all nursing activities in compliance with the written plan of care and using established policies. 3. Document daily care provided to all residents 4. Complete weekly summaries of residents' progress in restorative program 5. Observe and report changes in residents' condition to the charge nurse-and document same		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the restorative nursing aides (RNA) accurately documented care provided, and failed to ensure repositioning and bathing was performed and documented four of four sampled residents (Resident16, Resident 8, Resident 65, and Resident 11). These deficient practices resulted in clinical records that did not reliably reflect restorative nursing care provided to Residents 16, 28, and 65, which had the potential to impede the facility's ability to monitor implementation of restorative nursing services and timely re-evaluate resident treatment needs. These deficient practices also impeded in the facility's ability to verify implementation of pressure injury prevention and hygiene care for a resident at increased risk for skin breakdown. Findings:a. During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 65's diagnoses included spondylosis with radiculopathy (spinal degeneration) of the lumbar (low back), low back pain, intervertebral (in between the bones in the spine) disc degeneration, and history of falling. During a review of Resident 65's Minimum Data Set (IMDS), a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 65 required supervision for walking, toileting, showering, and putting on footwear. During a review of Resident 65's History and Physical (H&P), dated 12/2/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of the facility's Order Listing Report, dated 2/5/2026, the report indicated Resident 65 had orders for RNA to ambulate (walk) Resident 65 with a front wheeled walker every day for five times a week or as tolerated. During an observation and interview on 2/2/2026 at 9:15 a.m. in Resident 65's room, observed Resident 65 in bed. Resident 65 stated he had not been walking and that staff had not assisted him to walk on a regular basis or offered walking exercises. Resident 65 stated he would like to participate in walking exercises to improve his strength. During an observation and interview on 2/4/2026, at 12:20 p.m., in Resident 65's room, observed Resident 65 in bed. Resident 65 stated he did not walk with RNA staff and was not offered to walk that week (2/2/2026 through 2/4/2026). During a concurrent interview and record review on 2/5/2026. 2:00 p.m. with RNA 1, Resident 65's RNA Task Flow Sheet was reviewed. The flow sheet indicated Resident 65 was ambulated on 2/2/2026 and 2/4/2026 at 2:59 p.m. RNA 1 stated that she ambulated Resident 65 during the day shift on 2/4/2026. During a concurrent observation and interview on 2/5/2026 at 2:15 p.m. with RNA 1, in Resident 65's room, observed Resident 65 in bed. Resident 65 stated he was not ambulated or offered ambulation by any staff member from 2/2/2026 through 2/4/2026, including RNA 1. RNA 1 stated she was the assigned RNA on 2/2/2026 and 2/4/2026 and could not explain the discrepancy between Resident 65's statement and her documentation. During a concurrent interview and record review on 2/5/2026. 2:27 p.m. with RNA 1, Resident 65's RNA Task Flow Sheet was reviewed. RNA 1 stated she ambulated Resident 65 after dinner on 2/4/2026 at 6:00 p.m. RNA 1 stated documentation was not entered when the service was rendered and confirmed documentation was expected to be completed as accurately and timely as possible to reflect the care provided. b. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 28's diagnoses included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dysphagia (difficulty swallowing), and hypertensive heart disease (high blood pressure). During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 28 had functional range of motion (ROM) limitations to his upper and lower extremities. The MDS (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 28's H&P, dated 2/2/2026, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's Order Summary Report, dated 2/1/2026, the report indicated Resident 28 had the following RNA orders:1. RNA to splint (a medical device designed to treat a stiff elbow with limited range of motion by providing a prolonged, low-intensity stretch to tightened soft tissues) right elbow for two to three hours or as tolerated every day five times a week.2.RNA to provide bilateral (both) lower extremity (legs) passive range of motion (PROM -an outside force moves the joint) exercises everyday five times a week, or as tolerated.3.RNA to monitor for pain before and applying the splint, and to notify the charge nurse for the presence of pain.4. RNA to provide bilateral upper extremity (arms) active assist range of motion (AAROM- a technique that involves a patient using their own muscles to move a joint while receiving help from a therapist), followed by the application of bilateral hand rolls (devices used to maintain the hand in a functional position) for four to five hours or as tolerated everyday five times per week. During observations and interviews made on 2/4/2025 at 8:21 a.m., 10:16 a.m., 12:16 p.m., 1:31 p.m., 2:45 p.m., 3:37 p.m., and 4:42 p.m. in Resident 28's room, observed Resident 28 did not have bilateral hand rolls applied and did not have a right elbow splint. Resident 28 stated the staff did not apply hand rolls, nor provide ROM exercises for him that day. During a concurrent interview and record review on 2/5/2026 at 2:00 p.m. with RNA 1, Resident 28's RNA Task Flow Sheet, dated 2/4/2026, was reviewed. The RNA Task Flow Sheet indicated Resident 28 was provided 240 minutes (four hours) of bilateral hand roll splinting, 180 minutes of elbow splinting, and 15 minutes of range of motion exercises at 2:59 p.m. on 2/4/2026. The flow sheet indicated Resident 28 actively participated, exhibited no pain during the session, and tolerated the RNA session well on 2/4/2026. RNA 1 stated she did not apply bilateral hand rolls as ordered and instead placed bandages in the resident's palms to prevent skin break down. RNA 1 stated she did not apply the right elbow splint because the resident could not tolerate it. RNA 1 stated her documentation did not accurately reflect the services provided and Resident 28's ability to tolerate the current RNA program. RNA 1 stated the inaccurate documentation did not capture Resident 28's true clinical condition, which had the potential to result in a lack of timely re-evaluation and modification of treatment orders. c. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 16's diagnoses included polyneuropathy, fracture of the right femur (broken thigh bone), contractures of the left and right ankle, and disorders of the muscles. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 16 had functional range of motion limitations to his upper and lower extremities. The MDS indicated Resident 16 was entirely dependent on staff for ADLs. During observations made on 2/4/2026 at 8:10 a.m., 12:15 p.m., 1:48 p.m., and 2:48 p.m., observed Resident 16 in bed. Resident 16 stated he did not have PRAFO boots. During a concurrent interview and record review on 2/5/2026 at 2:30 p.m. with RNA 2, Resident 16's Order Summary, dated 2/1/2026, and RNA Task Flow sheet, dated 2/2026, were reviewed. The Order Summary indicated Resident 16 was to have bilateral lower extremity gentle PROM exercises five times a week, bilateral lower extremity PRAFO boots applied for four hours every day five days a week or as tolerated, and active assist ROM exercises to the upper extremities five days a week or as tolerated. The RNA Task Flow Sheet indicated, on 2/4/2026, Resident 16 received bilateral lower extremity gentle PROM exercises and PRAFO boots were applied. RNA 2 stated she did not apply the PRAFO boots on 2/4/2026 and did not follow the physician orders. RNA 2 stated there was no designated documentation field to record PRAFO boot application and that the documentation for RNA orders was unclear. RNA 2 stated RNA documentation should be as accurate as possible to ensure RNA services were provided on a consistent basis to prevent ROM of decline for Resident 16. During a concurrent interview and record review on 2/6/2026 at 9:41 a.m. (continued on next page)		

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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 02/09/2026
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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the Director of Staff Development (DSD), Resident 16, Resident 28, and Resident 65's RNA Task Flow Sheets, dated in 2/2026, were reviewed. The DSD stated documentation should be completed at the time the service was provided. The DSD stated there were no designated documentation fields specific to the type of splinting and range of motion exercises provided. The DSD stated if there were no designated documentation fields for the type of RNA orders, and times and participation levels were inaccurately documented, then the restorative nursing documentation for Residents 16, 28, and 65 had the potential to be deemed unreliable. The DSD stated that if the documentation was unreliable, the residents' tolerance to restorative nursing interventions may not be accurately captured, which had the potential to delay re-evaluation to the residents and modification of restorative nursing orders. d. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE]. Resident 11's diagnoses included palliative care (specialized medical care for individuals living with a serious, chronic, or life-threatening illness), cachexia (a complex syndrome associated with underlying illness and characterized by loss of muscle with or without loss of fat mass), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion of the left hand, and unstageable pressure ulcer (full-thickness wound whose depth and severity cannot be determined) of the sacral region (tailbone). During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 11 had functional impairments in range of motion to both sides of his upper and lower extremities The MDS indicated Resident 11 required substantial assistance (helper does more than half the effort) for ADLs. During a review of Resident 11's care plan titled, Sacrococcyx (tail bone) Pressure Injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), initiated 1/6/2026, the care plan indicated the interventions were to reposition Resident 11 as needed and every two hours. During a review of Resident 11's Braden Risk Assessment (a tool used to predict a patient's risk of developing pressure injuries), dated 1/23/2026, the assessment indicated Resident 11 was at high risk for developing a pressure injury. During a concurrent interview and record review on 2/6/2026 at 10:00 a.m. with the Director of Staff Development (DSD), Resident 11's Task Flow Sheets, dated 1/2026 to 2/6/2026, were reviewed. The Flow Sheets did not indicate Resident 11 was repositioned and bathed. The DSD stated that it was important to reposition and document repositioning for Resident 11 because the resident was prone to the development or worsening of pressure injuries. The DSD stated the facility could not verify repositioning was provided because there was no documentation. The DSD stated she could not verify when Resident 11 was last bathed. During a review of the facility's Policy and Procedure (P&P) titled, Documentation , revised 4/2008, the P&P indicated the documentation of procedures and treatments should include care-specific details and shall include at a minimum:The date and time the procedure/treatment was provided;The name and title of the individual(s) who provided the care;The assessment data and/or any unusual findings obtained during the procedure/treatment;How the resident tolerated the procedure/treatment;Whether the resident refused the procedure/treatment;Notification of family, physician or other staff, if indicated; andThe signature and title of the individual documenting. During a review of the facility's P&P titled, Activities of Daily Living, revised 3/2018, the residents would be provided with care treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The P&P indicated residents who were unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. During a review of the facility's Restorative Nursing Assistant Job Description (undated), the job description indicated the following:Provide restorative nursing care (ROM, exercises, ambulating) to residents as ordered by the resident's physicianPerform all nursing activities in compliance with the written plan of care and using established policies.Document daily care provided to all residentsComplete weekly summaries of residents' progress in restorative program		

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely submit a referral to the Office of the Long-Term Care Patient Representative (OLTCPR- office that provides a trained public representative for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized decision-maker) for one of one sampled residents (Resident 25). This deficient practice resulted in a delay in obtaining a representative for Resident 25, which resulted in the bio-ethics committee (a multidisciplinary team designed to address, guide, and resolve resident-care issues) overseeing Resident 25's care. Findings: During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 25's diagnoses included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), senile degeneration of the brain (a progressive, age-related decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record indicated the facility's bio-ethics committee as Resident 25's responsible party (decision maker when an individual does not have the mental capacity to do so). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 25's cognition (process of thinking) was severely impaired. The MDS indicated Resident 25 required maximal assistance (helper does more than half the effort) with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 25's History and Physical (H&P), dated [DATE], the H&P indicated Resident 25 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 25's H&P, dated [DATE], the H&P indicated Resident 25 did not have the capacity to understand and make decisions. During an interview on [DATE] at 8:29 a.m., with the Quality Assurance (QA) Nurse, the QA Nurse stated when a resident had fluctuating capacity to understand and make decisions and did not have any family or friends, the resident would be overseen by the bio-ethic committee. The QA Nurse stated the bio-ethics committee consisted of the resident's physician, herself, the Director of Nursing (DON), the Social Services Director (SSD), and any other department heads required to give input on the resident's plan of care. The QA Nurse stated the bio-ethics committee acted as the resident's responsible party to consent for any medical treatment the resident required. The QA Nurse stated the bio-ethics committee should only be a short-term solution and the resident should be referred to the Office of the Long-Term Care Patient Representative (OLTCPR- office that provides a trained public representative for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized decision-maker) as soon as possible. The QA Nurse stated for as long as she could remember, Resident 25's care was always overseen by the bio-ethics committee. During a concurrent interview and record review on [DATE] at 8:41 a.m., with the QA Nurse, the California Department of Aging's webpage topic, link https://aging.ca.gov/providers_and_partners/office_of_the_long-term_care_patient_representative/, titled, The Office of the Long-Term Care Patient Representative, undated, was reviewed. The webpage indicated the facility should request a public patient representative if the facility received an order for medical treatment for the resident, the medical treatment required informed consent, the physician determined the resident lacked capacity to provide informed consent, and the resident lacked a legal decision maker or family/friend who could participate in the IDT review. The QA Nurse stated Resident 25 met the requirements for a public patient representative based on her fluctuating mental capacity on [DATE]. The QA Nurse stated Resident 25 has received medical treatments which required informed consents. During a concurrent interview and record review on [DATE] at 11:13 a.m., with the QA Nurse, Resident 25's Progress Note, dated [DATE], was reviewed. The Progress Note indicated on [DATE], Resident 25 was readmitted to the facility and could make basic needs known. (continued on next page)		

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note indicated Resident 25 did not have any family or friends involved in her care. The Progress Note indicated Resident 25 would be referred to the OLTCPR for medical interventions requiring informed consents. The QA Nurse stated Resident 25 should have been referred to the OLTCPR earlier than [DATE] because Resident 25's care was overseen by the bio-ethics long before then. The QA Nurse stated timely referral to the OLTCPR would allow a representative to be assigned to oversee Resident 25's care. During an interview on [DATE] at 10:53 a.m., with the Director of Nursing (DON), the DON stated when a resident, who did not have the capacity to make medical decisions, did not have any friends or family involved in their care, the facility was responsible to refer the resident to the OLTCPR. The DON stated the referral should be done as soon as the resident was admitted or when a decline in mental capacity to make decisions was determined by the physician. The DON stated timely referral would prevent any delays in the process of appointing a representative. The DON stated Resident 25's referral was not submitted timely, which resulted in the bio-ethics committee overseeing her care and consenting to all medical treatments. The DON stated timely referral to the OLTCPR was necessary to prevent any conflicts of interests regarding Resident 25's care, to appoint a representative who could be more objective and make unbiased informed decisions. During a review of the California Department of Aging's webpage topic, link https://aging.ca.gov/providers_and_partners/office_of_the_long-term_care_patient_representative/, titled, The Office of the Long-Term Care Patient Representative, undated, the webpage indicated, The Office of the Long-Term Care Patient Representative (OLTCPR) provides trained public representatives for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized surrogate. The webpage indicated, Skilled nursing and intermediate care facilities may convene an interdisciplinary team (IDT) to make medical decisions for these residents. Facilities are required to include patient representatives on the IDT. If the facility cannot find a suitable person-such as a friend or family member-OLTCPR provides a trained public patient representative to help ensure the resident's rights, preferences, and dignity are supported in medical decision-making.		

