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	06/03/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident care plan was developed after brusing (a mark on skin, black and blue or red to purple form when blood pools under skin, caused by a blood vessel break) was noted for one resident out of three sampled residents (Residents 1). This deficient practice resulted in a delay in care and monitoring for Resident 1 and potentially negatively affected the delivery of care. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning[ability to think and reason] thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and legal blindness (impaired vision). During a review of Resident 1 ' s History and Physical (H&P) dated 3/30/2025, the H&P indicated Resident 1 was alert and oriented to person ([AAO x1] person knows their own name and can identify themselves, a shorthand way of describing a person's awareness and cognitive [ability to think and reason] function) and was nonverbal. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 1 ' s cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left to right in bed, moving from sitting to lying, lying to sitting, and transfering to and from a bed to a wheelchair. During a review of Resident 1 ' s Progress Notes, dated 5/16/2025, the progress notes indicated Resident 1 was noted with skin discoloration (abnormal change in the color of the skin, either darkening or lightening, compared to a person's normal skin tone). The progress notes indicated Resident 1 had discoloration to the left mid-arm, under the left breast and chest. During a review of Resident 1 ' s Progress Notes, dated 5/17/2025, the progress notes indicated Resident 1's skin discoloration spread to left rib extending toward the back. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Treatment Administration Record (TAR), dated 5/1/2025 - 5/31/2025, the TAR did not indicate the Treatment Nurse (TN) monitored Resident 1 ' s skin discoloration to the chest, left breast and flank from 5/16/2025 - 5/18/2025. The TAR did not indicate the TN monitored Resident 1 ' s skin discoloration to the left arm from 5/16/2025 - 5/18/2025. During a review of Resident 1 ' s Care plan for left arm skin discoloration, dated 5/18/2025, the care plan indicated Resident 1 ' s skin discoloration would be healed without complications. The care plan indicated it was developed on 5/18/2025. During a review of Resident 1 ' s Care plan for skin discoloration, dated 5/18/2025, the care plan indicated Resident 1 ' s skin discoloration would be healed without complications. The care plan indicated it was developed on 5/18/2025. During an interview on 6/2/2025 on 1:18 p.m. with TN 1, TN 1 stated when a resident has a change of a condition a care plan must be developed. TN 1 stated she did not develop the care plan for Resident 1. During an interview on 6/2/2025 at 2:38 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she created a care plan on 5/16/2025 for Resident 1 ' s bruises discovered on 5/15/2025. LVN 1 stated a care plan was important because it was the plan of care for residents and continuation of care. During an interview on 6/2/2025 at 3:42 p.m. with TN 1, TN 1 stated she developed a care plan for Resident 1 ' s bruises on 5/18/2025 after Resident 1 returned from the hospital. TN 1 stated she did not develop a care plan when she discovered Resident 1 ' s bruises because she was not the resident's assigned nurse. TN 1 stated it was important for residents to have a care plan to develop interventions for residents ' care. During an interview on 6/3/2025 at 2:18 p.m. with the Director of Nursing (DON), the DON stated she expected the licensed nurse to develop a care plan after the discovery of Resident 1 ' s bruises. The DON stated it was important to develop a care plan to develop interventions to prevent the resident's bruises from getting worse. During a concurrent interview and record review on 6/3/2025 at 3:32 p.m. with the DON, Resident 1 ' s Care Plan dated 5/18/2025 was reviewed. The care plan did not indicate it was developed on 5/16/2025 when Resident 1 ' s bruises were discovered. The DON stated Resident 1 ' s care plan should have been developed when Resident 1 ' s bruises were discovered on 5/16/2025. During a review of facility ' s Job Description for Treatment Nurse, dated 7/2012, the job description indicated the TN would assess resident needs and initiate the development of individualized care plans. During a review of facility ' s Policy and Procedure (P&P) titled Change of condition, dated 7/2022, the P&P indicated when there is a medical change in a resident, licensed nurses must document resident change of condition and update care plan. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident care plan was developed after brusing (a mark on skin, black and blue or red to purple form when blood pools under skin, caused by a blood vessel break) was noted for one resident out of three sampled residents (Residents 1). This deficient practice resulted in a delay in care and monitoring for Resident 1 and potentially negatively affected the delivery of care. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning[ability to think and reason] thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and legal blindness (impaired vision). During a review of Resident 1's History and Physical (H&P) dated 3/30/2025, the H&P indicated Resident 1 was alert and oriented to person ([AAO x1] person knows their own name and can identify themselves, a shorthand way of describing a person's awareness and cognitive [ability to think and reason] function) and was nonverbal. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 1's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left to right in bed, moving from sitting to lying, lying to sitting, and transfering to and from a bed to a wheelchair. During a review of Resident 1's Progress Notes, dated 5/16/2025, the progress notes indicated Resident 1 was noted with skin discoloration (abnormal change in the color of the skin, either darkening or lightening, compared to a person's normal skin tone). The progress notes indicated Resident 1 had discoloration to the left mid-arm, under the left breast and chest. During a review of Resident 1's Progress Notes, dated 5/17/2025, the progress notes indicated Resident 1's skin discoloration spread to left rib extending toward the back. During a review of Resident 1's Treatment Administration Record (TAR), dated 5/1/2025 – 5/31/2025, the TAR did not indicate the Treatment Nurse (TN) monitored Resident 1's skin discoloration to the chest, left breast and flank from 5/16/2025 – 5/18/2025. The TAR did not indicate the TN monitored Resident 1's skin discoloration to the left arm from 5/16/2025 – 5/18/2025. During a review of Resident 1's Care plan for left arm skin discoloration, dated 5/18/2025, the care plan indicated Resident 1's skin discoloration would be healed without complications. The care plan indicated it was developed on 5/18/2025. During a review of Resident 1's Care plan for skin discoloration, dated 5/18/2025, the care plan indicated Resident 1's skin discoloration would be healed without complications. The care plan indicated it was developed on 5/18/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/2025 on 1:18 p.m. with TN 1, TN 1 stated when a resident has a change of a condition a care plan must be developed. TN 1 stated she did not develop the care plan for Resident 1. During an interview on 6/2/2025 at 2:38 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she created a care plan on 5/16/2025 for Resident 1's bruises discovered on 5/15/2025. LVN 1 stated a care plan was important because it was the plan of care for residents and continuation of care. During an interview on 6/2/2025 at 3:42 p.m. with TN 1, TN 1 stated she developed a care plan for Resident 1's bruises on 5/18/2025 after Resident 1 returned from the hospital. TN 1 stated she did not develop a care plan when she discovered Resident 1's bruises because she was not the resident's assigned nurse. TN 1 stated it was important for residents to have a care plan to develop interventions for residents' care. During an interview on 6/3/2025 at 2:18 p.m. with the Director of Nursing (DON), the DON stated she expected the licensed nurse to develop a care plan after the discovery of Resident 1's bruises. The DON stated it was important to develop a care plan to develop interventions to prevent the resident's bruises from getting worse. During a concurrent interview and record review on 6/3/2025 at 3:32 p.m. with the DON, Resident 1's Care Plan dated 5/18/2025 was reviewed. The care plan did not indicate it was developed on 5/16/2025 when Resident 1's bruises were discovered. The DON stated Resident 1's care plan should have been developed when Resident 1's bruises were discovered on 5/16/2025. During a review of facility's Job Description for Treatment Nurse, dated 7/2012, the job description indicated the TN would assess resident needs and initiate the development of individualized care plans. During a review of facility's Policy and Procedure (P&P) titled Change of condition, dated 7/2022, the P&P indicated when there is a medical change in a resident, licensed nurses must document resident change of condition and update care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the following for one of three sampled residents (Resident 1): 1. Certified Nursing Assistant (CNA) 1 reported bruising (a mark on the skin, black and blue or red to purple form when blood pools under skin, caused by a blood vessel break) to Resident 1 ' s chest, left breast, flank, and left arm to the charge nurse or supervisor. 2. Treatment Nurse (TN) 1 documented the monitoring of Resident 1 ' s bruising. 3. TN 1 assessed Resident 1 ' s bruises. These deficient practices delayed Resident 1 ' s care and services. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included dementia (the loss of cognitive functioning [ability to think and reason], thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and legal blindness (impaired vision). During a review of Resident 1 ' s History and Physical (H&P) dated 3/30/2025, the H&P indicated Resident 1 was alert and oriented to person ([AAO x1] person knows their own name and can identify themselves, a shorthand way of describing a person's awareness and cognitive function) and was nonverbal. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 1 ' s cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left to right in bed, to move from sitting on side of bed to lying flat on bed, to moving from lying position to sitting on the side of bed and to transfer to and from a bed to a wheelchair. During a review of Resident 1 ' s Progress Notes, dated 5/16/2025, the progress notes indicated Resident 1 was assessed and skin discoloration (abnormal change in the color of the skin, either darkening or lightening, compared to a person's normal skin tone) was noted. The progress notes indicated Resident 1 had discoloration on the left mid-arm, and under the left breast and chest. During a review of Resident 1 ' s Progress Notes, dated 5/17/2025, the progress notes indicated Resident 1 ' s skin discoloration spread to the left rib extending toward the back. During a review of Resident 1 ' s Treatment Administration Record (TAR), for the month of May 2025, the TAR did not indicate TN 1 monitored Resident 1 ' s skin discoloration to the chest, left breast, flank, and left arm from 5/16/2025 - 5/18/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/2025 at 1:18 p.m. with TN 1, TN 1 stated on 5/16/2025 she discovered discoloration to Residents 1 ' s upper chest, under the left breast, and the left upper arm. TN 1 stated Resident 1 ' s discoloration was purple in color. TN 1 stated she notified the Director of Nursing (DON) of Resident 1 ' s skin discoloration. During an interview on 6/2/2025 at 2:14 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 5/15/2025, she discovered bruises on Resident 1 ' s body during a shower. CNA 1 stated the bruises were on the middle of Resident 1 ' s chest and under both breasts. CNA 1 stated she asked Resident 1 what happened and the resident replied she did not know. CNA 1 stated she did not report the bruises to anyone. CNA 1 stated she was supposed to notify the charge nurse about Resident 1 ' s bruises but she got busy. CNA 1 stated she was supposed to fill out a skin assessment form indicating new skin changes and give it to the charge nurse. CNA 1 stated it was important to report the findings because it was a change of condition and staff must be aware to keep an eye on it. CNA 1 stated if bruises were not reported, staff would not be aware and Resident 1 would not receive the care she needed. During an interview on 6/2/2025 at 3:42 p.m. with TN 1, TN 1 stated after she discovered Resident 1 ' s bruises on 5/16/2025, she did not document her findings. TN 1 stated she was supposed to document Resident 1's bruises but she did not. TN 1 stated she was supposed to document the location of the bruises and the color of the bruises. TN 1 stated she was supposed to monitor Resident 1 ' s bruises and document her findings but she did not. TN 1 stated it was important to document and inform staff of new findings. TN 1 stated it was important to monitor for new findings to be aware of any changes. During an interview on 6/3/2025 at 2:28 p.m. with the DON, the DON stated CNA 1 should have reported Resident 1 ' s bruises when she discovered them on 5/15/2025. The DON stated TN 1 did not document her findings because there was no treatment for bruises and TN was monitoring Resident 1 ' s bruises. The DON stated she expected TN 1 to document findings from monitoring bruises. The DON stated it was important to document if bruises were getting better or if there was any changes. The DON stated it was important to notify the charge nurse of any change of condition when discovered because it allowed staff to provide good quality of care to residents. During a review of the job description for CNA, dated 2/18/2019, the job description indicated CNAs must report changes in resident conditions to the charge nurse or supervisor. During a review of the facility ' s Policy and Procedure (P&P) titled Change of condition, dated 7/2022, the P&P indicated it was the facility ' s purpose to timely notify resident condition changes for immediate intervention. The P&P indicated the DON would be notified immediately of significant changes of conditions. Based on interview and record review, the facility failed to ensure the following for one of three sampled residents (Resident 1): 1. Certified Nursing Assistant (CNA) 1 reported bruising (a mark on the skin, black and blue or red to purple form when blood pools under skin, caused by a blood vessel break) to Resident 1's chest, left breast, flank, and left arm to the charge nurse or supervisor. 