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	03/19/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from verbal and mental abuse for two of three sampled residents (Resident 2 and Resident 3).This deficient practice resulted in Resident 1 verbally and mentally abusing Residents 2 and 3.Findings:1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included chronic respiratory failure with hypoxia (the body or brain is not getting enough oxygen), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and difficulty walking.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 3's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 3 required setup assistance (helper sets up or cleans up, resident completes activity) from staff with activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 3's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions.During an interview on 3/18/2026 at 10:03 a.m., Resident 3 stated her roommate (Resident 1) was not mentally stable and frequently used profanity towards staff and visitors. Resident 3 stated it was a sad experience sharing a room with Resident 1. Resident 3 stated she was scared and mentally exhausted.2. 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 type 2 diabetes mellitus, peripheral vascular disease (PVD- a slow progressive narrowing of the blood flow to the arms and legs), and hypertension (high blood pressure).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was independent with eating, oral hygiene, and toileting.During a review of Resident 2's H&P, dated 2/27/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions.During an interview on 3/18/2026 at 10:10 a.m., with Resident 2 (Resident 1's roommate), Resident 2 stated, Resident 1 had repeatedly called her offensive names. Resident 2 stated she felt neglected and verbally abused. Resident 2 stated Resident 1's mental condition was not a justification (a reason why something is okay) for exposing others to verbal abuse and yelling. Resident 2 stated the facility should have stepped in to help from the beginning.3. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included bipolar disorder (sometimes called manic- depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and dementia (a progressive state of decline in mental abilities) with behavioral disturbance.During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 required setup and clean-up assistance (helper sets up or cleans up, resident completes activity) from staff with ADLs.During a review of Resident 1's H&P, dated 11/15/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During an attempted interview on 3/18/2026 at 11:00 a.m., with (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1, Resident 1 became verbally aggressive and started yelling profanity. During an interview on 3/19/2026 at 9:00 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated abuse included verbal actions such as yelling and using profanity. LVN 1 stated this behavior could cause emotional harm to another resident. LVN 1 stated cognitive impairment did not excuse the impact of that behavior on others.During an interview on 3/19/2026 at 10:00 a.m., with the Administrator (ADM), the ADM stated he was the abuse coordinator and ensured the facility maintained a safe, respectful, abuse-free environment at all times. The ADM stated this included making sure staff were properly trained to recognize and report abuse and ensuring timely intervention to protect resident rights.During an interview on 3/19/2026 at 10:08 a.m., with the Director of Nursing (DON), the DON stated abuse included any behavior that caused harm, including verbal and emotional harm such as yelling, name calling, or intimidation. The DON stated regardless of a resident's cognitive status, the facility has the responsibility to protect all residents from abuse.During a review of the facility's Policy and Procedure (P&P) titled, Abuse and Neglect Prevention Management, revised 2/2018, the P&P indicated, the facility is committed to protecting residents against all forms of abuse, potential abuse, and to ensure residents safety, and neglect by staff members, other residents or any individuals.