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	10/22/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to follow its policy to document the findings related to a change of condition (COC) every shift for two of three sampled residents (Resident 1 and Resident 2). This deficient practice had the potential to result in serious harm such as another episode of aggression towards others, and a delay of necessary treatments. Findings: 1. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to facility on 12/21/2016 and readmitted on [DATE]. Resident 1 ' s diagnoses included seizures (a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness), dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental health condition that involved excessive and persistent feelings of fear, dread, and uneasiness), and insomnia (trouble falling asleep or staying asleep). During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/18/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment to both extremities and used a walker and/or wheelchair for mobility. During a review of Resident 1 ' s History and Physical (H&P), dated 9/30/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s care plan titled, Roommate (Resident 2) hit resident (Resident 1) on right side of the face related altercation regarding television. At risk for pain or discomfort, dated 10/8/2024, the care plan indicated staff would monitor every shift for any change of condition. During a review of Resident 1 ' s Nursing Notes dated 10/8/2024, the nursing notes indicated Resident 1 had an altercation with Resident 2, and the doctor ordered staff to monitor Resident 1. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/22/2024 at 10:39 AM with Registered Nurse (RN 1), Resident 1 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. RN 1 stated there were no documentations regarding Resident 1 ' s COC for the 11 PM to 7AM (night) shift on 10/8/2024, the 3 PM to 11 PM (evening) shift on 10/9/2024, the evening shift on 10/10/2024, or the night shift on 10/10/2024. RN 1 stated the licensed nurses should document every shift for 72 hours on the nursing note for Resident 1. RN 1 stated it was important to document so nurses could notify the doctor regarding any aftereffects on Resident 1 from the incident, and nurses could provide interventions to address any psychosocial needs. During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the Director of Nursing (DON), Resident 1 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. The DON stated there were no documentation regarding Resident 1 ' s COC for the night shift on 10/8/2024, the evening shift on 10/9/2024, the evening shift on 10/10/2024, or the night shift on 10/10/2024. The DON stated the licensed nurse assigned to Resident 1 should document every shift for 72 hours on the nursing note. The DON stated staff monitored Resident 1 ' s emotions to see if the resident was feeling depressed or happy every shift for three days. The DON stated it was important to document so nurses could know if Resident 1 had any negative outcomes from the incident. 2. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included hypertension (high blood pressure), Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which caused the heart to not pump the blood efficiently), and cardiomyopathy (a diseases of the heart muscle that made it harder for the heart to pump blood). During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was mildly impaired. The MDS indicated Resident 5 used a cane/ crutch for mobility. During a review of Resident 2 ' s H&P, dated 9/2/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s Nursing Notes dated 10/18/2024, the nursing notes indicated Resident 2 had an altercation with Resident 1, and the doctor ordered staff to monitor Resident 2. During a concurrent interview and record review on 10/22/2024 at 10:39 AM with RN 1, Resident 2 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. RN 1 stated there were no documentation regarding Resident 2 ' s COC for the night shift on 10/9/2024, the night shift on 10/10/2024, or the 7 AM to 3 PM (morning) shift on 10/11/2024. RN 1 stated the licensed nurses should document every shift for 72 hours on the nursing note for Resident 2. RN 1 stated it was important to document so nurses could notify the doctor regarding any aftereffects on Resident 2 from the incident, and nurses could provide interventions to address any psychosocial needs. RN 1 stated not documenting every shift possibly delayed necessary care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the DON, Resident 2 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. The DON stated there were no documentation regarding Resident 2 ' s COC for the night shift on 10/9/2024, the night shift on 10/10/2024, or the morning shift on 10/11/2024. The DON stated the licensed nurse assigned to Resident 2 should document every shift for 72 hours on the nursing note. The DON stated staff monitored Resident 2 ' s emotions to see if Resident 2 was feeling depressed or happy every shift for three days. The DON stated it was important to document so nurses could know if Resident 2 had any negative outcomes from the incident. The DON stated the potential risk of not documenting every shift was another altercation. During a review of the facility ' s Policy and Procedure (P&P) titled Change of Condition, revised on 7/2012, the P&P indicated the licensed nurse responsible for the resident would continue assessment and documentation every shift for 72 hours or until condition is stable.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure a resident was free from significant medication error by administering amiodarone (a medication that prevents and treats irregular heartbeat) and metoprolol tartrate (medicine to treat high blood pressure) outside the parameters (specific instructions that you could measure) as ordered by the physician for one of three sample residents (Resident 2). These deficient practices had the potential to cause complications of hypotension (low blood pressure, dizziness and fainting leading to falls) and low pulse (leading to loss of consciousness). Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included hypertension (high blood pressure), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which caused the heart to not pump the blood efficiently), and cardiomyopathy (a diseases of the heart muscle that made it harder for the heart to pump blood). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 2 used a cane/ crutch for mobility. During a review of Resident 2 ' s History and Physical (H&P), dated 9/2/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s Order Summary Report as of 10/22/2024, the report indicated on 9/19/2024 the physician ordered to hold amiodarone and metoprolol tartrate if Resident 2 ' s pulse was less than 60 beats per minute (BPM). During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the Director of Nursing (DON), Resident 2 ' s Medication Administration Record (MAR) for October 2024 was reviewed. The MAR indicated amiodarone was administered on 10/8/2024 at 9:00 AM with a pulse of 56 BPM, on 10/8/2024 at 5:00 PM with a pulse of 54 BPM, and on 10/9/2024 at 5:00 PM with a pulse of 54 BPM. The MAR also indicated metoprolol tartrate was administered on 10/8/2024 at 9:00 AM with a pulse of 56 BPM, on 10/8/2024 at 5:00 PM with a pulse of 54 BPM, on 10/9/2024 at 5:00 PM with a pulse of 54 BPM, on 10/15/2024 at 5:00 PM with a pulse of 56 BPM, and on 10/21/2024 at 9:00 AM with a pulse of 53 BPM. The DON stated the check mark on the MAR indicated the medication was administered. The DON stated the nurse should hold amiodarone and metoprolol tartrate with a pulse less than 60 BPM. The DON stated resident ' s pulse would go down and might lose consciousness if amiodarone and metoprolol tartrate were administered with a pulse less than 60 BPM. The DON stated the right thing to do was to call the doctor. (continued on next page)

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F 0760 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, Medication Administration, revised on 7/2013, the P&P indicated drugs must be administered in accordance with the written orders of the attending physician. The P&P further indicated that medication for hypertension that required parameters before administration should be complied with.