STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of South Gate	8455 State Street South Gate, CA 90280

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to answer the call light in a timely manner, ensure the resident's preference to shower by a certain time was honored, and ensure the call lights were not cancelled without asking the residents if they needed assistance for two residents out of two sampled residents (Resident 1 and Resident 2). These deficient practices had the potential to cause a negative impact on Resident 1's and Resident's ' 2s psychosocial well-being and caused a delay in care. Findings: 1. During an observation on 7/24/2024 at 10:15 a.m., in Resident 1's room, Resident 1's call light was not answered. During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the legs and lower body) and depression (a common and serious medical illness that negatively affects how a person feels, the way they think and how they act. Depression causes feelings of sadness and/or a loss of interest in activities they once enjoyed). During a review of Resident 1's History and Physical (H&P) dated 5/23/2024, the H&P indicated Resident 1 had the capacity to understand make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/21/2024, the MDS indicated that Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 was dependent on staff (helper does all the effort) for toileting hygiene, dressing, personal hygiene, and showering/bathing. The MDS indicated Resident 1 required maximal assistance (Helper does more than half the effort) from staff for eating and oral hygiene. During an interview on 7/24/2024 at 10:10 a.m. with Resident 1, Resident 1 stated the CNAs did not assist him as they should. Resident 1 stated the CNAs did not answer the call light in a timely manner and sometimes did not answer the call light at all. Resident 1 stated the CNAs cancelled the call light without asking him if needed assistance. Resident 1 stated he felt unimportant because no one cared that he was not getting the care he needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 7/24/2024 at 10:46 a.m. in Resident 2's room, Resident 2 put his call light on. Certified Nursing Assistant (CNA 1) passed by Resident 2's room while the call light was on but did not answer the call light. CNA 1 passed by Resident 2's room again and entered the room to cancel the call light and did not ask any of the residents in the room if they needed assistance. During an observation on 7/24/2024 at 11:02 a.m. in Resident 2's room, CNA 1 went to Resident 2's room. Resident 2 asked CNA 1 why she did not return for his shower. CNA 1 stated she was busy with another resident. Resident 2 asked CNA 1 why did she not tell him that before but instead told the resident she was going to be back at 10:00 a.m. but did not return. Resident 2 told CNA 1 he had told her that he had visitors coming at 11:00 a.m. and he needed to be showered by then. CNA 1 apologized and said she would return when she finished with her other resident. During a review of Resident 2's Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (heart's upper chambers [atria] beat out of coordination with the lower chambers [ventricles]) and heart failure (progressive heart disease that affects the pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 2's H&P dated 8/30/2023, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated that Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required maximal assistance for toileting hygiene, shower/bathing self, dressing and personal hygiene. The MDS indicated Resident 2 required set up or clean up assistance for oral hygiene and eating. During an interview on 7/24/2024 at 10:39 a.m. with Resident 2, Resident 2 stated every time he pushed his call light the CNAs ignored his call light. Resident 2 stated the CNAs had poor communication skills because he had been waiting to take a shower and no one had told him what the delay was. Resident 2 stated in the early morning he requested for his CNA to take his shower by 10:00 a.m. because he had visitors at 11:00 a.m. Resident 2 stated the CNA stated she would be back by 10:00 a.m. Resident 2 stated his CNA did not return. Resident 2 stated he was upset because the CNA never came back to tell him she was busy and instead he had been waiting and pushing the call light. During an interview on 7/24/2024 at 10:52 a.m. with CNA 1, CNA 1 stated she was supposed to answer the call light when she passed by Resident 2's room but she did not because she was busy with another resident. CNA 1 stated she was not supposed to cancel the call light without asking the residents if they needed anything. CNA 1 stated she did not know which resident pushed the call light but she cancelled it without asking who needed help because she assumed it was Resident 2. CNA 1 stated Resident 2 wanted to take a shower but she was busy showering another resident. CNA 1 stated she did not return to Resident 2's room to tell him she was running behind, and did not ask staff for help from other staff. CNA 1 stated she did not inform her charge nurse that she could not accommodate Resident 2's needs. CNA 1 stated she should have returned to Resident 2's room to notify him that she was busy with another resident. CNA 1 stated it was important to communicate with Resident 2 to prevent him from getting upset. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024 at 9:55 a.m. with the Director of Nursing (DON), the DON stated she expected all her staff to answer call lights when they hear it or see it on. The DON stated the process for answering call lights was to enter the residents' room and ask all residents if they needed anything. The DON stated it was important to answer residents call lights to meet resident needs. The DON stated if resident call lights were not answered the residents' care got delayed and residents could have an accident. The DON stated it was not acceptable to cancel call lights without asking residents if they needed anything. The DON stated if staff cancel call lights without asking residents if they need anything, they were not accommodating residents needs. The DON stated cancelling call lights was neglecting residents and their needs. The DON stated this practice would frustrate residents and residents would continue to push the call light until they get what they wanted. During a review of the facility's Policy and Procedure (P&P) titled Call Light/Bell , dated 1/2024, the P&P indicated call lights are to be answered within a reasonable time (3-5 minutes). The P&P indicated call light was to be turned off after the resident needs are attended to. The P&P indicated if staff is unable to help the resident, staff were to explain to the resident and notify the charge nurse for further instructions. During a review of facility's P&P titled Activities of Daily Living , dated 1/2024, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, Grooming and personal and oral hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47286 Based on interview and record review, the facility failed to ensure infection prevention and control was maintained when the following occurred: 1. Resident 8 was not tested for Covid-19 (an acute disease caused by a coronavirus, capable of progressing to severe symptoms, including death, especially in older people and those with underlying health conditions) after symptoms of phlegm and a runny nose were first reported on 7/7/2024. 2. Certified Nursing Assistant (CNA) 1 worked two shifts, on 7/9/2024 and 7/10/2024, while experiencing Covid-19 symptoms. These deficient practices created the risk for avoidable spread of infection to all facility residents and staff and placed vulnerable facility residents at risk of suffering severe illness and/or death. Findings: 1. During a review of Resident 8's Admission Record, the admission record indicated the facility admitted Resident 8 on 9/27/2023, and most recently readmitted the resident on 4/18/2024. Resident 8's admitting diagnoses included type 2 diabetes mellitus (uncontrolled blood sugar levels), chest pain, and nephrotic syndrome (a kidney disorder that causes the body to excrete too much protein in the urine). During a review of Resident 8's Minimum Data Set (MDS, a comprehensive assessment and care planning tool), dated 4/30/2024, the MDS indicated Resident 8 had intact cognition (having sufficient judgment, planning, organization, self-control). The MDS indicated Resident 8 was dependent on staff for toileting, showering/bathing, and dressing her lower body. The MDS further indicated Resident 8 required substantial to maximal assistance from staff to reposition herself in bed and was dependent on staff to transition from her bed to a chair, and vice versa. During a review of Resident 8's physician orders, dated 4/18/2024, the physician orders indicated Resident 8 was to receive a test for Covid-19 as needed to rule out (eliminate the presence of) Covid-19. During a review of Resident 8's Change of Condition assessment (COC), dated 7/7/2024, the COC indicated that on 7/7/2024, Resident 8 began experiencing phlegm (mucus, thicker than normal due to illness or irritation, coughed up from the respiratory tract) and a runny nose. The COC did not indicate Resident 8 was tested for Covid-19. During a review of Resident 8's progress note, dated 7/10/2024, the progress note indicated Resident 8 tested positive for Covid-19 on 7/10/2024, and was moved to another room to isolate from other facility residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2024 