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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 obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from one of five sampled residents' (Resident 10) responsible party (decision maker when an individual does not have the mental capacity to do so) prior to the administration of psychotropic medication (medications that affect the mind, emotions, and behavior). This deficient practice resulted in Resident 10, who did not have the capacity to consent, making uninformed decisions about her care and unable to understand the use, side effects, and risks of taking psychotropic medications. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The admission Record indicated Responsible Party ([RP], decision maker when an individual does not have the mental capacity to do so) 2 was Resident 10's responsible party. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 10's cognition (process of thinking) was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting on/taking off footwear. During a review of Resident 10's History and Physical (H&P), dated 12/24/2025, the H&P indicated Resident 10 did not have the capacity to consent. During a review of Resident 10's General Acute Care Hospital (GACH) Psychosocial Initial Assessment Note, dated 12/9/2025, the GACH Note indicated Resident 10 designated RP 2 as her primary surrogate decision maker. During a review of Resident 10's Order Summary Report, order dated 12/18/2025, the Order Summary Report indicated to give the following: 1. Divalproex Sodium (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions), 250 milligrams (mg, a unit of measurement), by mouth twice a day for bipolar disorder manifested by erratic mood swings. 2. Quetiapine (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]) 25mg, by mouth twice a day for bipolar disorder manifested by delusions (a firm, false belief that does not change) of being persecuted. During a concurrent interview and record review on 2/5/2026 at 10:25 a.m. with Registered Nurse (RN) 1, Resident 10's Verification of Informed Consent to Psychotropic Drug for Divalproex Sodium and Quetiapine, dated 12/17/2025, were reviewed. The Verification of Informed Consent to Psychotropic Drug indicated on 12/17/2025, Resident 10's physician obtained informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of Divalproex Sodium and Quetiapine from Resident 10. The Verification of Informed Consent to Psychotropic Drug indicated RN 1 verified informed consent was obtained from Resident 10. RN 1 stated Resident 10 should not have consented to receive Divalproex Sodium and Quetiapine because it was determined Resident 10 did not have the capacity to consent and appointed RP 2 as her surrogate decision maker. RN 1 stated due to Resident 10's impaired cognition, Resident 10 would not be completely aware of the risks associated with receiving Divalproex Sodium and Quetiapine, therefore unable to make an informed decision. During an interview on 2/9/2026 at 10:59 a.m., with the Director of Nursing (DON), the DON stated informed consent for psychotropic medication use had to be obtained from the resident, if they had decision-making capacity, or their responsible party. The DON stated psychotropic medications had associated risks and side effects which had to be conveyed and understood by the consenting individual. The DON stated Resident 10 did not have the capacity to consent to the use of psychotropic medications, which could result in Resident 10 not truly understanding the risks. During a review of the facility's (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy and Procedure (P&P) titled, Psychoactive Medication Informed Consent, dated 3/2024, the P&P indicated, It is the policy of this facility to ensure that informed consent is obtained for each resident's psychoactive medication is authorized in writing by a physician for specified time period and when necessary to protect the resident from self-injury or injury to others. The P&P indicated, If the resident is not capable of giving informed consent, consent will be obtained from resident's representative		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that residents use to request assistance from staff) was within reach for three of 18 sampled residents (Residents 28, 91, and 48). This deficient practice had the potential to negatively impact Residents 28, 91, and 48's psychosocial well-being and result in delayed provision of care and services. Findings: a. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 28's diagnoses included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dysphagia (difficulty swallowing), and hypertensive heart disease (high blood pressure). During a review of Resident 28's Minimum Data Set ([MDS], a resident assessment tool), dated 11/19/2025, the MDS indicated Resident 28's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 28 had functional ROM limitations to his upper and lower extremities. The MDS indicated required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 28's History and Physical (H&P), dated 2/2/2026, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's care plan titled, At Risk for Falls, initiated 2/21/2025, the care plan interventions were to keep the call light (a device that residents use to request assistance from staff) within reach and answer promptly. During observations made on 2/4/2026 at 8:21 a.m., 10:16 a.m., 12:16 p.m., 1:31 p.m., 2:45 p.m., and 3:37 p.m., in Resident 28's room, Resident 28's call light was pinned to his bed close to his right shoulder and was not within functional reach. Resident 28 had both hands clenched, and both elbows in a fixed flexed position. During a concurrent observation and interview on 2/5/2026 at 3:44 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 28's room, Resident 28's call light was pinned near his right shoulder and was not accessible to the resident. Resident 28 stated it was hard to grab the call light. LVN 3 stated the call light was not in reach and it was not an appropriate call light device for Resident 28 due to severe contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of both upper extremities. LVN 3 stated Resident 28 was at risk of being unable to call for timely assistance with toileting needs, repositioning, pain, or emergent needs because the call light was not accessible and not the appropriate type. b. During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 91's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a neurological disorder), and anxiety (a feeling of fear). (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 91's MDS, dated [DATE], the MDS indicated Resident 91's cognition (ability to think and process information) was severely impaired. The MDS indicated Resident 91 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for ADLs. During a review of Resident 91's care plan titled Risk for Falls, dated 1/29/2026, the care plan intervention indicated facility would ensure Resident 91's call light placed within reach and answered promptly. During observations on 2/2/2026 at 9:00 a.m., 9:55 a.m., 11:35 a.m., and 1:58 p.m., in Resident 91's room, the call light was observed on the floor behind the bed. The call light was out of Resident 91's reach. c. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE]. Resident 48's diagnoses included Parkinson's disease, schizoaffective disorder, and anxiety. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48' cognition was moderately impaired. The MDS indicated Resident 48 required maximum (helper does more than half the effort) assistance from staff for ADLs. During a review of Resident 48's care plan with a focus of Resident had behavioral patterns of restlessness., initiated on 9/29/2025, the care plan intervention indicated the facility would ensure Resident 48's call light was placed within reach. During an observation on 2/2/2026 at 10:30 a.m., in Resident 48's room, Resident 48 was lying in bed. Resident 48's call light was on the floor behind the curtain and not within reach. During a concurrent observation and interview on 2/2/2026 at 10:45 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 48's room, Resident 48's call light was on the floor. CNA 1 stated Resident 48's call light was on the floor behind the curtain and not within reach. CNA 1 stated the call light should always be placed within the residents' reach so they could call for help when needed. CNA 1 stated having the call light on the floor and not within reach placed Resident 48 at risk for unmet care needs, delayed assistance, increased risk for falls, and potential injury. During an interview on 2/6/2026 at 12:51 p.m., with Registered Nurse (RN) 1, RN 1 stated the call light must be placed within the resident's reach at the bedside. RN 1 stated the call light was important for residents to be able to communicate their needs to staff. RN 1 stated licensed staff were responsible for ensuring residents' call lights were checked and positioned within reach at bedside. RN 1 stated when a call light was not within reach, the residents would not be able to call for help, which was a safety issue. RN 1 stated not having call lights within reach placed residents at risk for delayed care needs and avoidable harm. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, revised 10/2010, the P&P indicated the facility would ensure resident's call light would be placed within easy reach of the resident.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of ten sampled residents' (Residents 11 and 10) Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) and advanced directive rights were reviewed, completed and accurately reflected the residents' wishes. This failure has the potential to result in Resident 11 receiving life-sustaining treatment that did not align with his preferences during a change in condition or medical emergency and Resident 10, who did not have the capacity to make medical decisions, not understanding the life-sustaining treatment she consented to. Findings: a. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE]. Resident 11's diagnoses included palliative care (specialized medical care for individuals living with a serious, chronic, or life-threatening illness), cachexia (a complex syndrome associated with underlying illness and characterized by loss of muscle with or without loss of fat mass), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left hand, and unstageable pressure ulcer (full-thickness wound whose depth and severity cannot be determined) of the sacral region. During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 11's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 11 required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 11's History and Physical (H&P), dated 1/3/2026, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During an interview on 2/4/2026, at 1:11 p.m. with Resident 11's Representative Party (RP) 1, RP 1 stated Resident 11 was able to make his own decisions, and RP 1 was available to consult him if he wished. During a concurrent interview and record review on 2/5/2026 at 11:30 a.m. with Quality Assurance Nurse (QAN), Resident 11's Physician Orders for Life-Sustaining Treatment (POLST &ndash; a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 1/1/2026, and H&P, dated 1/3/2026, were reviewed. The POLST was incomplete and lacked physician and witness signatures, and indicated Resident 11 signed do no resuscitate (DNR-a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). The H&P indicated Resident 11 lacked the capacity to make medical decisions. The QAN stated the POLST was incomplete and required an Interdisciplinary Team (IDT) review for the form to be completed again. The QAN stated if Resident 11's current POLST was left incomplete and inaccurate, there was a risk that staff would follow an incorrect code status during an emergency. During an interview on 2/6/2026 at 8:37 a.m. with Resident 11, in the presence of Registered Nurse (RN) 1, Resident 11 stated he was able to make decisions for himself but would also prefer to consult with his brother, RP 1, to help with making medical decisions. Resident 11 stated that he wished to have the facility attempt chest compressions in the event he is found unresponsive. RN 1 stated that if Resident 11 wished to receive chest compressions, then Resident 11 would need to be considered a full code. During a concurrent interview and record review on 2/6/2026 at 9:13 a.m., with the Social Services Director (SSD), Resident 11's POLST, dated 1/1/2026, was reviewed. The POLST indicated Resident 11 signed DNR and the POLST lacked physician and witness signatures. SSD stated that the POLST was incomplete and invalid. SSD stated that it was in her process to review the POLST upon admission, during advance directive acknowledgment review, but it was missed. The SSD stated that if she had reviewed the POLST, she would have had Resident 11 or RP 1 complete the POLST to (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure it accurately reflected Resident 11's end-of-life wishes and was completed with the necessary signatures. During a concurrent interview and record review on 2/9/2026 at 9:20 a.m. with SSD, all of Resident 11's medical record documentation, dated in 2026, was reviewed. Resident 11's medical record lacked a signed advanced directive acknowledgment form. The SSD stated the form was usually completed during the admission process to review wishes regarding code status, treatment and end-of-life preferences. The SSD stated the lack of the form demonstrated the facility was unable to verify that advance directive rights were reviewed with Resident 11 or RP 1 upon admission.b. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The admission Record indicated RP 2 was Resident 10's responsible party.During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognition was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting on/taking off footwear.During a review of Resident 10's H&P, dated 12/24/2025, the H&P indicated Resident 10 did not have the capacity to consent.During an interview on 2/9/2026 at 9:20 a.m., with the SSD, the SSD stated when a resident was admitted to the facility, she would review the advance directive acknowledgement and the POLST with the resident or their responsible party. The SSD stated upon admission, the resident's H&P may not be completed by their physician and she was responsible for reviewing the resident's medical records from the general acute care hospital (GACH). The SSD stated reviewing the GACH medical records would indicate whether the resident had the mental capacity to understand what the advance directive and POLST were and to continue with completing those forms.During a concurrent interview and record review, on 2/9/2026 at 9:22 a.m., with the SSD, Resident 10's GACH Psychosocial Initial Assessment Note, dated 12/9/2025, was reviewed. The GACH Note indicated Resident 10 designated RP 2 as her primary surrogate decision maker. The SSD stated RP 2 was Resident 10's decision maker for any medical decisions. The SSD stated reviewing GACH medical records was important to ensure Resident 10 had someone to make all medical decisions for her.During a concurrent interview and record review, on 2/9/2026 at 9:24 a.m., with the SSD, Resident 10's Advance Directive Acknowledgement Form, dated 12/17/2025, was reviewed. The Advance Directive Acknowledgement Form indicated Resident 10 was given written materials and informed about her right to accept or refuse medical treatments, was informed of her rights to formulate an Advance Directive and understood she was not required to have an Advance Directive. The Advance Directive Acknowledgement Form indicated Resident 10 did not have an Advance Directive. The SSD stated Resident 10's Advance Directive Acknowledgement Form should have been discussed with RP 2 because Resident 10 may not have the capacity to understand the information provided regarding the Advance Directive and her wishes.During a concurrent interview and record review, on 2/9/2026 at 9:25 a.m., with the SSD, Resident 10's POLST, dated 12/19/2025, was reviewed. The POLST indicated attempting resuscitation (the process of reviving an individual from unconsciousness or apparent death) and full treatment such as long-term artificial nutrition (food and fluids provided through a tube to an individual who is unable to eat or drink normally) was to be administered if Resident 10 required life-sustaining treatment. The POLST indicated with Resident 10's signature, she consented that the resuscitative measures were consistent with her own wishes. The SSD stated Resident 10 did not have the mental capacity to complete her POLST regarding the different options of life-sustaining measures and treatments. The SSD stated reviewing the POLST with RP 2 was important to ensure Resident 10's life-sustaining wishes were correct.During an interview on 2/9/2026 at 11:06 a.m., with the Director of Nursing (DON), the DON stated the Advance Directive was the resident's written down wishes for treatment and end-of-life if they were to lose the ability to make decisions. The DON stated the POLST was the life-saving treatment the resident, or their responsible party, consented to. The DON stated reviewing (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and completing the Advance Directive Acknowledgement Form and the POLST with the appropriate individual, whether the resident or their responsible party, was important to ensure the resident's expressed wishes were executed. The DON stated Resident 10 did not have the capacity to understand and make medical decisions, therefore should not have completed the Advance Directive Acknowledgement Form and the POLST. The DON stated Resident 10 may not understand what life-saving measures were and potentially indicate treatments that did not align with her previous expressed wishes when she did have the decision-making capacity. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directive, revised 9/2022, the P&P indicated the following: 1. The resident had the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. 2. Prior to or upon admission, the social services director or designee inquired of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 3. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 4. Upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. 5. If the resident or representative indicated that he or she had not established advance directives, the facility staff would offer assistance in establishing advance directives. 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 work with residents to complete advance directive documentation when appropriate.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 4) was free from unnecessary physical restraint when Resident 4's bed was placed against the wall with upper side rails raised. This failure resulted in Resident 4 being subjected to a restraint without clinical justification and had the potential for restricting Resident 4's freedom of movement, causing physical or psychological harm. Findings: 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 paraplegia (loss of movement and/or sensation, to some degree, of the legs), dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and history of falls. During a review of Resident 4's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 4's cognition was moderately impaired. The MDS indicated Resident 4 required maximum (helper does more than 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 observations on 2/2/2026 at 10:01 a.m., 12:30 p.m., and 3:45 p.m. at Resident 4's bedside, Resident 4 was observed lying in bed with the bed placed directly against the wall on the left side and both upper side rails were raised. During an interview on 2/5/2026 at 8:25 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident has a history of falls and was at high risk for falls, staff were to place the bed against the wall and apply side rails on both sides of the resident's bed to prevent the resident from falling. During a concurrent observation and interview on 2/5/2026 at 8:45 a.m. at Resident 4's bedside with LVN 1, Resident 4 was observed lying in bed with the bed placed directly against the wall on the left side. LVN 1 stated having the bed against the wall with raised upper side rails restricted Resident 4's ability to freely exit the bed. LVN 1 stated the bed had been positioned against the wall and the side rails were kept up as ongoing fall- prevention measures for Resident 4. LVN 1 stated this practice limited Resident 4's ability to get out of bed and prevented her from falling. LVN 1 stated physical restraints should not be used for fall prevention or staff convenience. LVN 1 stated placing Resident 4's bed against the wall in combination with raised side rails without a care plan, physician order, and informed consent would be considered a physical restraint. During a concurrent interview and record review on 2/5/2026 at 8:45 a.m., with LVN 1, Resident 4's Electronic Medical Record (EMR), was reviewed. LVN 1 stated there was no documented evidence that least restrictive interventions had been attempted or implemented prior to placing Resident 4's bed against the wall with bilateral side rails raised. LVN 1 stated there was no physician order or informed consent for the use of physical restraint for Resident 4. LVN 1 stated that using the bed against the wall as a physical restraint placed Resident 4 at risk for entrapment (capture, catch, and trap), injury, and loss of dignity. During a review of the facility's policy and procedure (P&P) titled Use of Restraints, revised 12/2007, the P&P indicated Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The P&P indicated Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement individualized care plans for four of eight sampled residents (Resident 11, Resident 3, Resident 10, and Resident 57) when care plans were not developed to address: a. Resident 11's identified range of motion impairments and comfort-focused mobility needs. b. Resident 3's use of the anticoagulant (blood thinner) medication, Apixaban (a medication used to prevent blood clots). c. Resident 10's use of grab bars for safe transfers. d. Resident 57's hearing impairment and use of hearing aids. These deficient practices placed Resident 11, Resident 3, Resident 10, and Resident 57 at risk for increased pain, stiffness, further development of contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), bleeding complications, unsafe transfers, falls, decreased communication, and decline in comfort and functional status. Findings: a. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE]. Resident 11's diagnoses included palliative care (specialized medical care for individuals living with a serious, chronic, or life-threatening illness), cachexia (a complex syndrome associated with underlying illness and characterized by loss of muscle with or without loss of fat mass), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left hand, and unstageable pressure ulcer (full-thickness wound whose depth and severity cannot be determined) of the sacral region (triangular bone at the base of the spine). During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 11's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 11 required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 11's Joint Mobility Assessment (JMA), dated 1/6/2026, the JMA did not indicate recommendations and interventions to address Resident 11's range of motion (ROM, the full, functional measurement of how far a specific joint or body part can move in various directions) needs. The JMA indicated Resident 11 had the following range of motion (ROM) limitations: 1. Severe limitations to his left and right shoulders. 2. Moderate limitations to his left and right elbows, fingers of the left hand, both hips, right knee and left and right ankle. 3. Moderate to severe limitations to the left wrist. 4. Minimal limitations to his right wrist and fingers of the right hand. During a concurrent interview and record review on 2/05/2026 at 4:08 p.m. interview with Minimum Data Set Nurse (MDSN) 1, Resident 11's MDS Section GG, dated 1/13/2026, and all of Resident 11's (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans, dated in 2026, were reviewed. The MDS Section GG indicated Resident 11 had functional impairments in range of motion to both sides of his upper and lower extremities. There were no care plans in place to address Resident 11's ROM impairments or comfort focused mobility interventions. MDSN 1 stated the lack of a care plan that addressed Resident 11's ROM limitations placed Resident 11 at risk for increased pain, stiffness, and decline in comfort. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, revised 7/2017, the P&P indicated the coordinated care plan would reflect the resident's goals and wishes as stated in his advanced directives and during ongoing communication with the resident or representative including palliative goals and objectives, interventions, and medical treatment. The P&P indicated the coordinated care plan would be revised and updated as necessary to reflect the resident's current status including mobility and positioning. b. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included acute embolism and thrombosis of the right popliteal vein (a sudden blood clot that forms in the vein behind the right knee which can block blood flow and travel to other parts of the body), presence of cardiac pacemaker (a device placed in the chest that helps the heart beat regularly), myocardial infarction (MI - heart attack), acute and chronic kidney disease (a sudden and long-term problem where the kidneys do not work remove waste and extra fluid from the body), anemia (a condition where the body does not have enough healthy red blood cells), and a history of falling. During a review of Resident 3's History and Physical (H&P), dated 10/18/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognitive skills were severely impaired. The MDS indicated Resident 3 required set-up or clean-up assistance (helper assists only prior to or following the activity) for eating and dressing. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) with toileting and bathing. The MDS indicated Resident 3 was receiving anticoagulant therapy. During a review of Resident 3's physician order dated 10/17/2025, the order indicated to observe closely for significant side effects of anticoagulant medications. During a review of Resident 3's physician order dated 10/25/2025, the order indicated to give one tablet by mouth of Apixaban (a medication used to prevent blood clots) 5 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) one time a day for deep vein thrombosis (DVT- a blood clot that forms in a vein deep in the body) prophylaxis (PPX- action taken to prevent disease). During an interview on 2/9/2026 at 12:59 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 3 was receiving Apixaban. LVN 3 stated there was no care plan. LVN 3 stated when a resident was initially placed on an anticoagulant, the resident would require laboratory monitoring, a physician order, and initiation of a care plan. LVN 3 stated a resident who received an anticoagulant would require monitoring for signs of bleeding. LVN 3 stated an anticoagulant care plan would include signs and symptoms of bleeding, instructions on when to hold the anticoagulant medication, and when to notify the physician to ensure a plan was in place if an adverse event occurred. c. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 57's diagnoses included dementia (a progressive state of decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (condition characterized by persistent, excessive, and uncontrollable fear or worry). During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57's cognition was intact. The MDS indicated Resident 57 required setup or clean-up assistance with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 57 had moderate difficulty (speaker has to increase volume and speak distinctly) with his hearing. During a review of Resident 57's H&P, dated 1/30/2026, the H&P indicated Resident 57 had the capacity to understand and make decisions. During a concurrent observation and interview on 2/2/2026 at 9:36 a.m., with Resident 57, in Resident 57's room, Resident 57 was observed with two hearing aids inside a case stored on his nightstand. Resident 57 picked up the hearing aids and stated he was given the hearing aids, however, they are no good to me. Resident 57 stated when speaking to another person, the outside noise was amplified, and he was unable to hear the other person clearly. During a concurrent interview and record review on 2/5/2026 at 11:03 a.m., with MDS Nurse (MDSN) 1, Resident 57's Care Plans, active on 2/5/2026, were reviewed. The care plan did not indicate there was a care plan to address Resident 57's hearing impairment and use of hearing aids. MDSN 1 stated Resident 57 had difficulty hearing, especially during conversations, which resulted in speaking in a louder volume during conversations. MDSN 1 stated a care plan should have been developed to address Resident 57's hearing and use of hearing aids to ensure all staff knew how to communicate with Resident 57. MDSN 1 stated a care plan would have included interventions to speak slower, clearer, and to write down communications if needed. MDSN 1 stated an important aspect of the care plan would be to assess Resident 57's hearing and use of hearing aids to determine if an audiology (examination of hearing) referral was needed. MDSN 1 stated without this care plan, Resident 57 was at risk of his needs not being met and ineffective communication with his peers and staff. During an interview on 2/9/2026 at 11:16 a.m., with the Director of Nursing (DON), the DON stated Resident 57 should have had a care plan developed to address his hearing and use of hearing aids. The DON stated the care plan should have included assessments of Resident 57's hearing and use of hearing aids. The DON stated the care plan would have outlined how to effectively communicate with Resident 57. The DON stated without a care plan, there would be no implementation of the process to care for Resident 57's hearing aids, refer to audiology if the hearing aids were not functioning properly, to monitor Resident 57's correct utilization of the hearing aids, and to monitor whether the hearing aids were effective. The DON stated without a care plan, Resident 57 was at risk of ineffective communication regarding his care. d. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included dementia 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 10's MDS, dated [DATE], the MDS indicated Resident 10's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on/taking off footwear. During a review of Resident 10's H&P, dated 12/24/2025, the H&P indicated Resident 10 did not have the capacity to consent. During a review of Resident 10's physician orders, active on 2/5/2026, the orders did not indicate the use of grab bars (a type of side rails, which are short rails on one or both sides of the bed that can be used to assist in bed mobility). During an observation on 2/2/2026 at 9:24 a.m., in Resident 10's room, Resident 10 was observed sitting at the edge of her bed. There were bilateral (both sides) grab bars on the bed. During a concurrent observation and interview on 2/5/2026 at 8:02 a.m., with Registered Nurse (RN) 1, in Resident 10's room, Resident 10 was observed sitting at the edge of her bed with bilateral grab bars on the bed. RN 1 stated Resident 10 did not have an indication for the grab bars because Resident 10 did not need assistance in her mobility or repositioning. RN 1 stated Resident 10 may have inherited a bed from a previous resident who used the grab bars. RN 1 stated the grab bars were not removed. During a concurrent interview and record review on 2/5/2026 at 8:03 a.m., with RN 1, Resident 10's Care Plans, active on 2/5/2026, were reviewed. The care plans did not indicate a care plan was initiated to address the presence of grab bars. RN 1 stated due to the presence of grab bars on Resident 10's bed, a care plan should have been developed to address the associated safety concerns such as entrapment (becoming caught, trapped, or tangled in between a small space) and injury. During an interview on 2/9/2026 at 11:16 a.m., with the DON, the DON stated Resident 10 should have had a care plan developed for the presence of the grab bars. The DON stated although Resident 10 was independent in her mobility, the grab bars could be used as a mobility aid if needed. The DON stated without a care plan, there was no documentation detailing the use of the grab bars and the interventions the nurses had to implement to ensure safety. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive, revised 9/2010, the P&P indicated the facility was to ensure the facility's Care Planning or Interdisciplinary Team, in coordination with the resident, or the representative party, developed and maintained a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. The comprehensive care plan was based on a thorough assessment that included but is not limited to, the MDS.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 53) received nail care and grooming services. This deficient practice had the potential to result in Resident 53 experiencing infection, compromised hygiene, skin injury from scratching, and diminished dignity. Findings: During a review of Resident 53's admission Record, the admission Record indicated Resident 53 was admitted to the facility on [DATE]. Resident 53's diagnoses included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), absence of left leg below the knee (BKA - surgical removal of the portion of the leg below the knee), chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental condition that can cause worry, fear, or distress and may interfere with daily activities). During a review of Resident 53's History and Physical (H&P), dated 12/15/2025, the H&P indicated Resident 53 could make needs known but could not make medical decisions. During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool) dated 12/26/2025, the MDS indicated Resident 53's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 53 was independent (resident completes activity by themselves with no assistance) with eating and required moderate assistance (helper does less than half the effort) for toileting, bathing, dressing and personal hygiene. The MDS indicated Resident 53 required a wheelchair for mobility (the ability to move freely and safely from one place to another). During a review of Resident 53's care plan titled Activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and functional mobility, initiated 12/18/2024, the care plan indicated Resident 53 required assistance with personal hygiene and grooming. The care plan indicated the goal was to groom and meet Resident 53 daily needs. The care plan interventions indicated to assist with ADLs as needed and monitor Resident 53 for ADL needs. During an observation on 2/2/2026 at 9:25 a.m., while in Resident 53's room, observed Resident 53 lying in bed, alert and awake. Resident 53's fingernails were overgrown with jagged, uneven edges extending beyond the fingertips. Yellow discoloration and dark debris were visible beneath several fingernails. The nails were untrimmed. During an interview on 2/5/2026 at 4:30 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 53's nails were dirty and untrimmed. CNA 5 stated nursing staff made sure residents' nails were clean and trimmed every day. CNA 5 stated dirty nails could cause infection and spread germs. CNA 5 stated residents who were not groomed may feel uncomfortable. During a concurrent interview and record review on 2/5/2026 at 4:43 p.m., with Licensed Vocational Nurse (LVN) 5, Resident 53's nursing progress notes from 1/31/2026 to 2/3/2026 were reviewed. The progress notes did not indicate documentation of Resident 53 refusal of fingernail grooming from 1/31/2026 to 2/3/2026. LVN 5 stated Resident 53 often refused to be groomed. LVN 5 stated when residents refused ADL care, the CNAs were required to report the refusal to the charge nurse and complete a Stop and Watch (a tool used to report observed changes in a resident's condition for further assessment). LVN 5 stated the charge nurse signed the Stop and Watch and implemented and documented interventions. LVN 5 stated refusals should have been documented. LVN 5 stated the CNAs should have either reported the refusal. LVN 5 stated it was important to clean the resident's nails due to risk of infection and overall well-being. LVN 5 stated eating with dirty nails could have been a hygiene issue. During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents would be provided care, treatment, and services to maintain or improve their ability to carry out ADLs. The P&P indicated residents unable to carry out ADLs independently would receive (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services necessary to maintain grooming and personal hygiene. The P&P further indicated appropriate care and services would be provided in accordance with the plan of care, including hygiene such as bathing, dressing, grooming, and oral care. The P&P indicated when residents refused care, the resident or representative would be informed of the risks and benefits of the proposed care or treatment, alternative interventions would be offered to minimize further decline, and the refusal and related information would be documented in the resident's clinical record. The P&P further indicated the resident's response to interventions would be monitored, evaluated, and revised as appropriate. During a review of the facility's Certified Nursing Assistant (CNA) job description, not dated, the job description indicated CNAs were responsible with assisting residents with nail care, including clipping, trimming, and cleaning fingernails and toenails.		

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the physician orders for Physical Therapy ([PT]- a licensed healthcare profession focused on restoring, maintaining, and promoting optimal physical function, movement, and quality of life) and Occupational Therapy ([OT]- enables people to engage in meaningful, everyday activities and promote well-being and independence) services for one of five sampled residents (Resident 12). This deficient practice placed Resident 12 at risk for avoidable decline in strength and functional status, increased dependence on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and decreased quality of life. Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness of one side of the body), chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 12's History and Physical (H&P), dated 10/6/2025, the H&P indicated Resident 12 had the capacity to make medical decisions. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 1/1/2026, the MDS indicated Resident 12's cognitive skills for daily decision making (ability to think and process information) was intact. The MDS indicated Resident 12 required maximum (helper does more 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 a review of Resident 12's physician order, dated 1/10/2026, the order indicated a referral for PT and OT to address Resident 12's impaired mobility and ADL dependence. During an interview on 2/2/2026 at 10:01 a.m., at Resident 12's bedside, Resident 12 stated she had not been seen by PT or OT since last year (2025). Resident 12 stated she wanted therapy to get stronger and improve her ability to walk. Resident 12 stated she spent most of the day in bed and felt weaker and more dependent since her admission to the facility. During a concurrent interview and record review on 2/5/2026 at 8:30 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there were no PT or OT evaluation notes or treatment notes in Resident 12's electronic medical record (EMR) following the physician's order dated 1/10/2026. LVN 1 stated there was no documentation that the PT/OT referrals had been sent. LVN 1 stated there was no documented evidence of any therapy services provided, and no documentation that Resident 12 refused therapy. LVN 1 stated when the physician orders PT and OT services, the licensed staff were expected to carry out the orders by initiating the referrals, follow up with the rehabilitation team to ensure the services are provided, and initiate a care plan addressing the resident's needs. During an interview on 2/5/2026 at 9:04 a.m., with the Director of Rehabilitation (DOR), the DOR stated she was not aware that Resident 12's attending physician ordered PT and OT on 1/10/2026. The DOR stated the therapy department had not received a referral or communication from nursing regarding Resident 12's need for PT and OT services. The DOR stated that timely implementation of PT and OT orders was essential to evaluate a resident's strengths, balance, ability to perform ADLs, and prevent further physical decline. During an interview on 2/6/2026 at 12:51 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 12's PT and OT orders had not been initiated. RN 1 stated the facility's failure to process and implement the therapy referrals was an oversight. RN 1 stated Resident 12 should have been receiving PT and OT to address her weakness and dependence with ADLs. RN 1 stated it was the responsibility of the licensed nursing staff to review new physician orders, notify the rehabilitation department, and follow up to make sure ordered services were started. During a review of the facility's policy and procedure (P&P) titled Registered Nurse Job Description, revised 3/12/2021, the P&P indicated Registered Nurse (RN) duties and responsibilities were to consult with (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's physician in providing resident care, treatment, rehabilitation and ensure timely documentation and carryout new orders.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow up on two of two sampled resident's (Resident 57 and Resident 42) audiology (examining hearing) and optometry (examining eyes for visual issues) referrals. This deficient practice resulted in Resident 57 being unable to use his hearing aids (small medical device worn in or behind the ear to amplify sound for individuals with hearing loss) since 9/29/2025 and continued to have difficulty hearing, and had the potential to result in miscommunication regarding Resident 57's care. This deficient practice also resulted in delaying Resident 42's ability to obtain glasses which resulted in difficulty seeing. Findings:a. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 57's diagnoses included dementia (a progressive state of decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (condition characterized by persistent, excessive, and uncontrollable fear or worry).During a review of Resident 57's Minimum Data Set (MDS- a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 57's cognition (process of thinking) was intact. The MDS indicated Resident 57 required setup or clean-up assistance with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 57 had moderate difficulty (speaker has to increase volume and speak distinctly) with his hearing. During a review of Resident 57's History and Physical (H&P), dated 1/30/2026, the H&P indicated Resident 57 had the capacity to understand and make decisions. During a review of Resident 57's Physician Order, dated 9/26/2025, the order indicated for audiology (examining hearing) consultation as needed for hearing problem.During a review of Resident 57's Ear, Nose, Throat (ENT- specialty specific to conditions affecting the ears, nose, and throat) Note, dated 9/29/2025, the ENT Note indicated Resident 57 had diminished hearing. The ENT Note indicated Resident 57 had working hearing aids (small medical device worn in or behind the ear to amplify sound for individuals with hearing loss) but had difficulty using them. The ENT Note indicated a referral for an audiogram (a hearing test) and servicing to Resident 57's hearing aids. During a concurrent observation and interview on 2/2/2026 at 9:36 a.m., with Resident 57, in Resident 57's room, Resident 57 was observed with two hearing aids inside a case stored on his nightstand. Resident 57 picked up the hearing aids and stated he was given the hearing aids. Resident 57 stated, They are no good to me. Resident 57 stated when speaking to another person, the outside noise was amplified, and he was unable to hear the other person clearly. During a telephone interview on 2/5/2026 at 3:01 p.m., with the Audiology Manager, the Audiology Manager stated, on 9/29/2025, the ENT provider assessed Resident 57's hearing and noticed Resident 57 had hearing aids but did not wear them. The Audiology Manager stated the ENT recommended Resident 57 to have an audiogram and servicing to his hearing aids. The Audiology Manager stated there was a clerical error at the audiology office and the referral was inaccurately inputted. The Audiology Manager stated due to the clerical error, Resident 57 did not receive an audiogram and service to his hearing aids.During an interview on 2/9/2026 at 9:39 a.m., with the Social Services Director (SSD), the SSD stated Resident 57 had difficulty using his hearing aids. The SSD stated Resident 57 had a referral for an audiogram and servicing to his hearing aids that was not completed. The SSD stated the facility should have followed up with the audiology office to clarify why Resident 57 was not seen by the hearing aid provider. The SSD stated Resident 57 had difficulty hearing and would continue to have difficulty hearing as long as Resident 57 did not wear his hearing aids.During an interview on 2/9/2026 at 11:20 a.m., with the Director of Nursing (DON), the DON stated referrals regarding difficulty hearing was important to follow up to increase Resident 57's quality of life so he could hear. The DON stated Resident 57 was self-responsible and made his own medical decisions. The DON stated by not having functional hearing aids, Resident 57 was at risk of not hearing everything being explained to him and could result in misunderstandings. During a review (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility's Policy and Procedure (P&P) titled, Hearing Impaired Resident, Care of, Revised 2/2018, the P&P indicated, Staff will assist the resident (or representative) with locating available resources, scheduling appointments, and arranging transportation to obtain needed services. The P&P indicated, Staff will help residents who have lost or damaged hearing devised in obtaining services to replace the devices.b. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was initially admitted to the facility on [DATE]. Resident 42's diagnoses included fracture (broken bone) of the left femur (thigh bone) and right clavicle (collar bone), traumatic shock, motor vehicle accident and lack of coordination. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 42 required setup assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 42's H&P, dated 10/23/2025, the H&P indicated Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's Order Summary, dated 1/1/2026, the Order Summary indicated the facility was to ensure Resident 42 received an eye health and vision consult with follow up treatment as indicated. During an interview on 2/2/2025 at 9:15 a.m. with Resident 42, in Resident 42's room, Resident 42 stated the SSD did not provide an update regarding the status of his glasses despite repeated requests. Resident 42 stated that due to not having his glasses, he was unable to enjoy reading his books as he previously did. During a concurrent interview and record review on 2/9/2026 at 9:52 a.m. with the SSD, Resident 42's Ophthalmology (diagnosis and treatment of disorders of the eye) Referral for Optometry (the occupation of measuring eyesight, prescribing corrective lenses, and detecting eye disease) for Glasses, dated 12/23/2025, was reviewed. The SSD stated she did not follow up on the referral until the week of the interview. The SSD stated timely follow up of referrals was necessary to avoid delays on obtaining glasses. The SSD stated the lack of timely follow-up placed Resident 42 at continued risk for difficulty seeing during day-to-day activities and reading fine print due to his visual impairments. During a review of the facility's P&P titled, Care of the Visually Impaired, revised 3/2021, the P&P indicated it was facility's responsibility to assist the resident and representatives in locating available resources, scheduling appointments and arranging transportation to obtain needed services.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 support services as needed for optometry, dental, and audiology.		

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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 provide visual monitoring every two hours and ensure floor mats were in place for two out of six sampled residents (Resident 23 and Resident 4). These deficient practices resulted in Resident 23 leaving the facility undetected and was later located approximately 9.5 miles from the facility placing the resident at risk for serious injury or harm. This deficient practice also placed Resident 4 at risk for injury from a fall. Findings: During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included atrial fibrillation (irregular heart rhythm) , schizophrenia (a mental illness that is characterized by disturbances in thought), hypertensive heart disease (high blood pressure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), suicidal ideations, and difficulty walking. During a review of Resident 23's Minimum Data Set ([MDS], a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 23 required supervision or touching assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 23's Progress Note, dated 2/2/2026, the Progress Note did not indicate Resident 23 was monitored between 2/1/2026 at 9:50 a.m. and 2/2/2026 at 10 p.m. The Progress Note did not indicate documentation that the exit door alarms were armed or actively engaged during the 3 p.m. to 11 p.m. shift on 2/2/2026. During a review of Resident 23's Progress Note, dated 2/2/2026, timed at 10:00 p.m., the Progress Note indicated Resident 23 was not in bed during room rounds at 10:00 p.m. and a facility-wide search was conducted. The Progress Note indicated, at 11 p.m., local authorities were notified. The Progress Note indicated, at 11:50 a.m., Licensed Vocational Nurse (LVN) 2 received a phone call from the general acute care hospital (GACH), located approximately 9.5 miles from the facility, that Resident 23 had been located and arrangements would be made to return him to the facility. During an interview on 2/9/2026 at 10:19 a.m., in the presence of Certified Nursing Assistant (CNA) 2, Resident 23 stated, on 2/2/2026, during the evening hours, he wheeled himself from his room through the hallways and exited the facility through the back door without staff awareness. Resident 23 stated he did not recall hearing an alarm when he exited the facility back door. Resident 23 stated he was able to open the back gate located near the exit door and wheel himself to the street. During an interview on 2/9/2026 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated he was assigned to Resident 23's care on 2/2/2026 (3 p.m. to 11 p.m.). LVN 2 stated he last saw Resident 23 at approximately 7:20 p.m. in the facility's patio. LVN 2 stated nursing staff were expected to round on their assigned residents every two hours and ensure facility exits were armed or secured. LVN 2 stated he did not recall hearing any exit alarms triggered during the shift and stated that if alarms were not triggered, the alarms may not have been engaged. LVN 2 stated if Resident 23 was not effectively monitored, there was potential for the resident to experience an accident or elope (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(the act of leaving a facility unsupervised and without prior authorization). During an interview on 2/9/2026 at 11:20 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was Resident 23's assigned CNA on 2/2/2026 (3 p.m. to 11 p.m.). CNA 1 stated the expectation was to round on assigned residents every hour to ensure safety. CNA 1 stated she last saw Resident 23 in his room at approximately 4:30 p.m. when he asked her for clothes. CNA 1 stated at approximately 4:45 p.m., Resident 23 was no longer in his room and she assumed he went to the patio. CNA 1 stated she became busy performing CNA duties and did not verify Residents 23's whereabouts. CNA 1 stated she relied on other CNAs who reported they had seen the resident earlier. CNA 1 stated she did verify Resident 23's whereabouts, and because she did not effectively monitor Resident 23's location, Resident 23 was at higher risk of elopement. During an interview on 2/9/2026 at 2:05 p.m. with the Maintenance Staff Director (MSD), the MSD stated, prior to Resident 23's elopement, the maintenance staff were responsible for checking the exit door alarms systems once a month. During an interview on 2/12/2026 at 3:46 p.m. with the Director of Nursing (DON), the DON stated that the facility's practice was to monitor and round on the residents every two hours to ensure safety. The DON stated if adequate supervision was not rendered for Resident 23, then there was a possibility that he could have hurt himself or elope. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents (undated) the P&P indicated the facility strived to make the environment free from accident hazards as possible and resident safety and supervision were facility-wide priorities. 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 paraplegia (loss of movement and/or sensation, to some degree, of the legs), dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and history of falls. 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 maximum (helper does more than 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 a review of Resident 4's Order Summary Report, dated 1/2/2026, the order summary report indicated to apply bilateral (both sides) floormats to decrease risk of injury related to fall. During observations on 2/2/2026 at 10:01 a.m., 12:30 p.m., and 3:45 p.m., at Resident 4's bedside, Resident 4 was observed lying in bed. A floormat was to the right side of the bed. There was no floormat on the left side of her bed. During an interview on 2/5/2026 at 8:25 a.m., with LVN 1, LVN 1 stated when a resident has a history of falls and was at high risk for falls, staff were to apply floormats on both sides of the resident's bed. During concurrent interview and record review on 2/5/2026 at 8:39 a.m., with LVN 1, Resident 4's care plan titled Physical Device bilateral floor mat: due to history of fall, revised 4/7/2025, and active (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order, dated 1/2/2026, were reviewed. The care plan indicated to apply bilateral floormats to decrease risk of injury related to fall. The physician order indicated apply bilateral floormats to decrease risk of injury related to fall. LVN 1 stated Resident 4's had a history of fall and the care plan intervention indicated Resident 4 was supposed to have bilateral floormats as ordered on both sides of her bed. LVN 1 stated the purpose of the floormats was to prevent injury if Resident 4 were to fall from her bed. During a concurrent observation and interview on 2/5/2026 at 8:45 a.m., at Resident 4's bedside, with LVN 1, Resident 4 was observed lying in bed. A floormat was on the right side of the bed. LVN 1 stated there was no floormat on the left side of Resident 4's bed. LVN 1 stated Resident 4 was at risk of injury and could hurt herself if she were to fall. During a review of the facility's P&P titled Falls and Fall Risk, Managing, revised 12/2007, the P&P indicated the staff will identify interventions to the resident's specific risks and prevent the resident from falling and minimize complications from falling.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedure titled, Catheter Care Urinary by not ensuring a resident's indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was maintained in a manner that prevented contact with contaminated surfaces during wheelchair mobility for one out of two sampled residents (Resident 2). This deficient practice resulted in Resident 2's catheter drainage bag being dragged on the floor on multiple occasions, which placed Resident 2 at risk for catheter contamination, urinary tract infection (UTI- an infection in the bladder/urinary tract), and accidental catheter dislodgement. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure (breathing problems), infection and inflammatory reaction due to indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine), urine retention, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 2's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 2 was dependent of staff for toileting and showering. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's History and Physical (H&P), dated 11/25/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's care plan titled, Foley Catheter (indwelling urinary catheter), initiated 11/11/2025, the care plan indicated interventions were to place all tubing suspended without touching the floor, and to provide indwelling catheter care each shift. During a review of Resident 2's Progress Note, dated 11/30/2025, the Progress Note indicated Resident 2's indwelling urinary catheter dislodged and resulted in penile trauma and continuous bleeding. During an observation on 2/4/2026 at 10:19 a.m., in the facility's smoking patio, observed Resident 2 self-propelling his wheelchair while his indwelling catheter drainage bag dragged against the pavement. During observations made on 2/4/2026 at 11:55 a.m. and 2:44 p.m. in the facility hallway, observed Resident 2 self-propelling himself to his room. Resident 2's indwelling catheter drainage bag dragged against the floor. During a concurrent observation and interview on 2/4/2026 at 3:15p.m. with Licensed Vocational Nurse (LVN) 1, observed Resident 2's indwelling catheter drainage bag attached beneath his wheelchair at a level low enough for the bag to rest on the floor. LVN 1 stated it was important to keep the indwelling catheter tubing and drainage bag off the floor to prevent accidental catheter removal, urethral trauma, and urinary tract infection. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care Urinary, revised 8/2022, the P&P indicated the facility was to ensure the catheter tubing and drainage bag were kept off the floor.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen (a medical gas used to help with breathing) therapy in accordance with the facility policy and physician orders for two of six sampled residents (Resident 2 and Resident 94), when the facility failed to ensure:1. Oxygen therapy was administered per physician order for Resident 22. The nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was dated for Resident 94.3. Required humidification (adding moisture to oxygen) was provided for Resident 94's continuous oxygen therapy.4. Required oxygen-in-use signage was posted outside of Resident 94's room. These deficient practices had the potential to place Residents 2 and 94 at risk for inadequate oxygen delivery, respiratory discomfort, nasal mucosal dryness (drying of the lining inside the nose), compromised respiratory status, and increased risk for injury related to fire hazards due to the absence of required oxygen signage. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), acute respiratory failure (breathing problems), infection and inflammatory reaction due to an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine), urine retention, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 2's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 2 was dependent on staff for toileting and showering. