| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056458 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenfield Care Center of South Gate | 8455 State Street<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858<br><br>Based on interview and record review, the facility failed to follow their Policy and Procedure (P&P), titled, Abuse and Neglect Prevention, when Certified Nursing Assistant (CNA) 2 did not report within two hours to the California Department of Public Health (CDPH), law enforcement, the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities),the Administrator (ADM) and the Director of Nursing Services (DON) when Resident 1 informed CNA 2 that CNA 1 was rough with Resident 1 for one out of three sampled residents (Resident 1).<br><br>This deficient practice resulted in a delay of an investigation by CDPH and had the potential for further abuse by CNA 1 to other residents within the facility while CNA 1 continued to work the remainder of CNA 1's scheduled shift.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included muscle weakness, spinal stenosis (abnormal narrowing of the spinal canal), and Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and, or touching as resident completes activity) for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene.<br><br>During a review of Resident 1 ' s Nursing Progress Notes, dated 1/19/2025, the progress note indicated Resident 1 ' s son made the facility aware that his mother told him a nurse was too rough on her (Resident 1) last night. The progress notes indicated Resident 1 stated a male CNA (CNA 1) was rough with her, hurt Resident 1 ' s arm, and cleaned Resident 1 with hot water last night.<br><br>During a review of the facility ' s Five-Day Investigation Report, dated 1/22/2025, the investigation report indicated CNA 1 asked CNA 2 to translate (in Spanish) for Resident 1 when Resident 1 became agitated. The report indicated Resident 1 told CNA 2 that CNA 1 was rough (during care).<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 2/3/2025, at 11:31 a.m., with CNA 1, CNA 1 stated, during the 11 p.m.- 7 a.m. shift on 1/19/2025 around 4 a.m., he asked CNA 2 to translate for him and Resident 1 (in Spanish) because Resident 1 pushed the call light and was very agitated. CNA 1 stated CNA 2 told him Resident 1 was agitated because Resident 1 complained thatthe water was too hot when CNA 1 provided perineal care (the cleaning and maintenance of the genital and anal areas) earlier in the shift. CNA 1 stated CNA 2 never told him Resident 1 complained about him being too rough with her. CNA 1 stated CNA 2 told him that Resident 1 was just confused. CNA 1 stated he did not report the incident to LVN 1 because he believed everything was solved.<br><br>During an interview, on 2/3/2025, at 11:51 a.m., with CNA 2, CNA 2 stated, during the 11 p.m.- 7 a.m. shift, on 1/19/2025, she helped translate for CNA 1 and Resident 1. CNA 2 stated Resident 1 told her CNA 1 was too rough. CNA 2 stated Resident 1 also asked for a pain pill because her left arm was hurting after CNA 1 repositioned her. CNA 2 stated she only told LVN 1 that Resident 1 wanted her pain pill, but did not report Resident 1 ' s complaint about CNA 1. CNA 2 stated she should have told LVN 1 or notified the proper agencies (CPDH, law enforcement, and the ombudsman) about Resident 1 ' s concern, because it was considered an abuse allegation. CNA 2 stated all staff were considered mandated reporters. CNA 2 stated there was potential for further abuse by CNA 1 to Resident 1 or all the other residents within the facility.<br><br>During an interview, on 2/3/2025, at12:46 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was assigned to care for Resident 1 for the 11 p.m. to 7 a.m. shift on 1/18/2025 and was not made aware of any incident or allegation of abuse between Resident 1 and CNA 1. LVN 1 stated he would have immediately reported the incident to the abuse coordinator, the police, the ombudsman, CDPH, and would have ensured CNA 1 was sent home.<br><br>During an interview, on 2/3/2025, at 1:12 p.m., with the Administrator (ADM), the ADM stated all facility staff were mandated reporters and did not have to wait for him to notify law enforcement, CDPH, and fill out the SOC 341 form (a form that documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult). The ADM stated CNA 2 should have reported the incident right away.<br><br>During a review of the facility ' s Policy and Procedure (P&P), titled, Abuse and Neglect Prevention Policy, revised 12/2014, the policy indicated the following:<br><br>1. When abuse or mistreatment of a resident is suspected staff must immediately notify their supervisor in duty, who, in turn, notifies the abuse prevention coordinator (Administrator) and the Director of Nursing Services.