

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 05/31/2024
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to obtain informed consent prior to the administration of psychotropics (medications that affect the mind, emotions, and behavior) for three out of five residents (Resident 31 and 32). This deficient practice placed Residents 31 and 32 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication or intervention) related to psychotropic medication use and removed the residents' rights to make decisions about the care and treatments they received in the facility. Findings: a. A review of Resident 31's Admission Record indicated Resident 31 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 31's admitting diagnoses included schizoaffective disorder (a mental health condition that is a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms such as depression and a milder form of mania), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). A review of Resident 31's History and Physical (H&P), dated 12/10/2023, indicated Resident 31 had fluctuating capacity to understand and make decisions. A review of Resident 31's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/5/2024, indicated Resident 31 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 31 required total assistance with toileting hygiene, showering/bathing, and dressing. A review of Resident 31's Physician Orders, dated 6/30/2022, indicated Resident 31 was prescribed Depakote (medication used to treat mood disorder) 1500 milligrams ([mg] a unit of weight measurement) at bedtime for schizoaffective disorder. A review of Resident 31's Informed Consent for Psychotherapeutic Drugs (drugs used to treat psychosis), dated 6/30/2022, indicated an informed consent was provided to Resident 31's family member (FM 4) for the use of Depakote. The consent further indicated there was no verification signature from FM 4. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056458	Facility ID: 056458 If continuation sheet Page 1 of 93

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 31's Physician Orders, dated 11/30/2023, indicated Resident 31 was prescribed Risperdal (medication used to treat psychotic disorders) 3 mg two times a day for schizoaffective disorder manifested by hearing and talking to voices. A review of Resident 31's Informed Consent for Psychotherapeutic Drugs, dated 3/27/2024, indicated an informed consent was provided to FM 5 for the use of Risperdal. The consent further indicated there was no verification signature from FM 5. A review of Resident 31's Medication Administration Record (MAR), dated 5/2024, indicated Resident 31 received Risperdal 3mg every day, twice a day for the month of May 2024. The MAR indicated Resident 31 received Depakote 1500 mg every night for the month of May 2024. b. A review of Resident 32's Admission Record indicated Resident 32 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 32's admitting diagnoses included anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), history of falling, insomnia (a sleep disorder), altered mental status (mentally declining), and dementia (a disorder where loss of memory, language, problem-solving, and other thinking abilities are impaired and interfere with daily life). A review of Resident 32's H&P, dated 8/19/2023, indicated Resident 32 did not have capacity to understand and make decisions. A review of Resident 32's MDS, dated [DATE], indicated Resident 32 was severely cognitively impaired. The MDS indicated Resident 32 required total assistance with toileting hygiene, showering/bathing, and dressing. A review of Resident 32's Physician Orders, dated 2/27/2024, indicated Resident 32 was prescribed Lorazepam (medication used to treat anxiety) 1 mg tablet at bedtime for sundown syndrome (a state of confusion that occurs in the late afternoon and lasts into the night manifested by increased confusion, anxiety, or aggression). A review of Resident 32's Informed Consent for Psychotherapeutic Drugs, dated 2/27/2024, indicated an informed consent was provided to Resident 32's family member (FM 3) for the use of Lorazepam. The consent further indicated there was no verification signature from FM 3. A review of Resident 32's MAR, dated 5/2024, indicated Resident 32 received Lorazepam 1 mg every night for the month of May 2024 on except 5/14/2024. During a concurrent observation and interview on 5/29/2024 at 10:32 a.m., with Licensed Vocational Nurse (LVN) 6, Resident 32 was observed sleepy but arousable. LVN 6 stated Resident 32 was probably sleepy from receiving Lorazepam the night before due to sun downing. LVN 6 stated she received report that Resident 32 was trying to roll over from the bed and onto the floor. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/2024 at 8:05 a.m., with Registered Nurse (RN) 1, Resident 31's Informed Consent for Psychotherapeutic Drugs, dated 6/30/2022 and 3/27/2024, and Resident 32's Informed Consent for Psychotherapeutic Drugs, dated 2/27/2024 was reviewed. RN 1 stated the process for informed consent was for the physician to assess the resident first and then receive informed consent from the resident or responsible party. RN 1 stated the informed consent for Resident 31 and Resident 32 did not have any signatures from their responsible parties, and that there should be a signature from either the residents' or their responsible parties on the consent form. During an interview on 5/30/2024 at 9 a.m., with FM 5, FM 5 stated she never received a phone call from Resident 31's physician or anyone regarding psychiatric medications. A review of the facility policy and procedure (P&P) titled, The use of Psychotropic Medication, dated 1/2024, indicated the facility will comply with regulatory requirements related to the use of psychotropic medications which included documenting discussions with resident and or responsible party regarding the risk versus benefit of the use of medications (informed consent). A review of the California Department of Public Health All Facilities Letter (AFL, a letter from the Center for Health Care Quality (CHCQ), Licensing and Certification [L&C] Program to health facilities that are licensed or certified by L&C), AFL 24-08, dated 2/28/2024, indicated facility's must obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and consent renewal every six months, which must be signed by the resident or resident's representative.