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's Order Summary Report, dated 2/1/2026, the report indicated oxygen at 2 liters (unit of volume) per minute via nasal cannula as needed. During a review of Resident 2's care plan titled, Ineffective Breathing Pattern, revised on 11/25/2025, the care plan interventions indicated to provide oxygen as ordered. During an observation and interview on 2/5/2026 at 8:14 a.m., in Resident 2's room, observed Resident 2 in bed receiving oxygen at 5 liters per minute via a nasal cannula connected to an oxygen concentrator. Resident 2 was observed groggy and confused. During a concurrent interview and record review on 2/5/2026 at 4:31 p.m., with Registered Nurse (RN) 1, Resident 2's Physician Orders, dated 2/1/2026, and a photograph taken on 2/5/2026 at 8:14 a.m., were reviewed. The photo showed Resident 2's oxygen at 5 liters per minute. The order indicated to administer oxygen at 2 liters per minute. RN 1 stated Resident 2 receiving 5 liters of oxygen per minute did not align with the physician's order. RN 1 stated, given Resident 2's diagnosis of COPD and respiratory failure, administration of oxygen above the ordered rate placed the resident at risk for hypercapnia (high levels of carbon dioxide [a gaseous waste product] in your blood), respiratory compromise, and altered mental status. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated the licensed nurse was to verify and review the physician's orders or facility protocol for oxygen administration and review the resident's care plan to assess for any special needs of the resident. b. During a review of Resident 94's admission Record, dated 2/9/2026, the admission Record indicated Resident 94 was admitted to the facility on [DATE] with diagnoses which included COPD, acute respiratory failure (condition in which not enough oxygen passes from the lungs into the blood), obstructive sleep apnea (OSA - a sleep-related breathing disorder where breathing repeatedly stopped and started during sleep), and morbid obesity with hypoventilation (severe obesity associated with shallow or ineffective breathing). During a review of Resident 94's History and Physical (H&P), dated 1/31/2026, the H&P indicated Resident 94 had the capacity to understand and make decisions. During a review of Resident 94's MDS dated [DATE], the MDS indicated Resident 94's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 94 required set-up or clean-up assistance (helper assists only prior to or following the activity) for eating and maximal assistance (helper does more than half the effort) for toileting, bathing, dressing and personal hygiene. The MDS indicated Resident 94 required continuous oxygen therapy. During a review of Resident 94's care plan titled Required continuous oxygen use related to diagnoses of COPD, acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), and OSA, initiated on 2/2/2026, the care plan interventions indicated to check and fill the humidifier every shift and change tubing once a week or as needed. During a review of Resident 94's Order Summary Report dated 2/2/2026, the Order Summary Report indicated continuous oxygen via nasal cannula. During an observation on 2/2/2026 at 10:29 a.m., in Resident 94's room, Resident 94 was observed lying in bed awake and alert. Oxygen via nasal cannula was infusing at 3.5 liters per minute. There was no humidifier observed. Resident 94's oxygen tubing was not labeled or dated. Resident 94 did not have oxygen in use signage posted outside of the doorway. During a concurrent observation and interview on 2/2/2026 at 10:40 a.m., with Licensed Vocational Nurse (LVN) 4, in Resident 94's room, observed Resident 94 receiving continuous oxygen via nasal cannula. LVN 4 stated the oxygen tubing was not labeled with a date and the oxygen signage was not present outside of Resident 94's doorway. LVN 4 stated oxygen tubing should be dated and changed every Sunday. LVN 4 stated it was important to label the oxygen tubing so staff would know when it needed to be changed. LVN 4 stated old or dirty oxygen tubing could cause an infection or may not provide proper oxygen. LVN 4 stated oxygen signage should have been posted outside of Resident 94's doorway. LVN 4 stated if oxygen signage was not posted, anyone could enter the room and start a fire. During an interview on 2/5/2026 at 4:50 p.m., with RN 1, RN 1 stated residents receiving oxygen required a concentrator, tubing, humidifier, doctor's order, oxygen signage, and oxygen monitoring every shift. RN 1 stated Resident 94's oxygen tubing should have been labeled and dated for infection control purposes. RN 1 stated oxygen tubing should be changed weekly on the night shift. RN 1 stated without a label and date on Resident 94's oxygen tubing, there was no way to determine when the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen tubing needed to be changed. RN 1 stated a humidifier was important to keep the nasal passages moisturized because oxygen had a drying effect. RN 1 stated oxygen signage was important to ensure no one smoked or caused sparks because oxygen was combustible (can easily start a fire). RN 1stated the admitting nurse was responsible for ensuring Resident 94's oxygen was labeled, a humidifier was provided, signage was posted, and the doctor's orders were followed upon admission. During a review of the facility's P&P, titled Oxygen Administration, revised 10/2010, the P&P indicated oxygen therapy required a physician's order, appropriate oxygen delivery equipment, humidification as needed, and the use of No Smoking/Oxygen in Use signage while oxygen was in use. The P&P further indicated staff were responsible for ongoing assessment of residents receiving oxygen therapy and for ensuring required equipment and safety measures were in place.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their process for proper use of side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility) for two of two sampled residents (Residents 10 and 62) by failing to:1. Conduct an accurate Bed Rail Assessment prior to installing Resident 10 and 62's side rails.2. Obtain an Order for Resident 10's use of side rails.3. Verify informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained prior to Resident 10 use of side rails. These deficient practices had the potential for the unsafe use of Resident 10 and 62's side rails which could lead to entrapment (becoming caught, trapped, or tangled in between a small space) and injury. Findings: a. During a review of Resident 10's admission Record (Face Sheet), the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The Face Sheet indicated RP 2 was Resident 10's responsible party (RP, decision maker when an individual does not have the mental capacity to do so). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 10's cognition (process of thinking) was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting on/taking off footwear. During a review of Resident 10's History and Physical (H&P), dated 12/24/2025, the H&P indicated Resident 10 did not have the capacity to consent. During a review of Resident 10's general acute care hospital (GACH) Psychosocial Initial Assessment Note, dated 12/9/2025, the GACH Note indicated Resident 10 designated RP 2 as her primary surrogate decision maker. During an observation on 2/2/2026 at 9:24 a.m., in Resident 10's room, observed Resident 10 sitting at the edge of her bed. Resident 10 had bilateral (both sides) grab bars (a type of side rails, which are short rails on one or both sides of the bed that can be used to assist in bed mobility) on the bed. During a concurrent observation and interview on 2/5/2026 at 8:02 a.m., with Registered Nurse (RN) 1, in Resident 10's room, observed Resident 10 sitting at the edge of her bed. Bilateral grab bars were applied to the bed. RN 1 stated Resident 10 did not have an indication for the grab bars because Resident 10 did not need assistance in her mobility or repositioning. During a concurrent interview and record review on 2/5/2026 at 8:03 a.m., with RN 1, Resident 10's Bed Rail Assessment, dated 12/18/2025, was reviewed. The Bed Rail Assessment indicated side rails were not indicated at that time. RN 1 stated the Bed Rail Assessment was used to determine whether the use of side rails was appropriate and safe for Resident 10. RN 1 stated side rail usage was not indicated for Resident 10's use. During a concurrent interview and record review on 2/5/2026 at 8:05 a.m., with RN 1, Resident 10's Orders, active on 2/5/2026, were reviewed. The Orders did not indicate the use of grab bars. RN 1 stated Resident 10 did not have an order for the grab bars. RN 1 stated an order was the physician's indication of the appropriateness and safety of the grab bar usage. RN 1 stated grab bars had the potential to be used as a restraint (device or material used to intentionally limit an individual's freedom of movement) and a physician's order was necessary to distinguish the actual use of the grab bars. During a concurrent interview and record review on 2/5/2026 at 8:07 a.m., with RN 1, Resident 10's electronic health record (eHR), dated 2/5/2026, was reviewed. The eHR did not indicate informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained and verified for Resident 10's use of grab bars. RN 1 stated informed consent for Resident 10's grab bars was not obtained from Responsible Party (RP) 2. RN 1 stated prior to (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	installing grab bars to the bed, RP 2 had to be notified of the reason for use, the risks, and the benefits and allow RP 2 to make an informed decision whether the grab bars could be used. RN 1 stated there was no documentation of RP 2's informed consent to install grab bars to Resident 1's bed. During an interview on 2/5/2026 at 8:10 a.m., with RN 1, RN 1 stated based on Resident 10's Bed Rail Assessment, Resident 10 did not have any indication to have grab bars on her bed. RN 1 stated Resident 10 may have inherited a bed from a previous resident, who did use the grab bars, and the grab bars were not removed. RN 1 stated because Resident 10 had grab bars on her bed, Resident 10 should have had another Bed Rail Assessment to reassess her need and an order and informed consent should have been obtained. RN 1 stated without those components, Resident 10 was at risk for bed rail entrapment (becoming caught, trapped, or tangled in between a small space), injury, and /or death. b. During a review of Resident 62's admission Record (Face Sheet), the admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included dementia, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blocked blood vessel in the brain) affecting the left side, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62's cognition was severely impaired. The MDS indicated Resident 62 required maximal assistance (helper does more than half the effort) with toileting, bathing, dressing, and personal hygiene. During a review of Resident 62's H&P, dated 10/24/2024, the H&P indicated Resident 62 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 62's Order Summary Report, order dated 12/3/2021, the Order Summary Report indicated to place bilateral side rails as an enabler. During an observation on 2/2/2026 at 9:34 a.m., in Resident 62's room, observed Resident 10 lying in bed with bilateral side rails. During a concurrent observation and interview on 2/5/2026 at 8:02 a.m., with RN 1, in Resident 62's room, observed Resident 62 lying in bed with bilateral side rails. RN 1 stated the side rails were used to aid Resident 62 in bed mobility and repositioning. RN 1 stated the Resident 62's family requested to have the side rails on Resident 62's bed. During a concurrent interview and record review on 2/5/2026 at 8:11 a.m., Resident 62's Bed Rail Assessment, dated 1/13/2026, was reviewed. The Bed Rail Assessment indicated side rails were not indicated at that time or requested. RN 1 stated Resident 62's Bed Rail Assessment was incorrect and should have indicated Resident 62's family's request for the side rails and the current use of the side rails. RN 1 stated an accurate Bed Rail Assessment should have been completed to ensure Resident 62 was safe and able to use the grab bars for mobility and repositioning. During an interview on 2/9/2026 at 11:11 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for conducting an accurate bed rail assessment, obtaining a physician's order, and verifying informed consent was obtained. The DON stated all components were necessary to ensure safety, prevent injuries, and/or entrapment. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, revised 9/2022, the P&P indicated Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. The P&P indicated, Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment. The P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The P&P indicated, The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of falling.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice for two of six sampled residents (Residents 72 and 82) when Licensed Vocational Nurse (LVN) 1 failed to explain medications to Resident 72 prior to administration, failed to administer medications at the time they were prepared to Resident 82, and failed to ensure medications for more than one resident was not prepared at the same time. These deficient practices resulted in Resident 72 not being informed of the medications being administered, and had the potential to result in medication errors and compromise Resident 82's safety. Findings: During an observation of the medication administration pass on 2/9/2026, at 8:04 a.m., with LVN 1, LVN 1 was observed at the medication cart with two medication cups filled with medications. LVN 1 placed one cup in the top drawer of the medication cart and locked the drawer. LVN 1 then entered Resident 72's room and administered the medications from the second cup. LVN 1 handed the cup to Resident 72. Resident 72 swallowed all the medications at once with water. LVN 1 did not identify the medications or explain the purpose of the medications prior to administration. During an observation of the medication administration pass on 2/9/2026, at 8:26 a.m., with LVN 1, LVN 1 was observed returning to the medication cart after administering medications to an unidentified resident. LVN 1 unlocked the top drawer of Medication Cart 3 and removed a medication cup containing loose pills. The medication cup was labeled in black marker with Resident 82's room number. The pre-prepared medications were stored in the locked drawer of the medication cart prior to administration. The medications were not administered at the time they were prepared and were left unattended in the medication cart until LVN 1 retrieved them to administer to Resident 82. During an interview on 2/9/2026, at 8:40 a.m., with LVN 1, LVN 1 stated during the medication pass, she had forgotten to inform Resident 72 of the medications he was receiving and their purpose. LVN 1 stated Resident 72 had a right to know what medications he was taking. LVN 1 stated it was not the facility's policy to hold opened medications in the medication cart or to prepare more than one resident's medications at a time because it could cause confusion. LVN 1 stated Resident 84's medications should have been opened in front of the resident immediately prior to administration and should not have been left open in the medication cart before administration. During a review of Resident 72's admission Record dated 2/9/2026, the admission Record indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) with severe psychotic (mental condition in which thought, and emotions are so affected that contact is lost with reality) symptoms, dysphagia (difficulty swallowing), and hypertensive chronic kidney disease (a condition where chronic high blood pressure causes damage to the kidney's blood vessels, restricting blood flow and impairing their ability to filter waste). During a review of Resident 72's History and Physical (H&P), dated 10/7/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 72's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 72 required maximal assistance (helper does more than half the effort) with toileting, bathing, dressing and personal hygiene and set-up or clean-up assistance for eating. During a review of Resident 72's Order Summary Report dated 2/9/2026, the Order Summary Report indicated the following medications were scheduled for administration at 8:00 a.m. and 9:00 a.m.: Amlodipine Besylate 10 milligrams (mg, unit of measurement) (high blood pressure medication). Aspirin 81 mg (blood thinner medication). B-Complex with C and Folic Acid 0.8 mg (vitamin supplement). Citalopram (continued on next page)		

