

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of South Gate		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure non consensual sexual contact (any sexual touching or contact that occurs without the explicit [clear] and voluntary agreement with individuals involved) did not recur for two of three sampled residents (Resident 1 and Resident 2), by failing to:1). Ensure Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) meeting was conducted and plan of care with interventions created after the incident on 6/13/2025 when Resident 2 kissed Resident 1 in Resident 1's room and attempted to climb into Resident 1's bed.This failure resulted in the second nonconsensual sexual contact on 11/8/2025 when Certified Nursing Assistant 3 (CNA 3) witnessed Resident 1 placing his hand on Resident 2's upper thigh while in the family room (a room where residents gather), unsupervised by facility staff.Cross Refer to F609 and F610.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1, a male resident, was admitted to the facility on [DATE], with diagnoses including history of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) and aphasia (a disorder that makes it difficult to speak). The admission Record indicated Resident 1 had a responsible party, Family Member 1 (FM 1). During a review of Resident 1's History and Physical (H&P), dated 4/27/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 1 had unclear speech, impaired vision, and severe cognitive impairment. The MDS indicated Resident 1 did not exhibit physical behavioral symptoms toward others such as abusing others sexually or engaging in public sexual acts. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort) on staff for personal hygiene (ability to maintain personal hygiene such as combing hair or shaving), rolling left and right (the ability to roll from lying on back to left and right side), and transferrin g from sitting to lying and from lying to sitting on the side of the bed. During a review of Resident 1's progress notes, dated 6/14/2025 at 1:32 a.m., the progress notes indicated on 6/13/2025 at 7:30 p.m., a CNA (unidentified) notified Licensed Vocational Nurse (LVN) 5 Resident 2 was observed kissing Resident 1 in Resident 1's room. The progress notes indicated upon LVN 5's arrival in Room A, LVN 5 observed Resident 2 kissing Resident 1 and was attempting to climb up the bed of Resident 1 from her wheelchair. The progress notes indicated both residents (Residents 1 and 2) were separated. The progress notes indicated Residents 1 and 2 were notified that male and female residents cannot be alone in each other's room, nor can be intimate in any way while under the facility's care. The progress notes indicated Resident 1 indicated that Resident 2 kissed him and accepted it. The progress notes indicated will continue with plan of care (POC). During a review of Resident 1's clinical records since admission [DATE]), Resident 1's clinical records did not indicate notes or consent provided for a consensual relationship with other residents in the facility. During a review of Resident 1's Care Plans, dated 6/2025, the care plans did not indicate a plan of care regarding the kissing incident on 6/13/2025 was created or interventions to address unconsented kissing incidents and prevention of potential sexual abuse. During a review of Resident 1's Weekly Nursing Summary, dated 6/16/2025, the weekly summary indicated Resident 1 was verbal, alert, and confused. During a review of Resident 1's Progress Notes, dated 11/8/2025 at 2:26 p.m., the progress notes indicated a Charge Nurse (CN- unidentified) reported to Registered Nurse (RN) 4 that a CNA (unidentified) saw Resident 1 put his hands in between Resident 2's thighs while the CNA (unidentified) was passing by the family room. The progress notes indicated the (unidentified) CNA told two (2) Restorative Nursing Assistants (RNA- unidentified) who were in the hallway at the time. The progress notes indicated one RNA removed Resident 2 from the family room. During a review of Resident 1's care plan titled At risk for emotional distress related to allegation of sexual abuse against resident, dated 11/8/2025, the interventions indicated to allow resident time to answer questions and to verbalize feelings, perceptions and fears, assessment of resident, place call light within reach at all times, identify resident's coping mechanisms, monitor every shift for any signs and symptoms (S/S) of emotional distress for 3 days, monitor/document Resident 1's feelings and notify the physician (MD) and resident representative for any S/S of change of condition (COC). 2). During a review of the Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including history of hydrocephalus</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of sexual abuse (non-consensual sexual contact of any type with a resident) to the California Department of Public Health (CDPH), for one of three sampled residents (Resident 1), when Resident 2 kissed Resident 1, who did not have the capacity to understand and make decisions (consent) and was found lying in Resident 1's bed. This failure resulted in a delay in the investigation by the CDPH and placed Resident 1 at risk for further abuse by Resident 2. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) and aphasia (a disorder that makes it difficult to speak).During a review of Resident 1's History and Physical (H&P), dated 4/27/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment and did not exhibit physical behavioral symptoms toward others such as abusing others sexually or engaging in public sexual acts. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort) on staff for personal hygiene (ability to maintain personal hygiene such as combing hair or shaving), rolling left and right (the ability to roll from lying on back to left and right side), and transferring from sitting to lying and from lying to sitting on the side of the bed.During a review of Resident 1's Weekly Nursing Summary, dated 6/9/2025, the summary indicated Resident 1 was verbal, alert, and confused. During a review of Resident 1's Progress Notes, dated 6/14/2025, the progress notes indicated another resident (Resident 2) kissed Resident 1 and attempted to climb into Resident 1's bed. The progress notes did not indicate the incident was reported to the Administrator (Admin) or the CDPH.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hydrocephalus (increased pressure in the brain which could cause problems with cognition [ability to think and reason] problems) and amnesic disorder (a condition with partial or total memory loss).