

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 12/04/2025
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552</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 notify one of three sampled residents' (Resident 1) responsible party (RP 1), regarding the resident's refusal of shower seven times. This failure resulted in Resident 1's RP 1 not being aware of the resident's refusal of shower and resident's hygiene needs not being assisted and met. 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 history of schizophrenia (a mental illness that is characterized by disturbances in thought), traumatic (a result of trauma) subdural (within the skull) hemorrhage (bleeding within the skull, near the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance which can cause confusion, agitation, movement problems, and coma). The admission Record indicated Resident 1 had a responsible party (RP-designated decision maker), RP 1. During a review of Resident 1's History of Physical (H&P), dated 9/7/2025, the H&P indicated Resident 1 did not have capacity to understand and make medical decisions. During a review of Resident 1's care plan titled, Non-Compliance of Plan of Care, Treatment, Medications. dated 5/15/2025, one of the care plan interventions indicated to notify Resident 1's Medical Doctor (MD) and Responsible Party (RP) for non-compliance. During a review of Resident 1's Documentation Survey Report, for 10/2025, the report indicated no bathing was offered or provided from 10/10/2025 through 10/16/2025. During a review of Resident 1's progress notes, for 10/2025, the progress notes did not indicate RP 1 was notified about Resident 1's shower and complete bed bath refusals. During a concurrent interview and record review on 10/31/2025 at 11:10 a.m. with Registered Nurse 1 (RN 1), the facility's P&P titled Refusal of Treatment, dated 5/2013, Resident 1's Documentation Survey Report, dated 10/2025, Resident 1's progress notes, dated 10/2025, and Resident 1's care plan titled Non-Compliance of Plan of Care, Treatment, Medications. dated 5/15/2025, were reviewed. RN 1 stated Resident 1 refused seven of eight showers or complete bed baths and had only received one shower from 10/1/2025-10/30/2025 as indicated in the report. RN 1 stated the facility did not implement the refusal P&P and Resident 1's non-compliance care plan after each refusal. RN 1 stated partial and other baths were only offered as alternatives after Resident 1 refused a complete bed bath and shower. RN 1 stated the 14 other and partial baths as indicated in Resident 1's Documentation Survey Report indicated Resident 1 refused full head-to-toe bed bath and shower. RN 1 stated the P&P and care plan intervention for Resident 1's refusal of shower should have been followed, including notifying the RP time Resident 1 refused complete bed bath or shower on 10/7/2025, 10/10/2025, 10/14/2025, 10/17/2025, 10/21/2025, 10/24/2025, and 10/28/2025. RN 1 stated the P&P titled Refusal of Treatment indicated, the date and time of the shower attempts, Resident 1's response and the reason for refusal, name of the person offering the shower, education about the risk of refusal, and any adverse effects from the refusal, should have been documented in the progress notes, but were not. RN 1 stated there was no documentation in the progress notes that RP 1 was notified about Resident 1's refusals to be bathed or showered. RN 1 stated not notifying RP 1 about Resident 1's refusal of care was a violation of the RP's rights. During an interview on 10/31/2025 at 12:20 p.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated other bath indicated Resident 1 frequently refused showers and only accepted showers when RP 1 was present. CNA 3 stated other bath meant Resident 1 was cleaned from waist to toe, partial bath meant Resident 1 was cleaned from neck to toe, and completed bed bath meant Resident 1 was completely cleaned from head to toe. CNA 3 stated Resident 1's refusal should have been documented alongside the alternate interventions of other and partial bath to show that complete baths and showers were offered to Resident 1. During an interview on 11/3/2025 at 12:20 p.m. with the Director of Nursing (DON), the DON stated Resident 1's care plan was not followed when the facility did not notify RP 1 of Resident 1's seven shower refusals. The DON stated the facility should have documented in Resident 1's progress notes about the refusal, how Resident 1 responded, and how Resident 1's care was provided. During a review of the facility's P&P titled Refusal of Treatment, dated 5/2013, the P&P indicated documentation pertaining to refusal of treatment should include the treatment refused, the resident's response and reason for refusal, and that the resident was informed of the purpose of treatment and consequences of not receiving the treatment.</p>		