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	07/09/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide copies of medical records to one of four sampled residents (Resident 2) Responsible Party (RP 1) upon request.This deficient practice was a violation of RP 1's right to obtain a copy of Resident 2's medical records.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 admitting diagnoses included muscle wasting and atrophy (thinning of muscle mass), lack of coordination, and generalized muscle weakness.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 2 did not have cognitive (ability to think and reason) impairments. The MDS indicated Resident 2 required substantial to maximal assistance from staff with all mobility while in and out of bed.During a review of Resident 2's record titled Notice of Medicare Non-Coverage (NOMNC), undated, the record indicated it was signed by Resident 2.During an interview on 7/9/2025 at 11:29 AM, with Resident 2's Responsible Party (RP 1), RP 1 stated she repeatedly requested copies of any documents signed by Resident 2, including Resident 2's record titled Notice of Medicare Non-Coverage (NOMNC). RP 1 stated she sent multiple emails to the facility and had not received a response or the requested record.During a review of RP 1's emails to the facility dated 6/18/2025 at 6:12 AM and 6/19/2025 at 9:43 AM, the emails indicated RP 1 requested copies of any documents signed by Resident 2. The emails were addressed to the facility's Business Office Manager (BOM), Social Services Director (SSD), and Administrator (ADM).During a review of an email from the SSD to RP 1 dated 6/20/2025 at 10:09 AM, the email did not indicate RP1's requests for Resident 2's signed documents were addressed. During a review of RP 1's email to the facility dated 6/20/2025 at 6:02 PM, the email indicated RP 1 requested copies of any documents signed by Resident 2. The email was sent by RP 1 to the BOM, ADM, SSD, and Medical Records Director (MRD).During a review of an email dated 6/24/2025 at 9:31 AM, the email indicated RP 1 requested copies of any documents signed by Resident 2. The email was sent to the BOM, ADM, SSD, and MRD.During an interview on 7/9/2025 at 2:09 PM, with the MRD, the MRD stated she received the emails sent by RP 1 on 6/20/2025 at 6:02 PM and 6/24/2025 at 9:31 AM. The MRD stated copies of documents signed by Resident 2, including the NOMNC, were not provided to RP 1. When asked why copies of the requested documents were not provided, the MRD stated the Administrator in Training (AIT) told her to not respond to RP 1's emails. During a concurrent interview and record review, on 7/9/2025 at 2:15 PM, with the SSD, the emails sent by RP 1 dated 6/18/2025 at 6:12 AM, 6/19/2025 at 9:43 AM, 6/20/2025 at 6:02 PM, and 6/24/2025 at 9:31 AM, were reviewed. The SSD stated she received the emails from RP 1 and stated she did not reply to RP 1's requests, including the request for a signed copy of Resident 2's NOMNC. The SSD stated she did not follow-up with any other staff to ensure the record request was fulfilled.During a concurrent interview and record review, on 7/9/2025 at 2:25 PM, with the BOM, the emails sent by RP 1 dated 6/18/2025 at 6:12 AM and 6/19/2025 at 9:43 AM were reviewed. The BOM stated she received the emails and was aware of RP 1's requests. The BOM stated she did not provide any copies of records to RP 1.During a concurrent interview and record review, on 7/9/2025 2:44 PM, with the AIT, the facility's policy and procedure (P&P) titled Access to Personal and Medical Records, undated, was reviewed. The P&P indicated it was the facility's policy to provide access to and/or copies of records within 24 hours. The AIT stated there was no reason Resident 2's signed NOMNC could not be provided to RP 1. The AIT stated RP 1's request was missed.