at 10:30 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident had an order for Covid-19 testing as needed to rule out Covid-19, nursing staff should administer a Covid-19 test if the resident was displaying symptoms of Covid-19. During an interview on 7/24/2024 at 11:17 AM, with the Director of Nursing (DON), the DON stated the facility document titled OSHA C19 Healthcare Emergency Temporary Standard Policy and Procedure Manual , undated, was the current Covid-19 guidance being followed in the facility. During a review of the facility document titled OSHA C19 Healthcare Emergency Temporary Standard Policy and Procedure Manual , undated, the document indicated the facility would ensure that each employee received training on COVID-19, including the signs and symptoms of COVID-19. During a concurrent interview and record review, on 7/24/2024 at 2:01 PM, with Infection Preventionist Nurse (IPN) 2, the facility's in-service training titled Covid-19 , dated 2/23/2024, was reviewed. IPN 2 stated the in-service training educated staff on the signs and symptoms of Covid-19, and stated congestion and a runny nose were symptoms of Covid-19. IPN 2 stated residents with Covid-19 symptoms were supposed to be tested for Covid-19. IPN 2 stated there was an increased risk of infection transmission to other residents if symptomatic residents were not tested and timely precautions implemented. 2. During an interview on 7/24/2024 at 12:19 PM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated she began to feel congested during her shift on 7/9/2024. CNA 1 stated she did not report the new onset of symptoms to anyone and completed her shift. CNA 1 stated she felt congested on 7/10/2024 and knew staff were not supposed to work if symptomatic. CNA 1 stated she did not notify anyone of her symptoms and proceeded to work a full shift on 7/10/2024. CNA 1 stated she took a Covid-19 test on 7/10/2024, after her shift, and she was positive for Covid-19. CNA 1 stated there was risk for spread of infection if staff came in to work while symptomatic or positive for Covid-19. During an interview on 7/24/2024 at 1:57 PM, with the Office Assistant (OA), the OA stated all persons entering the facility, including staff, were supposed to complete a screening form for Covid-19. The OA stated use of the screening forms was discontinued at some point and resumed on 7/12/2024. The OA stated staff were trained to self-report any Covid-19 symptoms regardless of the use of the screening forms. During a concurrent interview and record review, on 7/24/2024 at 2:01 PM, with IPN 2, the undated facility document titled OSHA C19 Healthcare Emergency Temporary Standard Policy and Procedure Manual was reviewed. IPN 2 stated the document indicated all staff were supposed to be screened for Covid-19 symptoms. IPN 2 stated that even when the screening forms were not being used, staff were still supposed to check themselves for symptoms and not come in to work if symptomatic. IPN 2 stated that symptomatic staff could infect other residents and other staff. During a concurrent interview and record review, on 7/24/2024 at 2:47 PM, with the DON, the facility's document titled Employee Daily Screening Tool , dated 5/16/2023, was reviewed. The DON stated it was important to identify symptomatic staff, and employees were supposed to complete the form prior to the start of their shift, and after their shift. The DON stated that if staff developed symptoms during their shift, they were supposed to notify her or IPN 2, and stated staff experiencing Covid-19 symptoms prior to their shift were not supposed to come in to work. The DON stated symptomatic staff create a risk of infection transmission in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility document titled OSHA C19 Healthcare Emergency Temporary Standard Policy and Procedure Manual , undated, the document indicated the facility was supposed to screen each employee before each workday and each shift. During a review of the facility document titled Employee Daily Screening Tool , dated 5/16/2023, the document indicated staff were supposed to indicate yes or no if experiencing any Covid-19 signs and symptoms, including congestion, prior to the start of their shift. The document further indicated symptomatic staff were supposed to be restricted from work, and if symptoms developed during the shift, they were supposed to notify their supervisor to arrange for departure from the workplace. The document indicated that at the end of their shift, staff were supposed to indicate if they experienced any symptoms, including congestion, during their shift. The document indicated that if staff indicated any symptoms, they were supposed to notify and consult with the DON and/or IPN.