<br><br>2. Staff must respond to all allegations immediately.<br><br>3. Notify the State Department of Public Health, and other regulatory agencies as assigned and according to state reporting requirements.<br><br>4. All facility employees were required by law to report any known or suspected abuse immediately upon identifying a concern.<br><br>Cross reference F610. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858<br><br>Based on interview, and record review, the facility failed to follow their Policy and Procedure (P&P), titled, Abuse and Neglect Prevention, when the following occurred for one out of three sampled residents (Resident 1) by failing to:<br><br>1.Ensure a prompt investigation was initiated when Certified Nursing Assistant (CNA) 2 had knowledge Resident 1 alleged that CNA 1 was rough during care.<br><br>2. Ensure the facility implemented prompt measures to protect Resident 1 when CNA 2 had knowledge that Resident 1 alleged that CNA 1 was rough during care.<br><br>These deficient practices resulted in the delay of a timely investigation and allowed for further potential abuse by CNA 1 to Resident 1 and other residents within the facility while CNA 1 continued to work the remainder of his scheduled shift.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1 ' s diagnoses included muscle weakness, spinal stenosis (abnormal narrowing of the spinal canal), and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and, or touching as resident completes activity) for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene.<br><br>During a review of Resident 1 ' s Nursing Progress Notes, dated 1/19/2025, the progress note indicated Resident 1 ' s son made the facility aware that his mother told him a nurse was too rough on her (Resident 1) last night. The progress notes indicated Resident 1 stated a male CNA (CNA 1) was rough with her, hurt Resident 1 ' s arm, and cleaned Resident 1 with hot water last night.<br><br>During a review of the facility ' s Five-Day Investigation Report, dated 1/22/2025, the report indicated CNA 1 asked CNA 2 to translate (in Spanish) for Resident 1 when Resident 1 became agitated. The report indicated Resident 1 told CNA 2 that CNA 1 was rough (during care).<br><br>During an interview, on 2/3/2025, at 11:51 a.m., with CNA 2, CNA 2 stated, during the 11 p.m.- 7 a.m. shift, on 1/19/2025, she helped translate for CNA 1 and Resident 1. CNA 2 stated Resident 1 told her CNA 1 was too rough and Resident 1 wanted a pain pill because her left arm was hurting after CNA 1 repositioned her. CNA 2 stated that she only told LVN 1 Resident 1 wanted her pain pill, but did not report Resident 1 ' s complaint about CNA 1. CNA 2 stated she should have told LVN 1 or notified the proper agencies (CPDH, law enforcement, and the ombudsman) about Resident 1 ' s concern because it was considered an abuse allegation. CNA 2 stated this delayed the facilities ' ability to investigate timely and prevent Resident 1 from possible further abuse.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 2/3/2025, at12:46 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was assigned to care for Resident 1 for the 11 p.m. to 7 a.m. shift on 1/18/2025 and was not made aware of any incident or allegation of abuse between Resident 1 and CNA 1. LVN 1 stated that he would have immediately reported the incident to the abuse coordinator, the police, the ombudsman, CDPH, and would have ensured CNA 1 was sent home. LVN 1 recalled that CNA 1 stayed in the facility until the end of his shift (7:30 a.m.). LVN 1 stated if he had known about the allegation, he would have started an investigation sooner.<br><br>During an interview, on 2/3/2025, at 1:12 p.m., with the Administrator (ADM), ADM stated that all facility staff members were mandated reporters and did not have to wait for him to notify law enforcement, CDPH, and to fill out the SOC 341 form (a form that documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult). The ADM stated CNA 2 should have reported the incident right away. The ADM stated this led to a delay in an investigation, and the facility could have acted on the information to prevent further abuse.<br><br>During a review of the facility ' s Policy and Procedure (P&P), titled, Abuse and Neglect Prevention Policy, revised 12/2014, the policy indicated the following for the management of abuse allegations:<br><br>1. Remove or protect the resident from danger<br><br>2. Assess the resident for injuries<br><br>3. Investigate the alleged incident immediately<br><br>4. Suspend the employee who may have been alleged perpetrators<br><br>Cross reference F609. |