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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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely report suspicions of abuse for one of four sampled residents (Resident 2).This deficient practice created a delay in the investigation of Resident 2's suspected abuse, and placed Resident 2 at risk for sustaining further abuse.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 admitting diagnoses included muscle wasting and atrophy (thinning of muscle mass), lack of coordination, and generalized muscle weakness.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 2 did not have cognitive (ability to think and reason) impairments. The MDS indicated Resident 2 required substantial to maximal assistance from staff with all mobility while in and out of bed.a. During a review of Resident 2's progress note dated 6/13/2025 at 3:13 PM, the progress note indicated on 6/13/2025, a verbal exchange, lasting approximately ten minutes, occurred between Resident 2 and RP 1. The progress note indicated RP 1 yelled at Resident 2 during the exchange.During an interview on 7/3/2025 at 12:09 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated verbal abuse was a type of abuse, and could appear as distress in the resident, including a change in their attitude or their demeanor. LVN 1 stated Resident 2 had a change in his demeanor since admission. LVN 1 stated Resident 2 used to smile more, but after interactions with RP 1, the resident was more upset and sadder than usual. LVN 1 stated Resident 2 told her he felt intimidated by RP 1.During a concurrent interview and record review, on 7/3/2025 at 12:18 PM, with LVN 1, Resident 2's progress note dated 6/13/2025, was reviewed. LVN 1 stated she wrote the progress note and observed the documented exchange between Resident 2 and RP 1. LVN 1 stated Resident 2's blood pressure was elevated after the incident. LVN 1 stated she reported the incident to Registered Nurse (RN) 1. LVN 1 stated she did not report the incident to any outside agencies, including the California Department of Public Health (CDPH). During an interview on 7/3/2025 at 12:47 PM, with RN 1, RN 1 stated LVN 1 informed her of the incident that occurred between Resident 2 and RP 1 on 6/13/2025. RN 1 stated she was not responsible for reporting the incident because she was not the staff who directly observed the incident. RN 1 stated that once she was made aware of the incident, she did not follow up further or assess Resident 2 for any harm or distress related to the incident. During an interview on 7/3/2025 at 1:55 PM, with the Director of Staff Development (DSD), the DSD stated all facility staff were mandated reporters and required to report suspected abuse if they had knowledge of it. The DSD stated all staff members were required to report suspected abuse, even if they did not directly witness it themselves.During a concurrent interview and record review, on 7/8/2025 at 2:01 PM, with the Director of Nursing (DON), Resident 2's progress note dated 6/13/2025 was reviewed. The progress note indicated RP 1 was yelling at the resident for approximately 10 minutes and that Resident 2 appeared visibly upset. The DON stated all staff were mandated reporters and stated the incident should have been reported in accordance with the facility's policy and procedure (P&P).During a concurrent interview and record review, on 7/8/2025 at 2:02 PM, with the DON, the facility's P&P titled Abuse and Neglect Prevention Management, revised 2/2018, was reviewed. The P&P indicated it was the facility's policy to ensure residents are safe and free from abuse. The DON stated the P&P indicated all staff were mandated reporters and that reporting of alleged abuse was to be completed according to state and federal guidance.During an interview on 7/8/2025 at 2:03 PM, with the DON, the DON stated the incident that occurred between Resident 2 and RP 1 on 6/13/2025 met the definitions of possible mental and/or verbal abuse in the facility's P&P titled Abuse and Neglect Prevention Management, revised 2/2018. The DON stated the incident should have been reported within two hours to the CDPH and other required agencies. The DON stated RN 1 and LVN 1 were both responsible for reporting.During a concurrent interview and record review, on 7/8/2025 at 2:26 PM, with the facility's Administrator in Training (AIT), Resident 2's progress note dated 6/13/2025 was reviewed. The AIT stated RP 1 yelling at Resident 2 was possible mental abuse. The AIT stated he was serving as the facility's abuse coordinator, and stated he was not made aware of the incident that occurred between Resident 2 and RP 1 on 6/13/2025. The AIT stated the incident should have been reported because RP 1 was causing distress to Resident 2. The AIT stated anyone with knowledge of the incident that occurred on 6/13/2025 should have reported it.b. During an interview on 7/3/2025 at 2:33 PM, with the Social Services Director (SSD), the SSD stated a meeting was held with Resident 2 on 6/26/2025. The SSD stated during interactions, Resident 2 agreed with RP 1 to avoid arguing or fighting. The SSD stated that during the