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on interview and record review, the facility failed to honor a resident's preference to have a female staff member escort the resident to clinic visits outside of the facility for one of one sampled resident (Resident 84's). This deficient practice caused Resident 84 to repeatedly be accompanied to appointments by a male staff member despite Resident 84's wishes to have a female escort. This failure also had the potential to cause unnecessary psychological harm to the resident. Findings: A review of Resident 84's Admission Record, dated 5/30/2024, indicated Resident 84 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 84's diagnoses included left hip fracture (a partial or complete break of the thigh bone, where it meets the pelvic bone), syncope (fainting) and collapse, hypertension (high blood pressure), type 2 diabetes (too much sugar circulating in the blood) hyperlipidemia (an abnormally high concentration of fat particles in the blood), and osteoarthritis (inflammation and swelling that occurs in the joints when the flexible tissue at the ends of bones begin to wear down over time). A review of Resident 84's History and Physical (H&P) dated 4/24/2024, P indicated Resident 84 had the capacity to understand and make decisions. A review of Resident 84's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/15/2024, indicated Resident 84 had a Brief Interview for Mental Status (BIMS - a screening tool used to identify the cognitive condition of residents upon admission into a long-term care facility) of 14 (cognitively intact, normal BIMS score is 13-15). The MDS also indicted Resident 84 required minimal assistance with eating, partial assistance with oral and personal hygiene and maximal assistance with toileting and bathing. The MDS indicated Resident 84 required extensive assistance with transfers, walking, toilet use, and limited assistance with dressing, eating and personal hygiene. A review of Resident 84's Care Plans on 5/30/2024, indicated the facility did not develop a care plan addressing Resident 84's preference to be accompanied by a female staff member during outside appointments. A review of Resident 84's Nursing Progress Notes on 5/30/2024, indicated Resident 84's preference to have a female escort for outside appointments was not addressed. A review of Resident 84's Social Services Progress Notes on 5/30/2024, indicated Resident 84's preference to have a female escort for outside appointments was not addressed. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2024 at 4:20 p.m. with Resident 84, Resident 84 stated she continued to have a male staff member as an escort to clinic appointments even though she repeatedly informed staff and the Social Services Director (SSD) that she preferred a female escort. Resident 84 stated that she reached out to the SSD two to three days in advance but was still given a male escort for her obstetrics and gynecology (OB/GYN) appointment. Resident 84 stated that the appointment was a waste of time because she refused to be examined and get undressed in front of the male escort. Resident 84 stated that her appointment had to be rescheduled. Resident 84 stated she developed vaginal bleeding but the appointment had to be delayed because the facility did not provide her with a female escort as requested. Resident 84 stated she has also had a male escort accompany her to her podiatry (pertaining to the feet) appointments even though she has asked for a female escort. Resident 84 stated that on one occasion the facility wanted to cancel her appointment at the last minute because they did not have a female staff member to escort her to the appointment. Resident 84 stated that she could not understand why the facility could not provide a female escort since they were aware of her clinic appointment schedule in advance. During a concurrent interview and record review on 5/30/2024 at 10:50 a.m. with Registered Nurse (RN) 1, Resident 84's medical record was reviewed. RN 1 stated the SSD was the one who assisted residents with coordinating transportation and assigning escorts to accompany the residents to clinic appointments. RN 1 stated that the facility would attempt to accommodate certain preferences of the residents when scheduling appointments. RN 1 stated that ideally the facility needed at least 3 days to set up the transportation for residents. RN 1 stated that the facility had dedicated staff members to escort the residents to these appointments. RN 1 stated that the SSD had a team that accompanied the residents, but if all the dedicated staff were occupied, then the SSD asked another team member to go out with the resident. RN 1 stated Resident 84's transportation and preferences were communicated by the SSD through the electronic medical records system however the information was temporary and was not a part of a resident's medial record. RN 1 stated that this was where the SSD gave details regarding the residents' transportation. RN 1 stated that she was aware of Resident 84's preference to only have a female escort but stated that she could not