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Printed: 07/18/2026
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrobromide 10 mg (depression medication).Lisinopril 20 mg (high blood pressure medication).Metoprolol Tartrate 50 mg (high blood pressure and heart rate medication).Quetiapine Fumarate 12.5 mg (antipsychotic medication).Levetiracetam 500 mg (seizure medication). b. During a review of Resident 82's admission Record dated 2/9/2026, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses which included DM, schizophrenia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertensive heart disease (damage to the heart caused by long-term high blood pressure), 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 82's History and Physical (H&P), dated 12/26/2025, the H&P indicated Resident 82 had fluctuating capacity to understand and make decisions. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82's cognition was severely impaired. The MDS indicated Resident 82 could eat independently and required supervision with toileting, and bathing. During a review of Resident 82's Order Summary Report dated 2/9/2026, the Order Summary Report indicated the following medications were scheduled for administration at 7:30 a.m. and 9:00 a.m.:Metformin HCl 1000 mg (diabetes medication).Aspirin 81 mg.Fenofibrate 48 mg (cholesterol medication).Folic Acid 1 mg (vitamin supplement).Losartan Potassium 25 mg (high blood pressure medication).Multiple Vitamin (vitamin supplement).Risperidone 0.5 mg (antipsychotic medication). During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2020, the P&P indicated medications shall be administered at the time they are prepared and shall not be pre-poured. The P&P indicated the person who prepares the dose for administration shall be the person who administers the dose. The P&P indicated medications shall be administered in accordance with good nursing principles and practices and only by persons legally authorized to do so. During a review of the facility's P&P titled, Resident Rights, revised 2/2021, the P&P indicated residents have the right to be informed of their medical condition and to participate in their care planning and treatment. The P&P indicated residents have the right to self-determination and to be treated with respect and dignity.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor one of five residents (Resident 10) for side effects related to their use of divalproex sodium (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions). This deficient practice had the potential to result in undetected side effects which could negatively affect Resident 10's well-being and could result in delay in physician notification and treatment. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included dementia (a progressive state of decline in mental abilities) 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 10's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 10's cognition (process of thinking) was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting on/taking off footwear. During a review of Resident 10's History and Physical (H&P), dated 12/24/2025, the H&P indicated Resident 10 did not have the capacity to consent. During a review of Resident 10's Order Summary Report, order dated 12/18/2025, the Order Summary Report indicated to give divalproex sodium (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions), 250 milligrams (mg, a unit of measurement), by mouth twice a day for bipolar disorder manifested by erratic mood swings. During a review of Resident 10's Care Plan titled, Behavioral Patterns, dated 12/18/2025, the Care Plan indicated to administer divalproex sodium to treat Resident 10's erratic mood swings related to bipolar disorder. The Care Plan's interventions indicated to monitor side effects every shift and notify Resident 10's physician if any were present. During a concurrent interview and record review, on 2/5/2026 at 10:31 a.m., with Registered Nurse (RN) 1, Resident 10's Orders, active on 2/5/2026, were reviewed. The Orders did not indicate to monitor for side effects related to the use of divalproex sodium. RN 1 stated divalproex sodium was an anticonvulsant but was used to treat behavioral symptoms. RN 1 stated Resident 10 should have been monitored for side effects while using divalproex sodium. RN 1 stated a main side effect of divalproex sodium was hepatotoxicity (liver damage and symptoms include fatigue, abdominal pain, nausea, and dark urine). RN 1 stated monitoring for symptoms of divalproex sodium and other side effects was important to ensure quick intervention to prevent them from worsening. During an interview on 2/9/2026 at 11:25 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for monitoring for side effects of medications used to treat behavioral symptoms. The DON stated side effects could affect Resident 19's general well-being. The DON stated if side effects were not monitored, the licensed nurses could miss any symptom of a change in condition and could result in a delay in physician notification and treatment. During a review of the facility's Policy and Procedure (P&P) titled, Psychotropic Medication Use, dated 7/2022, the P&P indicated, Resident receiving psychotropic medications are monitored for adverse consequences.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of five percent or greater, as evidenced by the identification of two medication errors out of 35 opportunities, resulting in a medication error rate of 5.71 percent for two of 24 sampled residents (Residents 72 and 82) when: 1. Licensed Vocational Nurse 1 (LVN 1) did not inform Resident 72 of the medications being administered or the purpose of the medications prior to administration. 2. LVN 1 pre-prepared medications for Resident 82 and did not administer the medications at the time they were prepared, resulting in medications being stored in the medication cart prior to administration. This deficient practice resulted in a medication error rate greater than five percent and had the potential to result in medication administration errors, including wrong medication, wrong dose, wrong time, or administration to the wrong resident. Findings: During an observation of the medication administration pass on 2/9/2026, at 8:04 a.m., with LVN 1, LVN 1 was observed at the medication cart with two medication cups filled with medications. LVN 1 placed one cup in the top drawer of the medication cart and locked the drawer. LVN 1 then entered Resident 72's room and administered the medications from the second cup. LVN 1 handed the cup to Resident 72. Resident 72 swallowed all the medications at once with water. LVN 1 did not identify the medications or explain the purpose of the medications prior to administration. During an observation of the medication administration pass on 2/9/2026, at 8:26 a.m., with LVN 1, LVN 1 was observed returning to the medication cart after administering medications to an unidentified resident. LVN 1 unlocked the top drawer of Medication Cart 3 and removed a medication cup containing loose pills. The medication cup was labeled in black marker with Resident 82's room number. The pre-prepared medications were stored in the locked drawer of the medication cart prior to administration. The medications were not administered at the time they were prepared and were left unattended in the medication cart until LVN 1 retrieved them to administer to Resident 82. During an interview on 2/9/2026, at 8:40 a.m., with LVN 1, LVN 1 stated during the medication pass, she had forgotten to inform Resident 72 of the medications he was receiving and their purpose. LVN 1 stated Resident 72 had a right to know what medications he was taking. LVN 1 stated it was not the facility's policy to hold opened medications in the medication cart or to prepare more than one resident's medications at a time because it could cause confusion. LVN 1 stated Resident 84's medications should have been opened in front of the resident immediately prior to administration and should not have been left open in the medication cart before administration. During a review of Resident 72's admission Record dated 2/9/2026, the admission Record indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) with severe psychotic (mental condition in which thought, and emotions are so affected that contact is lost with reality) symptoms, dysphagia (difficulty swallowing), and hypertensive chronic kidney disease (a condition where chronic high blood pressure causes damage to the kidney's blood vessels, restricting blood flow and impairing their ability to filter waste). During a review of Resident 72's History and Physical (H&P), dated 10/7/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 72's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 72 required maximal assistance (helper does more than half the effort) with toileting, bathing, dressing and personal hygiene and set-up or clean-up assistance for eating. During a review of Resident 72's Order Summary Report dated 2/9/2026, the Order Summary Report indicated the following medications were scheduled for administration at 8:00 a.m. and 9:00 a.m.: 1. Amlodipine Besylate 10 milligrams (mg, unit of (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurement) (high blood pressure medication).2. Aspirin 81 mg (blood thinner medication).3. B-Complex with C and Folic Acid 0.8 mg (vitamin supplement).4. Citalopram Hydrobromide 10 mg (depression medication).5. Lisinopril 20 mg (high blood pressure medication).6. Metoprolol Tartrate 50 mg (high blood pressure and heart rate medication).7. Quetiapine Fumarate 12.5 mg (antipsychotic, used to manage psychosis symptoms, such as hallucinations, delusions, and severely disorganized thinking).8. Levetiracetam 500 mg (used to treat seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). b. During a review of Resident 82's admission Record dated 2/9/2026, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses which included DM, schizophrenia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertensive heart disease (damage to the heart caused by long-term high blood pressure), 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 82's History and Physical (H&P), dated 12/26/2025, the H&P indicated Resident 82 had fluctuating capacity to understand and make decisions. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82's cognition was severely impaired. The MDS indicated Resident 82 could eat independently and required supervision with toileting, and bathing. During a review of Resident 82's Order Summary Report dated 2/9/2026, the Order Summary Report indicated the following medications were scheduled for administration at 7:30 a.m. and 9:00 a.m.:1. Metformin HCl 1000 mg (diabetes medication).2. Aspirin 81 mg.3. Fenofibrate 48 mg (cholesterol lowering medication).4. Folic Acid 1 mg (vitamin supplement).5. Losartan Potassium 25 mg (high blood pressure medication).6. Multiple Vitamin (vitamin supplement).7. Risperidone 0.5 mg (antipsychotic medication). During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2020, the P&P indicated medications shall be administered at the time they are prepared and shall not be pre-poured. The P&P indicated the person who prepares the dose for administration shall be the person who administers the dose. The P&P indicated medications shall be administered in accordance with good nursing principles and practices and only by persons legally authorized to do so. During a review of the facility's P&P titled, Resident Rights, revised 2/2021, the P&P indicated residents have the right to be informed of their medical condition and to participate in their care planning and treatment. The P&P indicated residents have the right to self-determination and to be treated with respect and dignity.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure dietary staff followed fortified diet (diet to increase caloric intake) guidelines during lunch service when fortified diets were not prepared and were not served to nine residents who were on fortified diet. This deficient practice had the potential to result in meal dissatisfaction, decreased caloric intake, and weight loss. Findings: During the tray line observation on 2/4/2026 at 12:00 p.m., observed [NAME] 1 did not communicate the fortified diet orders written on the meal tickets. The tray/meal tickets on the cart indicated fortified diets. [NAME] 1 did not read or communicate the fortified diets to [NAME] 2 who was serving the food. [NAME] 2 did not add any additional food items per the fortified menu. During an interview on 2/4/2026 at 12:45 p.m. with [NAME] 1 and [NAME] 2, [NAME] 2 stated butter was added to the vegetables during meal service for fortified diets. [NAME] 2 stated he relied on [NAME] 1 to communicate which trays were fortified diets. [NAME] 1 stated he was responsible for reviewing the meal tickets and communicating the diet orders, including fortified diets. [NAME] 1 stated that fortified diets should be communicated and implemented during tray preparation. During an interview with on 2/4/2026 at 1:15 p.m. with [NAME] 2 and the Dietary Supervisor (DS) [NAME] 1 stated he did not read and communicate the fortified diets during lunch service. The DS stated butter was added to vegetables during lunch service to increase calories. The DS stated the facility did not ensure that the residents on fortified diets received the ordered fortified modifications to meet their nutritional needs. The DS stated this failure placed residents on fortified diets at risk for inadequate caloric intake, unintended weight loss, malnutrition, and avoidable decline in nutritional status. During a review of the facility's policy and procedure (P&P) titled Fortified Diet, undated, the P&P indicated the fortified diet was designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutrition status. The P&P indicated extra margarine, or butter was to be added to food items such as vegetables, potatoes, meats, and pasta at breakfast, lunch, and dinner for residents on fortified diets.