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were developed for two of four sampled residents (Resident 2 and Resident 3). This deficient practice placed Resident 2 and Resident 3 at risk of not receiving resident-centered care and interventions to assist them in reaching their highest practicable physical and psychosocial well-being.Findings: a. During a review of Resident 3's admission Record, the record indicated Resident 3 was originally admitted to the facility on [DATE] and was most recently re-admitted on [DATE]. Resident 3's admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and hypotension (low blood pressure). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 3 did not have cognitive impairments (a decline in one or more areas of mental function, such as memory, attention, or problem-solving). The MDS indicated Resident 3 was dependent on staff for toileting hygiene and rolling from left to right while in bed. During a concurrent interview and record review, on 7/8/2025 at 11:29 AM, with the Minimum Data Set Nurse (MDSN), Resident 3's MDS dated [DATE] was reviewed. The MDS indicated Resident 3 required two person assist for repositioning from left to right while in bed. The MDSN stated the assistance of two staff, instead of just one, was for Resident 3's safety. The MDSN stated that if two-person assistance was not provided, there was potential for Resident 3 to sustain preventable accidents and injuries. The MDSN stated it was better to prevent harm to the resident, than to have an accident and address the harm after. The MDSN stated the requirement for two-person assistance should be care planned. During an interview on 7/8/2025 at 11:33 AM, with the MDSN, the MDSN stated Resident 3 did not have a care plan indicating the level of assistance required for the provision of safe, resident-centered care. The MDSN stated care plans guided the care provided to the residents, and the absence of a care plan placed Resident 3 at risk for injury from falls. During a review of the facility's policy and procedure (P&P) titled Policies and Procedure on Nursing Assessment, undated, the P&P indicated the results of the MDS assessment were to be used to formulate a plan of care. b. During a review of Resident 2's admission Record, the record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's admitting diagnoses included muscle wasting and atrophy (thinning of muscle mass), lack of coordination, and generalized muscle weakness. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 did not have cognitive impairments. The MDS indicated Resident 2 required substantial to maximal assistance from staff with all mobility while in and out of bed. During a review of Resident 2's progress note dated 6/13/2025 at 3:13 PM, the progress note indicated a verbal exchange, lasting approximately ten minutes, occurred on 6/13/2025, between Resident 2 and his Responsible Party (RP 1). The progress note indicated RP 1 yelled at Resident 2 during the exchange. During a concurrent interview and record review, on 7/3/2025 at 12:18 PM, with Licensed Vocational Nurse (LVN) 1, Resident 2's progress note dated 6/13/2025, was reviewed. LVN 1 stated she wrote the progress note and observed the documented exchange between Resident 2 and RP 1. LVN 1 stated she felt the exchange was possible verbal abuse. During an interview on 7/3/2025 at 12:24 PM, with LVN 1, LVN 1 stated that any incidents of suspected or alleged abuse were to be care planned. LVN 1 stated the purpose of developing a care plan was to ensure the resident did not sustain any psychosocial harm from the incident and prevent repeated incidents of abuse. LVN 1 stated the care plan would include interventions to ensure that the goal was met. During an interview on 7/8/2025 at 2:05 PM, with the Director of Nursing (DON), the DON stated a care plan should have been developed after the exchange between Resident 2 and RP 1 on 6/13/2025. The DON stated a care plan would address the suspected abuse between Resident 2 and RP 1 and would help prevent any future incidents of RP 1 yelling at Resident 2, potentially causing him distress. The DON stated the main goal of care would be to prevent any psychosocial harm to Resident 2. During a review of the facility's P&P titled Abuse and Neglect Prevention Management, revised 2/2018, the P&P indicated staff were to complete care plan updates to incorporate individualized recommendations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: 1. During a review of Resident 3's admission Record, the admission record indicated Resident 3 was originally admitted to the facility on [DATE] and was most recently re-admitted on [DATE]. Resident 3's admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and hypotension (low blood pressure).