find any documentation regarding Resident 84's preferences in the resident's medical record. RN 1 stated Resident 84's preferences should be documented in the medical record and care planned because it was not good to use word of mouth as a form of communication. RN 1 agreed that the lack of documentation regarding Resident 84's preference for a female escort was probably why the resident's preference was overlooked. During a concurrent interview and record review on 5/30/2024 at 11:04 a.m. with the SSD, the social services progress notes were reviewed. SSD stated that she had two escorts to accompany residents during outside appointment. The SSD stated she had one male and one female escort. The SSD stated that she was not initially aware of Resident 84's preference of a female escort until after the resident returned from her orthopedic appointment with the male escort on 5/13/2024. The SSD stated that Resident 84 complained at that time that her preference was to have a female escort that spoke English to accompany her. The SSD stated that did not have any documentation regarding Resident 84's preference for a female escort in her notes. The SSD stated that she did not document Resident 84's preferences in the medical records because the resident might have changed her mind. The SSD stated that documentation would have helped in communicating Resident 84's preferences to other staff especially if she (SSD) was not available. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/2024 at 2:46 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that resident's preferences should be communicated in the progress notes and the SSD should have put something in the notes regarding Resident 84's preferences. The ADON stated that Resident 84's preferences should have been care planned. The ADON stated that since Resident 84's preference to have a female escort during outside appointments was not documented, the preferences could not be implemented. The ADON stated that when Resident 84's preferences were not communicated, it could make Resident 84 feel like she was not being heard. A review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, dated January 2024, indicated the resident's individual needs and preference are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The P&P indicated that resident's individual needs and preferences, including the need for adaptive devices and modifications to physical environment are evaluated upon admission and reviewed on an ongoing basis. The P&P indicated that in order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. A review of the facility's P&P titled, Dignity, dated January 2024, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated that the facility culture supports dignity and respect for resident by honoring resident goals, choices, preferences, values and beliefs and individual needs and preferences of the resident are identified through the assessment process.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to notify the primary physician of the change in condition of decline in range of motion (ROM, full movement potential of a joint [where two bones meet]) in both ankles for one of four sampled residents (Resident 53), who had limited mobility (ability to move) concerns. This deficient practice resulted in Resident 53's development of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to both ankles. Cross reference F688 and F726. Findings: A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's admission Rehab Screening Form (brief assessment of a resident's abilities), dated 12/23/2023, indicated Resident 53 did not have any contractures, did not have any ROM impairments in both arms, but had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53's left leg was within functional limits ([WFL] sufficient movement without significant limitation) and the right leg had tightness into flexion (bending the leg at the hip joint toward the body) and abduction (moving the leg away from the body). The Rehab Screening Form recommendation indicated to provide Resident 53 with Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) for AAROM exercises on both arms and both legs, three to five times per week (3-5x/week) as tolerated. A review of Resident 53's physician orders, dated 5/1/2023, indicated for the RNA to provide Resident 53 with PROM on both arms and both legs, 3-5x/week with one person assist as tolerated. A review of Resident 53's physician orders, dated 3/25/2024, indicated for RNA to provide PROM on both arms and both legs, followed by the application of both elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours (4-6 hours), 3-5x/week. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 4/2/2024, indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember) and did not have any ROM impairments to both arms and both legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. A review of Resident 53's quarterly Rehab Screening Form, dated 4/9/2024, indicated Resident 53 did not have any contractures, did not have any ROM impairments in both arms, but had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue RNA ROM exercise program. During a concurrent interview and record review on 5/28/2024 at 10:48 a.m. with the Director of Rehabilitation (DOR), the facility's Rehab Screening Form was reviewed. The DOR stated the Rehab Screening Form was completed upon a resident's admission, quarterly, change of condition, and annually. The DOR stated ROM was assessed as either having no impairment, impairment on one side, or impairment on both sides. The DOR stated the Rehab Screening Form did not include a ROM assessment for limitations in each joint of the arms (shoulders, elbows, wrists, and hands) and the legs (hips, knees, ankles). During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the head-of-bed (HOB) elevated. Resident 53's elbows were in a bent position. Restorative Nursing Assistant (RNA) 3 performed ROM exercises on both of Resident 53's arms and then applied both elbow splints. Resident 53's legs were rotated away from the body, both knees were bent, and both ankles were positioned in plantarflexion (ankles bent with toes pointing away from the body). RNA 3 performed ROM exercises on Resident 53's right leg, including hip abduction (moving the leg away from the body) and adduction (returning the leg toward the body), hip rotation clockwise and counterclockwise while the knee was extended, hip flexion (bending the leg at the hip joint toward the body) with knee flexion (bending the knee), and ankle rotation. RNA 3 did not move Resident 53's right ankle into dorsiflexion (ankle bent with toes pointing toward the body). RNA 3 performed ROM exercises on Resident 53's left leg, including hip abduction, hip rotation clockwise and counterclockwise with the knee extended, hip flexion with knee flexion, and ankle rotation. RNA 3 did not move Resident 53's left ankle into dorsiflexion. During a concurrent interview and record review on 5/29/2024 at 4:23 p.m. with the DOR, Resident 53's admission Rehab Screening Form, dated 12/23/2022 was reviewed. The DOR stated Resident 53 had ROM impairments in the right leg due to tightness in the hip. The DOR stated Resident 53 did not have any contractures in either leg upon admission. During an observation on 5/29/2024 at 4:38 p.m., in Resident 53's room, with the DOR, Resident 53 was observed lying in bed with a bed sheet covering both legs. The DOR lifted the blankets to view both legs. Both of Resident 53's ankles were positioned in plantarflexion. The DOR attempted to provide ROM to Resident 53's ankles into dorsiflexion, but Resident 53's ankles continued to be positioned in plantarflexion. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview and record review, the facility staff failed to ensure one of six sampled residents (Resident 32) was free from an unnecessary physical restraint, as evidenced by: 1. Failing to ensure appropriate assessment for less restrictive measures prior to using a physical restraint for Residents 32. 2. Failing to obtain a physician order for the use of bed against the wall used as a physical restraint for Resident 32. 3. Failing to obtain a consent form for the use of a physical restraint, and of side rails for Resident 32. These deficient practices placed Resident 32 at risk for entrapment (when a person is trapped by the bed rail in a position they cannot move from) and had the potential to cause psychosocial harm from not being treated with dignity and respect. Findings: During an observation on 5/28/2024 at 11:32 a.m., in Resident 32's room, Resident 32 was observed lying in bed, eyes closed, visibly sleeping. Resident 32's bed was observed against the wall on the right side, big mattress on the floor on the left side of Resident 32's bed, and bilateral siderails in upper position. A review of Resident 32's Admission Record (Face Sheet), the Face Sheet indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a loss of brain function such as memory, thinking, language, behavior), anxiety (a feeling of worry or fear), hypertension (high blood pressure), and muscle weakness (loss of muscle strength). A review of Resident 32's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 3/15/2024, the MDS indicated Resident 32 makes self-understood and understand others. MDS indicated Resident 32 require maximum assistance (helper does more than half the effort) from staff for toileting hygiene, shower, and personal hygiene. A review of Resident 32's Interdisciplinary Team ([IDT]-a coordinated group of experts from several different fields who work together), dated 3/15/2024, the IDT indicated Resident 32's family requested for Resident 32 bed to be positioned against the wall. During a concurrent observation and interview on 5/28/2024 at 11:34 a.m., in Resident 32's room with Certified Nurse Assistant (CNA2). CNA 2 stated Resident 32 is at risk for falls, and injuries. CNA 2 stated the facility uses a mattress on the floor, and siderails for residents at high risk for falls. CNA 2 stated she was not sure if siderails were considered restraint. CNA 2 stated Resident 32's bed against the wall was considered a physical restraint and should be removed right away. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2024 at 12:40 p.m., with Registered Nurse1 (RN1), RN1 stated the facility placed Resident 32's bed against the wall to prevent Resident 32 from getting out of bed unassisted and to prevent Resident 32 from falling and having an injury. RN1 stated Resident 32 as at risk for falls. RN1 stated siderails and a bed against the wall was a physical restraint and should not be used for staff convenience. During a concurrent interview and record review on 5/29/2024 at 11:22 a.m., with RN1, Resident 32's Electronic Medical Record (EMR) was reviewed. RN1 stated there was no documentation on least restrictive measures were implemented prior placing bed rails, and bed against the wall. RN 1 stated there was not a physician order for the use of restraints for Resident 32. RN 1 stated there was not a consent form signed by Resident 32, or Resident 32's responsible party for the use of physical restraints or siderails. A review of facility policy and procedure (P&P) titled Use of Restraints, revised 12/14, the P&P indicated. Physical Restraints are defined as any manual method of physical device, which restricts freedom of movement. 1. Restraint shall be only used for the safety and well-being of the resident(s). 