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	04/14/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to maintain respect and dignity for one of three sampled residents (Resident 1) when Certified Nursing Assistant (CNA) 1 failed to ensure Resident 1 was cleaned timely as requested. This failure resulted in Resident 1 expressing feelings of anger towards CNA 1 and had the potential for Resident 1 to exhibit feelings of hopelessness and long-term psychological distress. Findings: During a record review of the facility ' s Five-Day Report, dated 4/7/2025, the Five-Day Report indicated Resident 1 alleged a night shift (11 p.m. to 7 a.m.) CNA had a bad attitude on 4/6/2025. The Five-Day Report indicated the CNA refused to change Resident 1 after she pressed the call light. The Five-Day Report indicated Resident 1 pressed the call light a second time because she needed to be changed, and the same CNA yanked her call light and told her not to press it anymore. 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 fracture (broken bone) of the left hip, history of a fall, lack of coordination and urinary retention (incomplete emptying of the bladder). During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 1 required substantial, maximal assistance (helper does more than half of the effort) for toileting hygiene, bathing and lower body dressing. The MDS indicated Resident 1 was dependent on staff (helper does all the effort, resident does none of the effort to complete the activity) for bed mobility and bed-to-chair transfers. During a review of Resident 1 ' s Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) Care Plan, initiated 4/2/2025, the UTI Care Plan indicated to provide good perineal (genital area) care each shift to keep Resident 1 clean and dry at all times. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/10/2025 at 11:57 a.m. with Resident 1, Resident 1's eyebrows were furrowed and was breathing at a fast pace. Resident 1 stated she was mistreated by CNA 1 on 4/6/2025 during the 11p.m. to 7 a.m. shift. Resident 1 stated she pushed the call light around 11 p.m. because she was soiled. Resident 1 stated CNA 1 walked in, opened the curtain, looked at Resident 1, and walked out. Resident 1 stated CNA 1 came back to clean Resident 1, aggressively separated her legs, pulled off her diaper and fanned it as if she was disgusted by the smell of Resident 1 ' s urine. Resident 1 stated CNA 1 acted as if she did not want to clean her. Resident 1 stated she pressed the call light again (around 2 a.m.) because she was soiled. Resident 1 stated CNA 1 went into the room, aggressively pulled the call light away from Resident 1 and told her not to use the call light and to stop calling. Resident 1 stated CNA 1 did not change her after that incident and was eventually changed by the following shift (7a.m. to 3 p.m. shift). Resident 1 stated this made her feel angry at CNA 1. During an interview on 4/10/2025 at 12:10 p.m. with CNA 3, CNA 3 stated CNA 1 tended to lose her patience with the residents and was frustrated at times. CNA 3 stated CNA 1 would complain about other CNAs not helping her clean her assigned residents. CNA 3 stated she recalled a time when CNA 1 worked the 7 a.m. to 3 p.m. shift (with CNA 3) and CNA 1 did not clean some of her residents. CNA 3 stated she had to step in and clean a few of CNA 1 ' s assigned residents. CNA 3 stated she and other CNAs have reported CNA 3 to the Director of Staff Development (DSD) before. During an interview and concurrent record review on 4/10/2025 at 3:33 p.m. with the DSD, CNA 1 ' s Disciplinary Action Forms, dated 2/3/2024 and 3/7/2025, were reviewed. The Disciplinary Action Form, dated 2/3/2024, indicated a resident assigned to CNA 1 was not changed throughout the night and the urinal was not emptied. The Disciplinary Action Form, dated 3/7/2025, indicated a resident assigned to CNA 1 was left soiled and laid on dry bowel movement throughout the shift. The DSD stated she recalled CNAs expressed concerns last month about CNA 1 not being a team player and refusing to help other CNAs with patient care. The DSD stated she was made aware CNA 1 struggled to complete patient-related tasks before the end of CNA 1's shift. The DSD stated she provided in-services to the CNAs about working as a team and helping each other. The DSD stated that if CNA 1 was not completing her tasks timely, then there was a potential for delayed care and for the residents to feel like they were not a priority. The DSD stated there was a possibility for the development of pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) if the residents were not cleaned timely. The DSD stated CNA 1 ' s job performance did not align with respecting residents ' rights and honoring the dignity of the residents. During an interview on 4/10/2025 at 4:06 p.m. with CNA 1, CNA 1 stated she was the assigned CNA for Resident 1 on 4/6/2025 from the 11 p.m. to 7 a.m. shift. CNA 1 stated the normal process was to notify the nearby assigned CNA to cover her assignment and ensure all call lights were answered before she went on break. CNA 1 stated she took her break around 3:30 a.m. and came back around 4 a.m. CNA 1 stated she did not notify any nurse before she went on break because it slipped [her] mind. CNA 1 stated she should have let another nurse know that she was going to take a break before she clocked out so that the needs of her assigned residents could be attended to timely. CNA 1 stated when she clocked in after her break, she saw that Resident 1 ' s call light was on. CNA 1 stated she did not know how long the call light had been on and there was a potential for Resident 1 ' s needs not to be met in a timely manner. CNA 1 stated she did not recall any other issues related to Resident 1 ' s care on the 11p.m. to 7 a.m. shift on 4/6/2025. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/14/2025 at 2:11p.m. with the Director of Nursing (DON), DON stated she expected the CNAs to find another CNA to answer call lights and ensure patient needs were met before they left the floor for a break. DON stated she expected residents to be changed right away after a resident requested to be changed. DON stated if the CNA was busy, she expected the CNAs to provide the resident with an explanation and reassurance that the resident would be changed in the language that the resident understood. DON stated there was potential to make a resident feel upset and disrespected if the call light was not answered promptly, dialogue was not translated in the resident ' s preferred language, and if the resident was not cleaned in a timely manner. DON stated turning off the call light, ignoring the resident, yanking the call light away from the resident and the act of fanning the resident ' s perineal (genital) area while changing his or her diaper did not align with respecting the resident and honoring the resident ' s dignity. During a review of the facility ' s P&P, titled, Quality of Life Dignity, revised 8/2009, the P&P indicated the facility was to ensure each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. During a review of the facility ' s P&P, titled, Accommodation of Needs, revised 1/2025, the P&P indicated the facility's environment and staff behaviors were directed towards assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. During a review of the facility ' s Policy and Procedure (P&P), titled, Call Light/ Bell, revised 12/2014, the P&P indicated the facility was to respond to a resident ' s request and provide an explanation if the item was not available or the facility staff was unable to provide aid. During a review of the facility ' s P&P, titled, Translation or Interpretation of Facility Services, revised 7/2009, the P&P indicated the following: 1) Providing meaningful access to services provided by the facility required that the Limited English Proficiency (LEP) resident's needs and questions are accurately communicated to the staff. The P&P indicated oral interpretation services therefore include interpretation from the LEP resident's primary language back to English. 2) In order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to follow their Policy and Procedure (P&P), titled, Abuse and Neglect Prevention Management, for one out of three sampled residents (Resident 2) by failing to: 1. Ensure Registered Nurse (RN) 1 reported within 24 hours to the Administrator (ADM), the Director of Nursing Services (DON) and the California Department of Health (CDPH) when Resident 2 ' s family member (FM 1) alleged Certified Nursing Assistant (CNA) 2 was physically rough handling Resident 2. 2. Suspend CNA 2 after an allegation of rough handling was made by Resident 2. This resulted in a delay of an investigation by CDPH and had the potential for further abuse by CNA 2 to other residents. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a chronic lung disease causing difficulty in breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body), muscle wasting and atrophy (muscle shrinking), difficulty in walking, and history of falling. During a review of Resident 2 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 4/6/2025, indicated Resident 2 ' s cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 2 was dependent (helper does all the effort) on staff to perform toileting hygiene, sitting to lying, and performing chair or bed- to-chair transfers. During an interview on 4/10/2025 at 2:02 p.m. with FM 1, FM 1 stated on 4/5/2025, around 6:00 p.m., she witnessed CNA 2 roughly grab Resident 2 ' s arm and rush Resident 2 into the restroom. FM 1 stated she was so upset she went directly to RN 1 to report the incident. FM 1 stated RN 1 brought CNA 2 into the room to discuss and resolve the issue. FM 1 stated CNA 2 denied the allegations and justified her actions. FM 1 stated RN 1 assigned a different CNA to care for Resident 2. During an interview on 4/10/2025 at 3:54 p.m. with RN 1, stated his role was to report any allegation of abuse to the Administrator (ADM), the Director of Nursing (DON) and CDPH. RN 1 stated FM 1 reported to him CNA 2 was rough handling Resident 2. RN 1 stated he did not report the allegation to the DON or the ADM because he was busy, and he forgot during the shift. RN 1 stated it was important to report any allegations of abuse to ensure that it does not happen again to any other resident. RN 1 stated CNA 2 was permitted to work the remainder of the shift until 11 p.m. RN 1 stated he should have suspended CNA 2 for the remainder of the shift to protect other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/14/2025 at 2:11pm with the DON, the DON stated the expectation of the staff was to report any allegation of abuse to ensure the abuse did not occur again. The DON stated if an allegation of abuse involved a staff member, the staff member should be sent home immediately pending the investigation. The DON stated she was never informed of an allegation of physical abuse on 4/5/2025. During an interview on 4/14/2025 at 3:19 p.m. with the ADM, the ADM stated he was not notified of any allegation of abuse on 4/5/2025. The ADM stated an allegation of abuse, should be reported to the CDPH. The ADM stated all staff were expected to ensure the safety of the residents by immediately suspending the alleged employee involved with the abuse allegation. During a review of the facility ' s Policy and Procedure (P&P), titled, Abuse and Neglect Prevention Management revised 2/2018, the P&P indicated the following: 1. In the event of an allegation of abuse, the named employee would be suspended immediately, pending an investigation by the Administrator, Director of Nursing Services, and Social Services. 2. The facility would ensure all alleged violations involving mistreatment, neglect or abuse, are immediately reported to the Administrator and Director of Nursing Services; with subsequent mandatory reporting in accordance with state law, through established procedures (including law enforcement, the state survey and certification agency, Ombudsman, Licensing Boards and Registries, and other agencies as required.) 3. Allegations involving abuse, neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property are reported no later than two (2) hours after the allegation is made.