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 3 did not have cognitive impairments (a decline in one or more areas of mental function, such as memory, attention, or problem-solving). The MDS indicated Resident 3 was dependent on staff for toileting hygiene and rolling from left to right while in bed, requiring two-person assist. During a review of Resident 3's progress note, dated 6/20/2025, the progress note indicated that on 6/20/2025 at 8:30 AM, Registered Nurse (RN) 1 overheard Certified Nursing Assistant (CNA) 1 shouting for help. The progress note indicated RN 1 went to Resident 3's room and observed Resident 3 in a face-down position on the floor next to her bed. The progress note indicated RN 1 observed blood on the floor from Resident 3's head and foot. The progress note indicated Resident 3 stated she was being cleaned from behind when she fell from her bed onto the floor.During an interview on 7/8/2025 at 8:32 AM, with Resident 3, Resident 3 stated that on 6/20/2025, CNA 1 repositioned her onto her side facing away from CNA 1. Resident 3 stated there was no other staff on the opposite side of the bed where she was facing. Resident 3 stated she began to slide off the right side of her bed and fell to the floor.During an interview on 7/8/2025 at 9:06 AM, with CNA 1, CNA 1 stated she turned Resident 3 onto her right side, towards the edge of the mattress without any other staff present. CNA 1 stated Resident 3 required two staff during care for safety. CNA 1 stated she made a mistake by not waiting for another staff person to assist. CNA 1 stated Resident 3 fell from the bed and scraped her head on the bedrail. CNA 1 stated Resident 3 was receiving blood thinners at the time and she bled from her wounds. During an interview on 7/8/2025 at 10:05 AM, with RN 1, RN 1 stated Resident 3 required assistance from two staff for safety. RN 1 stated CNA 1 did not request assistance. RN 1 stated that if a resident required two-person assist but it was not provided, there was potential for injury, and the inability to provide safe or correct care. RN 1 stated that as a result of the fall, Resident 3 sustained injuries requiring first aid (the immediate care given to someone who is injured). During a concurrent interview and record review, on 7/8/2025 at 11:06 AM, with the Director of Rehabilitation (DOR), Resident 3's assessment titled Rehab Screening Form, dated 6/20/2025, was reviewed. The DOR stated the assessment was completed for Resident 3's fall on 6/20/2025, and the assessment indicated she re-educated staff on having at least two staff present when assisting Resident 3 while repositioning in bed due to obesity (a medical condition characterized by excessive accumulation of body fat). The DOR stated Resident 3 had required two-person assistance since her admission to the facility and staff were aware. The DOR stated all obese residents required at least two-person assist for safety. The DOR stated staff were educated to not overestimate what they can safely perform alone and to always have a second person to assist them.During a concurrent interview and record review, on 7/8/2025 at 11:29 AM, with the Minimum Data Set Nurse (MDSN), Resident 3's MDS dated [DATE] was reviewed. The MDS indicated Resident 3 required two staff to perform repositioning from left to right while in bed. The MDSN stated the assistance of two staff, instead of just one, was for Resident 3's safety. The MDSN stated that if two-person assistance was not provided, there was potential for Resident 3 to sustain preventable accidents and injuries. The MDSN stated it was better to prevent harm to the resident than to have an accident and address the harm after. During a concurrent interview and record review, on 7/8/2025 at 1:42 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Safey and Supervision of Residents, undated, was reviewed. The DON stated the P&P indicated indicate staff were to use various sources to identify risk factors for falls, including the resident's MDS.During an interview on 7/8/2025 at 1:43 PM, with the DON, the DON stated Resident 3 required assistance from two staff for repositioning in bed and toileting hygiene. The DON stated Resident 3's fall on 6/20/2025 could have been avoided if CNA 1 had waited for another staff to assist her.During a review of the facility's P&P titled Safety and Supervision of Residents, undated, the P&P indicated resident safety and assistance to prevent accidents were facility-wide priorities. The P&P indicated staff were to analyze information obtained from assessments to identify specific accident hazards or risks for the resident, and target interventions to reduce the potential for accidents.2. During a review of Resident 1's