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment and could independently (resident completes the activity by themselves with no assistance) wheel 150 feet in a manual wheelchair. The MDS indicated Resident 2 required setup assistance (helper assists only prior to or following the activity, resident completes the activity) to transfer between a wheelchair and bed.During a review of Resident 2's Progress Notes, dated 6/13/2025, the Progress Notes indicated Certified Nurse Assistant (unnamed) reported Resident 2 kissed Resident 1 and attempted to climb into Resident 1's bed. The Progress Notes did not indicate the incident was reported to the Administrator (Admin) or the CDPH. During an interview on 11/12/2025 at 12:21 p.m. with Registered Nurse (RN) 1, RN 1 stated she was assigned to Resident 1 and Resident 2 on 6/14/2025, the day after the alleged sexual abuse between the residents and had not reported the incident to the Administrator (ADM) nor the CDPH. RN 1 stated Residents 1 and Resident 2 had cognitive impairment, and neither could consent. RN 1 also stated, Resident 2 kissing Resident 1 and the incident (on 6/14/2025) licensed nurses should have followed the abuse policy to report the allegation of sexual abuse. During a concurrent interview and record review on 11/12/2025 at 2:48 p.m. with the Director of Nursing (DON), the facility's P&P titled, Abuse and Neglect Prevention Management dated 2/2018, Resident 1's Progress Notes dated 6/2025, Resident 1's MDS, dated [DATE], and Resident 2's Progress Notes, dated 6/13/2025, were reviewed. The DON stated on 6/13/2025, Licensed Vocational Nurse (LVN) 5 notified her that Resident 2 was found kissing Resident 1 and had climbed on top of him (Resident 1) in his bed. The DON stated she did not instruct LVN 5 to report the incident to the CDPH. The DON stated nonconsensual sexual contact of any type was considered sexual abuse. The DON stated Resident 2 kissing Resident 1 was considered sexual contact and sexual abuse because Resident 1 and Resident 2 had severe cognitive impairment and neither resident could consent to sexual contact. The DON stated the incident between Resident 1 and Resident 2 should have been reported to the CDPH. The DON also stated the incident on 6/13/2025 was not reported to the CDPH in part because Resident 2 had forgotten the incident and there were no complaints from the residents or the resident representatives. The DON stated it was important to ensure allegations of sexual abuse were reported to the CDPH for resident safety. During a</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an allegation of sexual abuse (non-consensual sexual contact of any type with a resident) for one of three sampled residents (Resident 1), when Resident 2 kissed Resident 1, who did not have the capacity to understand and make decisions (consent), and was found lying in Resident 1's bed. This failure resulted in a sexual abuse not being addressed, resulting in the potential for repeated sexual abuse. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1, a male resident, was admitted to the facility on [DATE], with diagnoses including history of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) and aphasia (a disorder that makes it difficult to speak). The admission Record indicated Resident 1 had a responsible party, Family Member 1 (FM 1). During a review of Resident 1's History and Physical (H&P), dated 4/27/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 1 had severe cognitive impairment and did not exhibit physical behavioral symptoms toward others such as abusing others sexually or engaging in public sexual acts. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort) on staff for personal hygiene (ability to maintain personal hygiene such as combing hair or shaving), rolling left and right (the ability to roll from lying on back to left and right side), and transferring from sitting to lying and from lying to sitting on the side of the bed. During a review of Resident 1's Weekly Nursing Summary, dated 6/9/2025, the summary indicated Resident 1 was verbal, alert, and confused. During a review of Resident 1's Progress Notes, dated 6/14/2025, the progress notes indicated another resident, Resident 2, kissed Resident 1 and attempted to climb into Resident 1's bed. The progress notes did not indicate whether Resident 1, Resident 2, or any potential witnesses were interviewed. 2. During a review of the Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including history of hydrocephalus (increased pressure in the brain, can cause cognitive problems), bacterial diseases (illnesses caused by bacteria that can multiply and cause harm within the human body), amnesic disorder (a condition with partial or total memory loss), and mild cognitive impairment (decline in thinking, remembering, or reasoning). The admission Record indicated Resident 2 had a power-of-attorney for care (an agent who makes decisions on behalf of the resident). During a review of Resident 2's History and Physical (H&P), dated 10/28/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment and could independently (resident completes the activity by themselves with no assistance) wheel 150 feet in a manual wheelchair. The MDS indicated Resident 2 required setup assistance (helper assists only prior to or following the activity, resident completes the activity) to transfer between a wheelchair and bed. During a review of Resident 2's Progress Notes, dated 6/13/2025, the progress notes indicated another resident, Resident 2, kissed Resident 1 and attempted to climb into Resident 1's bed. The progress notes did not indicate whether Resident 1, Resident 2, or any potential witnesses were interviewed. During an interview on 11/12/2025 at 12:21 p.m. with Registered Nurse 2 (RN 2), RN 2 stated she was the RN assigned to Resident 1 and Resident 2 on 6/14/2025, the day after the sexual abuse. RN 2 stated there was no investigation into the incident. During a concurrent interview and record review on 11/12/2025 at 2:48 p.m. with the Director of Nursing (DON), the facility's P&P titled Abuse and Neglect Prevention Management, dated 2/2018, Resident 1's Progress Notes, dated 6/2025, Resident 1's MDS, dated [DATE], and Resident 2's Progress Notes, dated 6/13/2025, were reviewed. The DON stated the P&P indicated nonconsensual sexual contact of any type was sexual abuse. The DON stated that both residents' progress notes indicated Resident 2 kissed Resident 1 and kissing was considered sexual contact. The DON stated Resident 1's MDS indicated Resident 1 had severe cognitive impairment. The DON stated Resident 2's MDS indicated Resident 2 had severe cognitive impairment. The DON stated neither resident could consent to sexual contact and thus the nonconsensual kissing was sexual abuse and should have been investigated according to the P&P. The DON stated Licensed Vocational Nurse 5 (LVN 5) notified her that Resident 2 kissed Resident 1 and climbed on top of him in his bed in the evening 6/13/2025. The DON stated she did not instruct LVN 5 to investigate the incident. The DON stated the incident on 6/13/2025 was</p>		