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	04/08/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview and record review, the facility failed to ensure one of 10 sampled residents (Resident 3) who received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment received care in accordance with standards of practice, when the facility failed to: 1. Ensure nursing staff follow up on Resident 3 ' s potassium ([K] - a mineral the body needs, to help nerves and muscles work properly, especially your heart) lab order and notify the clinician of the abnormal results. 2. Ensure nursing staff ordered a potassium leverl instead of a Levetiracetam (Keppra - medications used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] level as ordered by the clinician. These deficient practices had the potential to delay necessary care and treatment for hyperkalemia placing Resident 3 at serious risk for heart rhythm problem, cardiac arrest or even death. During a review of Resident 3 ' s Admission Record (Face Sheet - front page of the chart that contains a summary of basic information about the resident), dated 4/7/2025, the admission record indicated Resident 3 was initially admitted to the facility on [DATE]. The admission record indicated the following diagnoses which included hyperkalemia (too much K in the blood usually greater than 5.0 milliequivalents per liter [mEq/L- a unit of measure]), hydrocephalus (excessive fluid in the brain and spinal cord), spina bifida (a condition that occurs at birth where the spine and spinal cord do not form properly), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis. During a review of Resident 3 ' s History and Physical (H&P), dated 10/28/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/6/2025, the MDS indicated Resident 3 ' s cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 3 had the ability to eat and perform toileting hygiene with setup or clean-up assistance (helper assists only prior to or following the activity) and required supervision (helper provides verbal cues and/or touching as resident completes the activity) for bathing and personal hygiene. The MDS indicated Resident 3 required a wheelchair for mobility (ability to get from one place to another). (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3 ' s care plan titled, At risk for abnormal lab values and other medical problems, initiated on 10/29/2024 and revised on 2/14/2025, the care plan indicated Resident 3 ' s abnormal lab values and other medical problems were related to a history of hyperkalemia. The care plan goal indicated Resident 3 would have less episodes of abnormal lab values for three months. The care plan interventions indicated to notify MD for all lab values. During a review of Resident 3 ' s care plan titled, The Resident Needs Dialysis, initiated on 10/29/2024 and revised on 2/14/2025, the care plan indicated Resident 3 ' s needed dialysis related to renal failure. The care plan goal indicted resident would have no signs and symptoms of complications of dialysis. The care plan interventions indicated to monitor labs and report to doctor as needed. During a review of Resident 3 ' s care plan titled, The Resident has episodes of tachycardia, initiated on 1/22/2025 and revised on 2/24/2025, the care plan goal indicated resident will be free from complications of cardiac problems. The care plan interventions indicated to check potassium level. During a review of Resident 3 ' s Nurses Progress Note on 3/26/2025 at 6:41 a.m., the Nurses Progress Note indicated Licensed Vocational Nurse (LVN 1) received a phone call on 3/26/2025 at 6:35 a.m. from the dialysis center to send Resident 3 out to the General Acute Care Hospital (GACH) emergency room (ER) due to Resident 3 having a high potassium level of 7.3 mEq/L. During a review of Resident 3 ' s Nurses Progress Note on 3/26/2025 at 5:22 p.m., the Nurses Progress Note indicated RN 1 notified the Medical Director (MD) and the MD ordered 15 grams (gm - metric unit of measurement, used for medication dosage and/or amount) of Kayexalate (a medication used to treat elevated levels of potassium in the blood) every 12 hours times two doses and repeat a K level in the morning (3/27/2025). The Nurses Progress Note indicated the orders were carried out. During a review of Resident 3 Medication Administration Record (MAR) dated March 2025, the MAR indicated Resident 3 was administered Sodium Polystyrene Sulfonate Combination suspension 15 gm/60ml on 3/26/2025 at 6:08 p.m. and 8:52 p.m. and repeat K level in AM. During a review of Resident 3 ' s Nurse Progress Note on 3/27/2025 at 3:03 a.m., the Nurses Progress Note indicated Resident 3 continued to be monitored for hyperkalemia. During a review of Resident 3 ' s Telephone Order, dated 3/27/2025 at 4:58 a.m., the Telephone Order indicated to order a Repeat K level one time only. During a review of Resident 3 ' s lab requisition form dated 3/27/2025, the lab requisition form indicated in the profile/other tests section to draw a K level. The lab requisition indicated the lab was drawn from the right arm on 3/27/2025 at 6:05 a.m. During a review of Resident 3 ' s General Lab Work - Final Report on 3/27/2025 at 6:05 a.m., the final lab report indicated a Keppra lab result. The final lab report did not indicate a K level was drawn or resulted. During a review of Resident 3 ' s IDT (Interdisciplinary Team) Rounding Report from the dialysis center on 3/31/2025, the IDT Rounding Report indicated Resident 3 ' s K level result was 7.9 mEq/L. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/7/2025 at 2:30 p.m., with Registered Nurse (RN 1), Resident 3 ' s Nursing Progress Notes, Doctor ' s Orders, and lab results and lab requisition were reviewed. RN 1 stated according to Resident 3 ' s lab requisition and lab order by the MD, a K level was ordered and drawn on 3/27/2025 at 6:05 a.m. RN 1 stated she could not find the lab result for K but did see lab results for Keppra on 3/27/2025 at 6:05 a.m. RN 1 stated there was no documentation in the Nursing Progress Notes indicating Resident 3 had refused the K lab or that the MD was notified regarding the K results. RN 1 stated the MD should have been notified and the nurse should have documented that the MD was notified regarding the K results. RN 1 stated she was not sure why a Keppra was blood draw was done instead of a K level, but would contact the lab for clarification. During an interview on 4/7/2025 at 3:27 p.m., with RN 1, RN 1 stated she called the lab and spoke with the lab director (LD). RN 1 stated the LD informed her the lab technician had drawn blood for Keppra instead of K in error. RN 1 stated once the Keppra lab came back in error, the nurse should have followed up with the lab regarding the K level. During an interview on 4/8/2025 at 4:17 p.m., with the Director of Nursing (DON), the DON stated if Resident 3 had a lab order for K, the nurses should have called the MD with the results. The DON stated if the K lab result was not there, the nurse should have called the lab to follow up. The DON stated the nurses should check on the lab orders and follow up every day to see if the results have been returned. The DON stated a high K could lead to heart issues, so it was important to check for the results. During a telephone interview on 4/8/2025 9:21 a.m., with the MD, the MD stated if there was a lab order for K for Resident 3, it was the expectation for the lab to be drawn and the nurse should have reported the results to him. The MD stated he received a lab result for Keppra on 3/27/2025 but never received a K result on that day. The MD stated he did not order a Keppra level on 3/27/2025. The MD stated if Resident 3 ' s K had come back very high on 3/27/2025, he would have sent the resident to the GACH ER to get the K level down and perform an electrocardiogram (EKG - an instrument used to measure the heart ' s electrical activity). The MD stated a K level above a 6.0 mEq/L would be considered very high and Resident 3 would have been sent to the GACH. The MD stated persistent hyperpotassemia (high K in the blood) could cause cardiac issues and that was the main concern for getting a K level on the resident. During a telephone interview on 4/9/2025 at 10:18 a.m., with the LD, the LD indicated on 3/27/2025, a Keppra level was ordered incorrectly by the date entry team at the lab. The LD stated RN 1 called him to inquire about the K level for Resident 3 on 4/8/2025. The LD stated he informed RN 1 that the nurses should have followed up on the lab request for a K level. The LD stated the instead of the nurse checking the potassium on lab requisition form, the nurse wrote in to draw a K level in the Other section on the lab requisition form. The LD stated when the nurse wrote K level in the other section of the lab requisition form instead of checking the potassium box, that meant to order something other than potassium. The LD stated the K level could have stood for many labs besides the potassium level. The LD stated the error fell on the nurses for not following up on the potassium level and his lab technicians for not confirming lab tests that are questionable. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/9/2025 at 11:01 a.m., with RN 5, RN 5 stated she was the desk nurse on 3/26/2025 and received an endorsement from the previous shift that Resident 3 ' s K level was high, to give doses of Kayexalate and draw a K level after the Kayexalate was given. RN 5 stated she completed the lab requisition for the K level, but did not check the potassium box on the requisition because she did not see it. RN 5 stated she wrote K level in the other section. RN 5 stated she should have checked the potassium box or added a plus sign (+) to the K level to eliminate any confusion. RN 5 stated the K level was not done because she did not order the lab correctly. RN 5 stated without a K level, the nurses would not know if the Kayexalate was effective and Resident 3 ' s K level could have still been very high and could have led to heart failure if not addressed. During a review of the facility ' s policy and procedure (P&P) titled, Laboratory and Radiology, dated January 2012, the P&P indicated, it was the policy of the facility that laboratory and reports be performed as prescribed by the physician filed in the resident ' s medical record. The P&P also indicated the following: 1. Licensed nurses will notify laboratory services to perform the lab test, record the notification in the Nurses Notes, document in the Lab Control Log and complete a lab requisition form. 2. The lab technician will check the Lab Control Log at the nurse ' s station to confirm the request. 3. As the laboratory results are received by the facility, the licensed nurse notifies the physician. 4. Abnormal laboratory results are to be called into the physician promptly and notification be recorded in the resident ' s medical record. 5. The abnormal laboratory results are to be signed by the reviewing licensed nurse who notifies physician and filed in the medical record. 6. If the laboratory report is not received with 48 hours, contact the services and immediately request a copy. During a review of the facility ' s P&P titled, Dialysis Services, dated August 2012, the P&P indicated, it was the policy of the facility to provide adequate and appropriate care to dialysis clients in coordination with the dialysis center, under the management and direction of the resident ' s attending physician. The P&P indicated the facility may be required to provide interventions for dialysis residents such as assessment of potassium lab values.