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	09/12/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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 protect one of three resident's (Resident 1) right to be free from physical abuse by another resident (Resident 2). This deficient practice resulted in Resident 1 being slapped on the right side of the face by Resident 2.Findings:a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/16/2025, the MDS indicated Resident 1 had severely impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 1 required supervision with eating and using a wheelchair. The MDS indicated Resident 1 required partial assistance (helper did less than half the effort) with oral hygiene and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) with toileting hygiene and showering/ bathing. The MDS indicated Resident 1 was dependent (helper did all the effort) on staff for bed-to-chair transferring. During a review of Resident 1's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's care plan titled Resident at risk for recurrent fall/injury, revised on 7/23/2025, the care plan indicated staff were to observe Resident 1 frequently and to place Resident 1 in a supervised area when out of bed.During a review of Resident 1's nursing progress notes, dated 9/10/2025 at 9:33 a.m., the nursing progress notes indicated on 9/10/2025 at 9:05 a.m., Licensed Vocational Nurse (LVN) 1 reported to Registered Nurse (RN) 1 that Resident 2 slapped Resident 1. b. 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 diagnoses included dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), and major depressive disorder. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 required setup assistance with eating, oral hygiene, toileting hygiene, and bed-to-chair transferring. The MDS indicated Resident 2 required supervision with showering/ bathing, personal hygiene, and walking. During a review of Resident 2's H&P, dated 8/18/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's care plan titled Chronic confusion related to dementia as evidenced by altered interpretation (a changed understanding or explanation of something) or response to stimuli (anything that caused a physical or behavioral change), revised on 8/29/2025, the care plan indicated staff were to maintain a pleasant and quiet environment.During a review of Resident 2's nursing progress notes, dated 9/10/2025 at 9:41 a.m., the nursing progress notes indicated on 9/10/2025 at 9:05 a.m., LVN 1 reported to RN 1 that Resident 2 slapped Resident 1. During an interview on 9/11/2025 at 11:14 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 9/10/2025 around 8:50 a.m., he informed Resident 1 that it was time to shower, and Resident 1 replied No. CNA 1 stated Resident 2 was upset because Resident 1 yelled No when getting ready for the shower. CNA 1 stated that Resident 2 was looking at Resident 1 with furrowed eyebrows before she (CNA 1) stepped out of the room to get the Hoyer lift (a device that helped move people with limited mobility safely between surfaces). CNA 1 stated she left Resident 1 in the wheelchair by her bed. CNA 1 stated she went to get the Hoyer lift to transfer Resident 1 from wheelchair to shower chair. CNA 1 stated within four seconds of leaving the room, she heard Resident 2 cursing (using rude, offensive, or swear words) at Resident 1. CNA 1 stated Resident 1 was sitting in the wheelchair next to Resident 2's left side of the bed. CNA 1 stated Resident 1 asked Resident 2 Why are you cussing at me? I never did anything to you. CNA 1 stated Resident 2 got out of the bed, cursed at Resident 1, slapped Resident 1's right side of her face and punched Resident 1's stomach. CNA 1 stated she stopped Resident 2 and separated the residents. CNA 1 stated that she would not have left Resident 1 alone in the room with Resident 2, if she had known that Resident 1 could unlock the wheelchair and wheel to Resident 2's bedside. CNA 1 stated Resident 2 was ambulatory (able to walk) and capable of being physically aggressive (ready to fight or forceful) toward other residents. CNA 1 stated she should have taken Resident 1 with her when she left the room to get the Hoyer lift to prevent Resident 2 from physically attacking Resident 1. During an interview on 9/11/2025 at 12:23 p.m. with LVN 1, LVN 1 stated on

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed nurse failed to follow physician's orders for two of three sampled residents (Resident 2 and Resident 3) when:1. Resident 2's blood pressure readings and heart rate were not recorded and documented on the Medication Administration Record (MAR), for six days in the month of August 2025 and one day in the month of September 2025.2. Resident 3's arteriovenous fistula (AV fistula, direct connection between an artery and a vein) dressing was not removed four hours after dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment on 9/10/2025 and 9/11/2025.3. Resident 3 was not administered oxygen as ordered at two liters (measurement for gas volume) per minute.4. Resident 3's oxygen saturation level (O2 sat- a measurement of how much oxygen the blood was carrying as a percentage) was not assessed on room air. These deficient practices demonstrated a lack of nursing competency in assessment, documentation, and implementation of care, which had the potential to compromise the residents' health and safety. Findings:1. 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 diagnoses included dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 8/29/2025, the MDS indicated Resident 2 had severely impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 2 required setup assistance with eating, oral hygiene, toileting hygiene, and bed-to-chair transferring. The MDS indicated Resident 2 required supervision with showering/ bathing, personal hygiene, and walking. During a review of Resident 2's History and Physical (H&P), dated 8/18/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, dated 9/11/2025, the report indicated to hold lisinopril (medication to treat high blood pressure [HTN]) and metoprolol tartrate (medication to treat HTN) for systolic blood pressure (top number in a blood pressure reading) less than 110 beats per minute (BPM) or heart rate less than 60 BPM. During a review of Resident 2's Medication Administration Records (MAR), dated from 8/1/2025 to 9/11/2025, the MAR indicated Resident 2's blood pressure was below the parameter (a set value that helped control something) and did not receive lisinopril and metoprolol on 8/2, 8/14, 8/16, 8/21, 8/23, 8/27, and 9/6/2025. During a concurrent interview and record review on 9/11/2025 at 12:23 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Vital Summary, dated from 8/1/2025- 9/11/2025 was reviewed. There were no blood pressure or heart rate readings documented on 8/2, 8/14, 8/16, 8/21, 8/23, 8/27, and 9/6/2025. LVN 1 stated that Resident 2's blood pressure or heart rate readings should be documented. LVN 1 stated the licensed nurse was responsible for taking vital signs (basic measure of how your body was working) and documenting in the residents' progress notes or MAR. LVN 1 stated the licensed nurse should have completed the documentation by the end of the shift to make sure the residents were in safe and stable condition. LVN 1 stated it was important to document the blood pressure readings and heart rate on the Vital Summary or the MAR for residents' safety. LVN 1 stated it was important to know the residents' blood pressure to prevent medication error (mistake in giving medicine). LVN 1 stated that incomplete documentation posed risks such as not knowing if Resident 2's blood pressure was too low, the next shift being unaware of prior events, difficulty tracing the resident's history, and potential delays in necessary care.During an interview on 9/12/2025 at 11:36 a.m. with the Director of Nursing (DON), the DON stated the licensed nurse should measure and document the residents' blood pressure on the MAR. The DON stated that documentation was necessary so the next shift would know the previous blood pressure reading. The DON stated it was important to document the blood pressure readings in the MAR to ensure the continuity of care. The DON stated documentation must be completed by the end of the shift to serve as a baseline for the next shift. The DON stated that documentation should be timely and accurate, and failing to document blood pressure was unacceptable. The DON stated that without documented blood pressure, administering blood pressure medication could cause hypotension (low blood pressure) leading to dizziness, weakness, or fainting. The DON stated the facility's policy required blood pressure readings to be documented in the MAR.During a review of the facility's policy and procedure (P&P) titled Vital Sign, dated 7/2012, the P&P indicated the vital signs and O2 saturations would be documented in all appropriate areas in the resident's medical record. 2a