2. If the resident cannot remove a device in which the staff applied it given that resident's physical condition (side rails are put back down, rather that climbed over), that device is considered a restraint. 3. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and /or responsible party. 4. Family and /or responsible party members may not give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary. 5. Facility staff will not use a restraint based solely of family request. A review of facility's P&P titled Policy and Procedure on Restraint, revised 7/2012, the P&P indicated: 1. Physical restraint will never be used for the convenience of the staff. 2. Residents are to be evaluated regarding safety measures, including the use of physical restraint. 3. Based on the assessment result if physical restraint is needed consent will be obtained by the doctor from the resident/ resident representative or both of use of such restraint. 4. All necessary and possible human approaches should be implemented before the use of restraint. A review of facility's P&P titled Policy and Procedure on Side Rails, revised 5/12, the P&P indicated: (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical Director (MD) should obtain informed consent from resident, resident representative, or both before an order for a physical restraint such as side rails could be carried out by the licensed nurses. 2. Licensed nurse receiving the order from MD should verify from resident or resident representative or both that consent was obtained by the MD from him/her. 3. Documentation of the reason for side rails implementation with the obtained consent of MD from resident, resident representative, or both.		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) signed the Minimum Data Set (MDS, a resident standardized assessment and care-screening tool) assessments for four of 26 sampled residents (Resident 53, 61, 56, and 3) and failed to ensure the MDS assessment was complete prior to certification (action or process of providing someone or something with an official document attesting to a status of level of achievement) of completion. This deficient practice had the potential to affect the provision of care and provided inaccurate information upon submission to the Federal database. Findings: a. A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's MDS, dated [DATE], indicated the MDS Coordinator (MDS 1) signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 1/3/2023. Resident 53's MDS Section Z - Assessment Administration indicated MDS 1 completed Sections A, B, C, G, GG, H, I, J, portions of K, L, M, N, O, and P on 1/10/2023. A review of Resident 53's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 4/7/2023. A review of Resident 53's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 7/12/2023. A review of Resident 53's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 10/8/2023. Resident 53's MDS Section Z - Assessment Administration indicated the Social Services Designee completed Section D, E, and Q0110C on 10/13/2023. A review of Resident 53's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 1/6/2024. Resident 53's MDS Section Z - Assessment Administration indicated MDS 1 completed Section A, B, C, G, GG, H, I, J, L, M, N, O, P, Q, and S on 1/10/2024. (continued on next page)		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 53's MDS, dated [DATE], indicated the MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 4/15/2024. Resident 53's MDS Section Z - Assessment Administration indicated MDS 1 completed Section A, B, C, G, GG, H, I, J, L, M, N, O, P, Q, S, and X on 5/29/2024 (more than month after the assessment completion date). b. A review of Resident 61's Admission Record, indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included cerebral palsy (condition marked by impaired muscle coordination and/or other disabilities, typically caused by damage to the brain before or at birth), type 2 diabetes mellitus (high blood sugar), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) of both knees, muscle weakness, and attention to gastrostomy. A review of Resident 61's MDS, dated [DATE], indicated the MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 10/23/2023. A review of Resident 61's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 2/1/2024. Resident 61's MDS Section Z - Assessment Administration indicated MDS 1 completed Sections A, B, C, GG, H, I, J, L, M, N, O, P, and portions of Section Q on 2/13/2024. A review of Resident 61's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 5/3/2024. Resident 61's MDS Section Z - Assessment Administration indicated MDS 1 completed Sections A, B, C, GG, H, I, J, L, M, N, O, P, and X on 5/29/2024. c. A review of Resident 3's Admission Record, indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included type 2 diabetes mellitus (high blood sugar), myocardial infarction (heart attack), hemiplegia or hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (stroke, brain damage due to a loss of oxygen to the area) affecting the right dominant (used most often) side, dysphagia (difficulty swallowing), acquired absence of the left toes, and acquired absence of the right leg below the knee. A review of Resident 3's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 5/3/2024. Resident 3's MDS Section Z - Assessment Administration indicated MDS 1 completed Section A, B, C, G, GG, H, I, J, L, M, N, O, P, and X on 5/29/2024. d. A review of Resident 56's Admission Record, indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, hemiplegia or hemiparesis following a cerebrovascular disease affecting the left dominant side, aphasia (loss of ability to understand or express speech as a result of brain damage), and dysphagia. A review of Resident 56's MDS, 