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court) was provided to and signed by an individual with decision making capacity for one of three sampled residents (Resident 10). This deficient practice resulted in Resident 10 being unaware of her right to resolve a dispute in court was waived after entering into the binding arbitration agreement. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The admission Record indicated Responsible Party (RP) 2 was Resident 10's responsible party (RP, decision maker when an individual does not have the mental capacity to do so). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 10's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with toileting, bathing, and putting on/taking off footwear. During an interview on 2/4/2026 at 3:39 p.m., with Receptionist 1, Receptionist 1 stated she assisted with explaining the Arbitration Agreement to the residents upon admission. Receptionist 1 stated she was responsible for reviewing the arbitration with the residents and/or their RP. Receptionist 1 stated prior to reviewing the Arbitration Agreement with the resident or their RP, she would review the resident's admission Record, the hospital clinical documents, and/or the history and physical (H&P) to check if an RP was listed. During a concurrent interview and record review on 2/4/2026 at 3:42 p.m., with Receptionist 1, Resident 10's general acute care hospital (GACH) Psychosocial Initial Assessment Note, dated 12/9/2025, was reviewed. The GACH Note indicated Resident 10 designated RP 2 as her primary surrogate decision maker. Receptionist 1 stated RP 2 was appointed by Resident 10 to be her surrogate decision maker which meant any medical discussions should involve RP 2. During a concurrent interview and record review on 2/4/2026 at 3:45 p.m., with Receptionist 1, Resident 10's H&P, dated 12/24/2025, was reviewed. The H&P indicated Resident 10 did not have the capacity to consent. Receptionist 1 stated Resident 10 did not have the decision-making capacity to make medical decisions therefore all medical discussions and documents to be signed should involve RP 2. During a concurrent interview and record review on 2/4/2026 at 3:48 p.m., with Receptionist 1, Resident 10's Arbitration Agreement, dated 12/17/2025, was reviewed. The Arbitration Agreement indicated, By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. The Arbitration Agreement indicated, on 12/17/2025, Resident 10 signed her name and entered the facility's binding arbitration agreement. Receptionist 1 stated the Arbitration Agreement should not have been reviewed with Resident 10 not only because Resident 10 appointed RP 2 as her surrogate decision maker, but also because Resident 10 was assessed to not have the capacity to consent. During an interview on 2/4/2026 at 3:53 p.m., with Receptionist 1, Receptionist 1 stated Resident 10 did not have the capacity to consent, therefore, did not have the ability to make an informed decision to enter the binding arbitration agreement. Receptionist 1 stated Resident 10's hospital documents should have been reviewed prior to reviewing facility documents with Resident 10 because the hospital documents indicated RP 2 as Resident 10's surrogate decision maker. Receptionist 1 stated if she had been aware of Resident 10's mental status and RP 2's role, she would not have approached Resident 10 to review the arbitration agreement and would have called RP 2 instead. During an interview on 2/9/2026 at 10:11 a.m., with the Administrator (ADM), the ADM stated the Arbitration Agreement had to be (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed with an individual with decision-making capabilities. The ADM stated this was to ensure the residents or their RP understood they were waiving their right to settling a dispute in court and instead the dispute would be settled by neutral arbitration. The ADM stated the Arbitration Agreement should not have been reviewed and signed by Resident 10 because Resident 10 lacked the ability to consent therefore did not have the full capability to understand what entering into the arbitration agreement meant. During a review of the facility's Policy and Procedure (P&P) titled, Arbitration Agreement, dated 7/2022, the P&P indicated, The admission staff will explain and offer an Arbitration Agreement to the resident or responsible party. The P&P indicated, The agreement must be explained so that the resident or his or her representative understands the terms of the agreement and understands that they are giving up their right to litigation in a court proceeding.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedure titled, Food for Residents from Outside Sources, which indicated prepared food brought in for a resident must be consumed within one hour of receiving or stored in the facility kitchen, nursing station refrigerator, or resident's personal refrigerator for one of six sampled residents (Resident 53). This deficient practice had the potential to expose Resident 53 to foodborne illness, bacterial growth, contamination, and gastrointestinal infection due to improper storage and prolonged room temperature exposure of perishable food items. Findings: During a review of Resident 53's admission Record, dated 2/9/2026, the admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), absence of left leg below the knee (BKA - surgical removal of the portion of the leg below the knee), chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 53's History and Physical (H&P), dated 12/15/2026, the H&P indicated Resident 53 could make needs known but could not make medical decisions. During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool) dated 12/26/2025, the MDS indicated Resident 53's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 53 was independent (resident completes activity by themselves with no assistance) with eating and required moderate assistance (helper does less than half the effort) for toileting, bathing, dressing and personal hygiene. The MDS indicated Resident 53 was on a therapeutic diet. During a review of Resident 53's Order Summary Report, dated 12/15/2025 the Order Summary Report indicated consistent carbohydrate (CCHO - an eating plan for managing diabetes or blood sugar by eating the same amount of carbohydrates at each meal every day), no added salt diet, regular texture, with regular/thin consistency. During a concurrent observation and interview on 2/5/2026 at 9:25 a.m., in Resident 53's room, observed Resident 53 lying in bed awake and alert. A clear plastic container with a yellow food substance and two individual cardboard pizza boxes was on top of Resident 53's bedside table. The food was room temperature and unrefrigerated. Resident 53 stated a family member brought the food for him the day before (2/5/2026). During an interview on 2/5/2026 at 4:30 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated outside food must be labeled by the CNA. CNA 5 stated if the resident preferred to keep the food, the food was refrigerated. CNA 5 stated food must be stored in the refrigerator to prevent spoilage. CNA 5 stated the food must be refrigerated within one hour. CNA 5 stated if a resident ate food that had been left out overnight the resident could become ill. During an interview on 2/5/2026 at 4:43 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated there was a refrigerator designated to residents for food brought in from outside the facility. LVN 5 stated it was important to put the food away because improperly stored food could make a resident sick and attract pests. LVN 5 stated staff should store the food in the refrigerator if observed at the resident's bedside. LVN 5 stated food should not be stored at the bedside overnight. During a review of the facility's policy and procedure (P&P) titled, Food for Residents from Outside Sources, not dated, the P&P indicated prepared food brought in for a resident must be consumed within one hour of receiving it to prevent foodborne illness and unused food would be disposed of immediately thereafter. The P&P indicated prepared foods, beverages, or perishable foods requiring refrigeration must be stored in the facility kitchen, nursing station refrigerator, or resident's personal refrigerator. The P&P indicated if food was opened, the food must be sealed, dated to the date opened, and disposed of within two days after opening.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was operational for one of six sampled residents (Resident 3). This deficient practice placed Resident 3 at risk for delayed response to care needs, unmet assistance requests, and potential harm. Findings: During a review of Resident 3's admission Record, dated 2/9/2026, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included epilepsy (a disorder in which electrical activity in the brain causes seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), cognitive communication deficit (difficulty understanding, processing, or expressing information), traumatic brain injury (TBI - a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), anxiety (a mental health condition characterized by excessive worry, fear or nervousness), acute embolism and thrombosis of the right popliteal vein (a sudden blood clot that forms in the vein behind the right knee which can block blood flow and travel to other parts of the body), presence of cardiac pacemaker (a device placed in the chest that helps the heart beat regularly), myocardial infarction (MI - heart attack), acute and chronic kidney disease (a sudden and long-term problem where the kidneys do not work remove waste and extra fluid from the body), anemia (a condition where the body does not have enough healthy red blood cells), and a history of falling. During a review of Resident 3's History and Physical (H&P), dated 10/18/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 11/26/2025, the MDS indicated Resident 3's cognitive skills for daily decision making were severely impaired (ability to think and reason). The MDS indicated Resident 3 required set-up or clean-up assistance (helper assists only prior to or following the activity) for eating and dressing and required moderate assistance (helper does less than half the effort) for toileting and bathing. During a concurrent observation and interview on 2/2/2026 at 10:06 a.m., with Resident 3, in Resident 3's room, observed Resident 3 lying in bed awake and alert. Resident 3's call light was attached to the sheet on the right side of the bed. Resident 3's call light did not have a push button and was in non-working order. Resident 3 stated, The call light does not work. During a concurrent observation and interview on 2/2/2026 at 10:51 a.m., with Certified Nursing Assistant (CNA) 4, in Resident 3's room, observed Resident 3's call light was non-operational. CNA 4 stated Resident 3's call light was not working and the button was missing. CNA 4 stated if Resident 3 needed anything or had an emergency the nursing staff would not know because the call light was not working. CNA 4 stated nursing staff were required to ensure call lights were in working order. CNA 4 stated she placed the call light near Resident 3 but she did not check to make sure the call light was in working order. During an interview on 2/2/2026 at 10:55 a.m., with the Maintenance Staff Assistant (MSA), the MSA stated he was responsible for replacing and repairing broken call lights. The MSA stated nursing staff were to notify him immediately when call lights were not working. The MSA stated he was not made aware Resident 3's call light was not working. The MSA stated he was also required to make rounds every morning to ensure the call lights were functioning; however, he was too busy to complete the checks that morning (2/2/2026). The MSA further stated there was a maintenance log located at the nursing station where nursing staff documented repair requests, which he checked every morning. The MSA stated Resident 3's call light was not documented in the maintenance log. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised 10/2010, the P&P indicated staff were required to report all defective call lights to the nurse supervisor promptly and answer resident call lights as soon as possible. During a review of the facility's P&P titled, Nurse Call / Call Light System Inspection, Testing, and Maintenance Policy & Procedure, undated, the P&P indicated nursing staff were required to verify call lights were accessible to residents, pull cords (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were reachable from the bed and toilet, audible and visual indicators activated, and staff response was confirmed during daily checks. The P&P indicated when a call light failed, staff were required to notify nursing immediately, provide an alternative method for summoning assistance, repair the call light within 24 hours or sooner, and document corrective action.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft.- a unit of measurement) of room space per resident for 22 of 39 rooms. This deficient practice had the potential to result in inadequate space for daily living, and for facility staff to care for the residents. Findings: During a review of the facility's Room Waiver Request Letter, dated 2/9/2026, the letter indicated the following rooms did not meet 80 square feet (sq. ft.- a unit of measurement) per resident requirement: Rooms 11, 12, 14, 15, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36. The Letter indicated, The lack of space on the new building code has no adverse effect in the health, safety, or in maintaining the well-being of the residents. During an interview on 2/9/2026 at 10:23 a.m., with the Administrator (ADM), the ADM stated she had not received any complaints regarding the size of the rooms. The ADM stated the impact on the residents' care was minimal and the facility strived to ensure residents' care was not negatively impacted. The ADM stated all 22 rooms had sufficient space for Hoyer lifts (an electronically operated patient lift for the safer lifting of heavier patients), wheelchairs, and gurneys (a wheeled bed used to transport patients who need medical care) to enter and operate inside the rooms. During observations made throughout the course of the survey, from 2/2/2026 through 2/9/2026, there were no adverse effects that pertained to the residents' care provided by the staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life- Homelike Environment, revised 4/2014, the P&P indicated the facility was to ensure residents were provided with a safe, clean, comfortable, and homelike environment.		