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	03/10/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the physician for five of five sampled residents (Resident 2, 3, 4, 5, and 6).This failure resulted in residents' delay in receiving prescribed medications, which could lead to adverse drug reactions and ineffective treatment of medical conditions.Findings:a. During a review of Resident 2's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 2/17/2026 with diagnoses including type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor would healing) and hypertension (HTN- high blood pressure).During a review of Resident 2's Medication Administration Record (MAR) dated March 2026, the MAR indicated metformin (medication that treats high blood sugar) oral (by mouth) tablet 1000 milligram (mg- unit of measurement) was scheduled for 7:30 a.m.During a concurrent observation and interview on 3/10/2026 at 9:55 a.m. with Licensed Vocational Nurse (LVN) 1 outside of Resident 2's room, LVN 1 stated she was going to administer metformin 1000 mg tab to Resident 2. LVN stated metformin was scheduled to be given at 7:30 a.m. and stated the medication was being administered late.During an observation on 3/10/2026 at 10:00 a.m. in Resident 2's room, LVN 1 handed the metformin to Resident 2. Resident 2 refused to take the metformin pill and stated that his primary care physician (PCP) instructed him to take metformin along with his last bite of breakfast. Resident 2 stated he was supposed to take the medication with his breakfast and not two hours later.b. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 2/23/2026 with diagnoses including type 2 diabetes mellitus and hypertension.During a review of Resident 3's MAR dated March 2026, the MAR indicated clonidine (medication that relaxes blood vessels) 0.1 mg oral tablet scheduled for 9:00 a.m.During a concurrent observation and interview on 3/10/2026 at 10:18 a.m. with LVN 2, outside of Resident 3's room, LVN 2 stated he was preparing Resident 3's medications. LVN 2 stated he was going to administer clonidine 0.1 mg tablet to Resident 3 which was scheduled to be administered at 9:00 a.m. but he was running behind on passing medications.c. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 10/8/2025 and re-admitted the resident on 12/18/2025 with diagnoses including congestive heart failure (condition where the heart is unable to pump blood efficiently) and atrial flutter (abnormal heart rhythm).During a review of Resident 4's MAR dated March 2026, the MAR indicated, glipizide (medication that lowers high blood sugar level) 2.5 mg oral tablet was scheduled for 7:30 a.m.During an observation on 3/10/2026 at 10:40 a.m. with LVN 1 outside of Resident 4's room, LVN 1 was observed administering glipizide 2.5 mg tablet to Resident 4.d. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023 and re-admitted the resident on 12/28/2023 with diagnoses including hypertension and congestive heart failureDuring a review of Resident 5's MAR dated March 2026, the MAR indicated carvedilol (medication that treats heart problems and high blood pressure) 25 mg oral tablet was scheduled for 7:30 a.m. and furosemide (medication that removes excess water and salt in the body) 20 mg oral tablet was scheduled for 9:00 a.m.During a concurrent observation and interview on 3/10/2026 at 10:28 with LVN 2, outside of Resident 5's room, LVN 2 stated he was (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preparing Resident 5's medications. LVN 2 stated he was going to administer carvedilol 25 mg tablet which was scheduled for 7:30a.m. and furosemide 20 mg tablet which was scheduled for 9:00 a.m.e. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 10/18/2024, and re-admitted the resident on 2/24/2026 with diagnoses including end stage renal disease (condition where the kidneys stop working) and hydrocephalus (condition where to much fluid build inside the brain).During a review of Resident 6's MAR dated March 2026, the MAR indicated levetiracetam (medicine used to treat seizures) 500 mg oral tablet was scheduled at 9:00 a.m. and valproic acid (medication that helps stop seizures and treats mood swings) 250 mg oral capsule was scheduled for 9:00 a.m.During a concurrent observation and interview on 3/10/2026 at 10:45 a.m. with LVN 2, outside of Resident 6's room, LVN 2 stated he was preparing Resident 6's medications. LVN 2 stated he was going to administer levetiracetam 500 mg oral tablet and valproic acid 250 mg oral tablet to Resident 6. LVN stated levetiracetam and valproic acid were scheduled for 9:00 a.m.During an interview on 3/10/2026 at 2:36 p.m. with LVN 1, LVN 1 stated nurses administer medications one hour before or one hour after scheduled time per physician's order. LVN stated that timely pain medications prevent unnecessary discomfort and pain, diabetes medications often require food for proper absorption, late seizure