12/17/2023, indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 12/29/2023. A review of Resident 56's MDS, dated [DATE], indicated MDS 1 signed the assessment as the RN Assessment Coordinator verifying the assessment completion on 3/21/2024. (continued on next page)		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/2024 at 3:36 p.m. with MDS 1, MDS 1 stated he was a Licensed Vocational Nurse (LVN) and stated the Director of Nursing (DON) signed the facility's MDS assessments. A review of the Federal Resident Assessment Instrument ([RAI] comprehensive assessment, which includes the MDS, to assist nursing homes in providing appropriate and overall care to residents) User's Manual, effective date 10/1/2023, indicated federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. The RAI User's Manual further indicated the actual date the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator must be equal to the latest date, or later than the date(s) completed by assessment team members.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility failed to ensure the Preadmission Screening and Resident Review ([PASRR] resident screening prior to admission, to determine if the person has, or is suspected of having, a mental illness) Level I screen was completed accurately for one of one resident, (Resident 22). This deficient practice had the potential for Resident 22 to not receive the necessary and appropriate behavioral treatment and services and placed Resident 22 at risk for further complications of schizophrenia (mental illness that effects how person thinks, feels, and behaves) and major depressive disorder (a mental health condition that causes loss of interest in activities of daily living). Findings: A review of Resident 22's Admission Record (Face Sheet), the Face Sheet indicated Resident 22 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including schizophrenia, major depressive, Chronic Obstructive Pulmonary Disease ([COPD]- a lung disease causing restricted airflow and breathing problems), diabetes (high blood sugar),heart failure (a condition when your heart doesn't pump enough blood for your body's needs), and muscle weakness(loss of muscle strength). A review of Resident 22's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 4/21/2024, the MDS indicated Resident 22 was able to be self-understood and had the ability to understand others. The MDS indicated Resident 22 required maximum assistance (helper does more than half the effort) from staff for dressing, toilet use, personal hygiene, and was dependent (helper does all the effort) from staff with transfers, and showers. A review of Resident 22's PASRR, dated 11/25/2023, in Section III indicated that Resident 22 did not have a Serious Mental Illness and was inaccurate. During an interview on 5/30/2024 at 10:29 a.m., with Registered Nurse (RN1). RN1 stated a PASRR Level I screen, must be completed accurately for each resident admitted to the facility. RN 1 stated, if the PASRR Level I screen was not completed correctly, facility cannot provide adequate services regarding specialized care to residents with mental illness. RN1 stated the PASRR Level I screen, was important to be completed accurately so the residents with mental illness would receive proper care and services at the facility. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/2024 at 10:42 with the Assistant Director of Nursing (ADON), Resident 22's PASRR Level I, dated 11/25/2023 was reviewed. The ADON confirmed Resident 22's PASSR Level I screen was inaccurate. The ADON stated Resident 22 was admitted to the facility with diagnoses including schizophrenia, and major depression. The ADON stated, the Admission Nurse was responsible for completing the PASSR Level I screen and was required to check if it was completed correctly upon admission and quarterly. The ADON stated if a PASSR Level I was completed inaccurately the residents would not receive the needed care/services, and the facility staff would not know how to care for the resident with mental illness. The ADON stated it was important the PASSR Level I was completed accurately to address the resident mental health needs and to implement the care plan to reflect resident care needs. A review of facility's Policy and Procedure (P&P) titled Pre-Admission Screening and Resident Review (PASRR), revised 12/16, the P&P indicated: 1. Each resident admitted to the facility shall have a PASRR Level I Screening completed. 2. Identify residents with mental illness (MI) and/or intellectual disability (ID). 3. Ensure these residents receive the services they require for their MI or ID in the appropriate setting .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to develop care plans for 2 of 26 sampled residents (Resident 84 and 53) when: a. For Resident 84, the facility failed to develop a care plan for both 1/2 bedrails up to assist Resident 84 with repositioning and Resident 84's preference to have a female escort during outside clinic appointments. b. For Resident 53, the facility failed to develop a care plan for range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) impairments, including the provision of Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) services and activities of daily living (ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility). This deficient practice had the potential to delay necessary monitoring and safety interventions related to both 1/2 side rails being in the up position while Resident 84 was in bed. This deficient practice also resulted in Resident 84 repeatedly having a male escort during outside appointments despite wishes for a female escort. This deficient practice also had the potential for Resident 53 to experience a decline in ROM and a decline in ADLs due to the absence of a care