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1, Registered Nurse (RN) 1, and the Social Services Director (SSD) implemented the facility's policy and procedure titled Abuse and Neglect Prevention Management, revised 2/2018, related to abuse reporting, for one of four sampled residents (Resident 2).This deficient practice resulted in LVN 1 and RN 1 not reporting suspicions of Resident 2's abuse on 6/13/2025, and the SSD not reporting suspicions of Resident 2's abuse on 6/26/2025. 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 admitting diagnoses included muscle wasting and atrophy (thinning of muscle mass), lack of coordination, and generalized muscle weakness.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 2 did not have cognitive impairments (a decline in mental abilities, such as memory, thinking, and problem-solving). The MDS indicated Resident 2 required substantial to maximal assistance from staff with all mobility while in and out of bed.a. During a review of Resident 2's progress note dated 6/13/2025 at 3:13 PM, the progress note indicated a verbal exchange, lasting approximately ten minutes, occurred on 6/13/2025, between Resident 2 and his Responsible Party (RP 1). The progress note indicated RP 1 yelled at Resident 2 during the exchange.During an interview on 7/3/2025 at 12:09 PM, with LVN 1, LVN 1 stated she received training related to abuse and abuse reporting about a month ago. During a concurrent interview and record review, on 7/3/2025 at 12:18 PM, with LVN 1, Resident 2's progress note dated 6/13/2025, written by LVN 1, was reviewed. LVN 1 stated on 6/13/2025, she observed the documented exchange between Resident 2 and RP 1. LVN 1 stated Resident 2's blood pressure was elevated after the incident. LVN 1 stated she felt the exchange was possible verbal abuse and stated she reported the incident to Registered Nurse (RN) 1. LVN 1 stated she did not report the incident to any outside agencies, including the California Department of Public Health (CDPH). During an interview on 7/3/2025 at 12:47 PM, with RN 1, RN 1 stated she received training related to abuse and abuse reporting in the last month. RN 1 stated LVN 1 informed her of the incident that occurred between Resident 2 and RP 1 on 6/13/2025. RN 1 stated she did not report the suspected verbal abuse. RN 1 stated she was not responsible for reporting the incident because she was not the staff who directly observed the incident.During an interview on 7/3/2025 at 1:55 PM, with the Director of Staff Development (DSD), the DSD stated all facility staff were mandated reporters and required to report if they had knowledge of suspected abuse. The DSD stated all staff members were required to report suspected abuse, even if they did not directly witness it themselves.During a concurrent interview and record review, on 7/8/2025 at 2:01 PM, with the Director of Nursing (DON), Resident 2's progress note dated 6/13/2025 was reviewed. The progress note indicated RP 1 was yelling at the resident for approximately 10 minutes and that Resident 2 appeared visibly upset. The DON stated all staff were mandated reporters and stated the incident should have been reported in accordance with the facility's policy and procedure (P&P).During a concurrent interview and record review, on 7/8/2025 at 2:02 PM, with the DON, the facility's P&P titled Abuse and Neglect Prevention Management, revised 2/2018, was reviewed. The P&P indicated it was the facility's policy to ensure residents are safe and free from abuse. The DON stated the P&P indicated all staff were mandated reporters and that reporting of alleged abuse was to be completed according to state and federal guidance. The DON stated the incident that occurred between Resident 2 and RP 1 on 6/13/2025 met the definitions of possible mental and/or verbal abuse according to the facility's P&P. The DON stated the incident should have been reported within two hours to the CDPH and other required agencies. The DON stated RN 1 and LVN 1 were both responsible for reporting.During a review of RN 1's job description and performance standards, titled RN Supervisor, dated 6/2/2025, the document indicated the purpose of this position was to supervise and coordinate nursing care in compliance with facility policies and procedures. The document indicated RN 1 was responsible for the safety of residents under their supervision, and RN 1 was to observe all facility policies and procedures. During a review of LVN 1's job description and performance standards, titled Medication Nurse, dated 1/27/2022, the document indicated the LVN 1 was responsible for the safety of residents under their supervision, and LVN 1 was to observe all facility policies and procedures,b. During an interview on 7/3/2025 at 2:33 PM, with the SSD, the SSD stated on 6/26/2025, a meeting was held with Resident 2 following a visit from the local police department related to an Adult Protective Services report filed by RP 1. The SSD stated that during the