medications increases seizure risk, and delayed blood pressure medications can affect blood pressure control.During an interview on 3/10/2026 at 2:57 p.m. with LVN 2, LVN 2 stated medications must be given on time, especially those administered multiple times a day, to avoid doses being given too close to each other. LVN 2 stated staff has a oneˆhour window before and after the medication scheduled time of the physician's order, and giving blood pressure or seizure medications late can result in elevated blood pressure or increased seizure risk for residents.During an interview on 3/10/2026 at 4:36 p.m. with Assistant Director of Nursing (ADON), the ADON stated medications should be given on time for maximum effect, with a oneˆhour window before or after the scheduled time. ADON stated that diabetic medications must be given with meals to prevent low blood sugar. ADON stated some blood pressure medications may cause stomach problems if not given with food and may not control blood pressure effectively if administered late.During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure in Medication Administration dated July 2013, the P&P indicated, Drugs must be administered in accordance with the written orders of the attending physician.Medication must not be prepared in advance and must be administered within one hour before or after administration time per M.D. [doctor] order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 disinfected the glucometer (device to measure blood sugar) and blood pressure cuff when used between two of four sampled residents (Resident 3 and Resident 5).This failure had the potential to place the residents at risk for cross-contamination and infections, compromising residents' overall health and safety.Findings:During a review of Resident 3's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 2/23/2026 with diagnoses including Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN-high blood pressure).During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023 and re-admitted the resident on 12/28/2023 with diagnoses including muscle weakness and hypertension.During a concurrent observation and interview on 3/10/2026 at 10:18 a.m. with LVN 2 outside of Resident 3's room, LVN 2 was observed walking out of Resident 3's room and placed the glucometer and blood pressure cuff on top of the medication cart 1. LVN 2 stated he had just checked Resident 3's blood sugar and blood pressure. LVN 2 did not disinfect the glucometer or blood pressure cuff after use.During an observation on 3/10/2026 at 10:22 a.m. in Resident 3's room, LVN 2 administered Resident 3's medications. LVN 2 then walked out of Resident 3's room, grabbed the glucometer that was on top of medication cart 1, and placed it inside a medication cart 1 drawer without disinfecting. LVN 2 then positioned medication cart 1 outside of Resident 5's room.During a concurrent observation and interview on 3/10/2026 at 10:28 a.m. with LVN 2 outside of Resident 5's room, LVN 2 stated he was going to check Resident 5's blood pressure before medication administration. LVN 2 took the same blood pressure cuff from the medication cart 1 and proceeded to check Resident 5's blood pressure. LVN 2 did not disinfect the blood pressure cuff before or after using on Resident 5.During an interview on 3/10/2026 at 2:57 p.m. with LVN 2, LVN 2 stated he did not disinfect the glucometer after he checked Resident 3's blood sugar and before placing the glucometer back in the medication cart 1 drawer. LVN 2 stated he did not disinfect the blood pressure cuff before and after using the blood pressure cuff to check Resident 5's blood pressure. LVN 2 stated not disinfecting the glucometer and blood pressure cuff between residents could have resulted in contagious infections being passed on from one resident to another.During an interview on 3/10/2026 at 3:15 p.m. with the Infection Control Nurse (ICN), the ICN stated glucometers and blood pressure cuffs were cleaned and disinfected between residents and before and after each use. The ICN stated the importance of disinfecting the equipment was to prevent passing on infections, and failing to do so could cause infections to be spread from person to person.During an interview on 3/10/2026 at 4:36 p.m. with Assistant Director of Nursing (ADON), the ADON stated glucometers and blood pressure cuffs needed to be disinfected before and after each use and failing to do so could cause outbreaks of infections within the facility.During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated October 2018, the P&P indicated, Reusable items are cleaned and disinfected or sterilized between residents.Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions.During a review of glucometer's Assure Manufacturer's Guide undated instructions, the instructions indicated, The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of blood-borne pathogens [blood germs].