plan to guide interventions. Cross reference F676 or F677 and 688. Findings: a. A review of Resident 84's Admission Record, dated 5/30/2024, indicated Resident 84 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 84's diagnoses included left hip fracture (a partial or complete break of the thigh bone, where it meets the pelvic bone), syncope (fainting) and collapse, hypertension (high blood pressure), type 2 diabetes (too much sugar circulating in the blood) hyperlipidemia (an abnormally high concentration of fat particles in the blood), and osteoarthritis (inflammation and swelling that occurs in the joints when the flexible tissue at the ends of bones begin to wear down over time). A review of Resident 84's History and Physical (H&P) dated 4/24/2024, indicated Resident 84 had the capacity to understand and make decisions. A review of Resident 84's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/15/2024, indicated Resident 84 had a Brief Interview for Mental Status (BIMS - a screening tool used to identify the cognitive condition of residents upon admission into a long-term care facility) of 14 (cognitively intact, normal BIMS score is 13-15). The MDS indicted Resident 84 required minimal assistance with eating, partial assistance with oral and personal hygiene and maximal assistance with toileting and bathing. extensive assistance with transfers, walking, toilet use, and limited assistance with dressing, eating and personal hygiene. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 84's Order Summary Report, dated 4/24/2024, indicated an active order dated 4/3/2024 for both 1/2 side rails up when in bed for turning and repositioning as an enabler. A review of Resident 84's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Care Conference Note, dated 4/8/2024, indicated that Resident 84 used both 1/2 side rails as enablers for turning and repositioning. A review of Resident 84's Care Plans, indicated there was no care plan developed addressing Resident 84's physician order for both 1/2 side rails to be up when in bed for turning and repositioning. During a review of Resident 84's IDT Care Conference Note, dated 4/8/2024, the IDT note did not address Resident 84's preference for a female escort to accompany her to clinic appointments. A review of Resident 84's Care Plans, indicated there was no care plan developed addressing Resident 84's preference to be accompanied by a female during outside clinic appointments. During a concurrent observation and interview on 5/29/2024 at 4:20 p.m. with Resident 84, in Resident 84's room, observed Resident 84 sitting in a wheelchair next to her bed. Observed both 1/2 side rails were raised while Resident 84 was out of bed. Resident 84 pointed to her side rails with padding and asked, Do others have these on their bed? During a concurrent interview and record review with Registered Nurse (RN) 1 on 5/31/2024 at 9:43 a.m., Resident 84's medical record was reviewed. RN 1 stated that Resident 84 had an order for 1/2 side rails for repositioning and turning. RN 1 stated that there should a care plan for the use of 1/2 side rails but she could not find one in Resident 84's medical record. RN 1 stated she was aware of Resident 84's preference to have a female escort to outside clinic appointments. RN 1 stated that a care plan was not developed for Resident 84's preferences. RN 1 stated that there should have been a care plan addressing Resident 84's preferences. During a concurrent interview and record review on 5/31/2024 at 2:46 p.m. with the Assistant Director of Nursing (ADON), Resident 84's medical record was reviewed. The ADON looked through Resident 84's medical record but was unable to locate a care plan addressing Resident 84's preferences or use of bed rails. The ADON stated that care plans were important to make sure residents had a plan of care. The ADON also stated that no care plan for restraints meant that there were no interventions carried out for Resident 84's safety. The ADON stated that if bed rails were initiated upon admission, the nursing staff did not assess the resident to see if side rails were needed. The ADON stated the resident would feel like the restraints were not communicated to them. The ADON stated the side rails made the resident feel like they were in a hospital instead of a home like environment. The ADON also stated that Resident 84's preferences should have been communicated in the progress notes and a care plan should have been initiated. The ADON stated that since Resident 84's preferences were not documented or care planned, Resident 84's preferences were not followed. A review of the facility's policy and procedure (P&P) titled, Resident Safety, dated April 2021, indicated residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. The P&P indicated after a risk evaluation is completed by the IDT, a resident-centered care plan will be developed to mitigate safety risk factors. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Policy and Procedure - Care Plans, dated January 2024, indicated a care plan is the summation of the resident concerns, goals, approaches and interventions in order to meet the goals and help minimize if not totally eradicate residents' problems. The P&P indicated that the care plan is accomplished through the IDT and is based on the assessment by the group. The P&P indicated that the care plan identified the professional services and the responsible person that evaluates the concerns and carried out the intervention to prevent or reduce re-occurrences of the same problems and concerns and prevents further decline and deterioration in resident's function or status. The P&P further indicated that a care plan is developed within 7 days upon admission, reviewed quarterly, annually, and as often as needed as there is a change of condition. 