2. Treatment Nurse (TN) 1 documented the monitoring of Resident 1's bruising. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. TN 1 assessed Resident 1's bruises. These deficient practices delayed Resident 1's care and services. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included dementia (the loss of cognitive functioning [ability to think and reason], thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and legal blindness (impaired vision). During a review of Resident 1's History and Physical (H&P) dated 3/30/2025, the H&P indicated Resident 1 was alert and oriented to person ([AAO x1] person knows their own name and can identify themselves, a shorthand way of describing a person's awareness and cognitive function) and was nonverbal. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 1's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left to right in bed, to move from sitting on side of bed to lying flat on bed, to moving from lying position to sitting on the side of bed and to transfer to and from a bed to a wheelchair. During a review of Resident 1's Progress Notes, dated 5/16/2025, the progress notes indicated Resident 1 was assessed and skin discoloration (abnormal change in the color of the skin, either darkening or lightening, compared to a person's normal skin tone) was noted. The progress notes indicated Resident 1 had discoloration on the left mid-arm, and under the left breast and chest. During a review of Resident 1's Progress Notes, dated 5/17/2025, the progress notes indicated Resident 1's skin discoloration spread to the left rib extending toward the back. During a review of Resident 1's Treatment Administration Record (TAR), for the month of May 2025, the TAR did not indicate TN 1 monitored Resident 1's skin discoloration to the chest, left breast, flank, and left arm from 5/16/2025 – 5/18/2025. During an interview on 6/2/2025 at 1:18 p.m. with TN 1, TN 1 stated on 5/16/2025 she discovered discoloration to Residents 1's upper chest, under the left breast, and the left upper arm. TN 1 stated Resident 1's discoloration was purple in color. TN 1 stated she notified the Director of Nursing (DON) of Resident 1's skin discoloration (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/2025 at 2:14 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 5/15/2025, she discovered bruises on Resident 1's body during a shower. CNA 1 stated the bruises were on the middle of Resident 1's chest and under both breasts. CNA 1 stated she asked Resident 1 what happened and the resident replied she did not know. CNA 1 stated she did not report the bruises to anyone. CNA 1 stated she was supposed to notify the charge nurse about Resident 1's bruises but she got busy. CNA 1 stated she was supposed to fill out a skin assessment form indicating new skin changes and give it to the charge nurse. CNA 1 stated it was important to report the findings because it was a change of condition and staff must be aware to keep an eye on it. CNA 1 stated if bruises were not reported, staff would not be aware and Resident 1 would not receive the care she needed. During an interview on 6/2/2025 at 3:42 p.m. with TN 1, TN 1 stated after she discovered Resident 1's bruises on 5/16/2025, she did not document her findings. TN 1 stated she was supposed to document Resident 1's bruises but she did not. TN 1 stated she was supposed to document the location of the bruises and the color of the bruises. TN 1 stated she was supposed to monitor Resident 1's bruises and document her findings but she did not. TN 1 stated it was important to document and inform staff of new findings. TN 1 stated it was important to monitor for new findings to be aware of any changes. During an interview on 6/3/2025 at 2:28 p.m. with the DON, the DON stated CNA 1 should have reported Resident 1's bruises when she discovered them on 5/15/2025. The DON stated TN 1 did not document her findings because there was no treatment for bruises and TN was monitoring Resident 1's bruises. The DON stated she expected TN 1 to document findings from monitoring bruises. The DON stated it was important to document if bruises were getting better or if there was any changes. The DON stated it was important to notify the charge nurse of any change of condition when discovered because it allowed staff to provide good quality of care to residents. During a review of the job description for CNA, dated 2/18/2019, the job description indicated CNAs must report changes in resident conditions to the charge nurse or supervisor. During a review of the facility's Policy and Procedure (P&P) titled Change of condition, dated 7/2022, the P&P indicated it was the facility's purpose to timely notify resident condition changes for immediate intervention. The P&P indicated the DON would be notified immediately of significant changes of conditions.