36943 b. A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's physician orders, dated 3/25/2024, indicated for RNA to provide passive range of motion ([PROM] movement of joint through the ROM with no effort from the person) on both arms and both legs, followed by the application both elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours, three to five times per week. A review of Resident 53's MDS, dated [DATE], indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember) and did not have any ROM impairments to both arms and both legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. A review of Resident 53's quarterly Rehab Screening Form (brief assessment of a resident's abilities), dated 4/9/2024, indicated Resident 53 did not have any contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), did not have any ROM impairments in both arms, but had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue RNA ROM exercise program. During an observation on 5/29/2024 at 8:13 a.m., in Resident 53's room, Resident 53 was observed wearing a hospital gown while lying awake in bed with the head-of-bed (HOB) elevated. Resident 53 smiled but did not speak and was receiving liquid feeding through the G-tube. Resident 53 did not actively move either arm or leg upon request. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of South Gate		STREET ADDRESS, CITY, STATE, ZIP CODE 8455 State Street South Gate, CA 90280	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the HOB elevated. Resident 53's elbows were in a bent position. Restorative Nursing Assistant (RNA) 3 performed ROM exercises on both of Resident 53's arms and then applied both elbow splints. Resident 53's legs were rotated away from the body, both knees were bent, and both ankles were positioned in plantarflexion (ankles bent with toes pointing away from the body). RNA 3 performed ROM exercises on Resident 53's legs but did not provide any ROM to both ankles into dorsiflexion (ankle bent with toes pointing toward the body). During an observation on 5/29/2024 at 1:12 p.m., in Resident 53's room, Certified Nursing Assistant (CNA) 8 cleaned Resident 53 in bed. During an observation on 5/29/2024 at 2:27 p.m., in Resident 53's room, Resident 53 was observed lying awake in bed. During a concurrent interview and record review on 5/29/2024 at 3:36 p.m. with the MDS Coordinator (MDS 1), Resident 53's care plans were reviewed. MDS 1 stated care plans included interventions provided to the resident. MDS 1 reviewed Resident 53's care plans and stated Resident 53 did not have any care plans for RNA services and ADLs. During an interview on 5/30/2024 at 8:54 a.m. with MDS 1, MDS 1 stated care plans ensured the facility provided care to meet the resident's needs. A review of the facility's undated P&P titled, Care Plans, Comprehensive Person-Centered, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (social conditions related to mental health) and functional needs is developed and implemented for each resident.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview and record review, the facility staff failed to review, update and /or revised a care plan (a form that summarizes a person's health conditions and current treatments for their care) addressing fall, and the use of physical restraints for one of six sampled residents (Resident 32). These deficient practices had the potential to place Resident 32 at risk for recurrent falls, and to negatively affect the provision of care, and physical well-being of Resident 32. Findings: During an observation on 5/28/2024 at 11:32 a.m., in Resident 32's room, Resident 32 was observed in bed. Resident 32 was observed the bed against the wall on the right side of the room. A review of Resident 32's Admission Record (Face Sheet), the Face Sheet indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a loss of brain function such as memory, thinking, language, behavior), anxiety (a feeling of worry or fear), hypertension (high blood pressure), and muscle weakness (loss of muscle strength). A review of Resident 32's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 3/15/2024, the MDS indicated Resident 32 was self-understood and had the ability to understand others. The MDS indicated Resident 32 required maximum assistance (helper does more than half the effort) from staff for toileting hygiene, shower, and personal hygiene. A review of Resident 32's Interdisciplinary Team ([IDT]-a coordinated group of experts from several different fields who work together), dated 3/15/2024, the IDT indicated family requested Resident 32's bed to be positioned against the wall. During a concurrent interview and record review on 5/29/2024 at 11:22 a.m., with RN1, Resident 32's Electronic Medical Record (EMR) was reviewed. RN1 stated there was no physician order in the EMR for the use of physical restraints for Resident 32. RN 1 stated there was no documentation in the EMR that the care plan was reviewed and /or revised to address the use of physical restraints for Resident 32. A review of Resident 32's progress note, dated 3/4/2024, the progress note indicated Certified Nurse Assistant1 (CNA 1) reported that resident was found on the floor mat facing the bed. A review of Resident 32's progress note, dated 3/5/2024, the progress note indicated Resident 32 was being monitored for falls. A review of Resident 32's progress note, dated 4/10/2024, the progress note indicated CNA 1 reported Resident 32 was found on the floor, by her bedside. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/29/2024 at 11:25 a.m., with RN1, Resident 32's EMR was reviewed. RN1 stated there was no documented evidence in the EMR the care plan was reviewed and /or revised to address Resident 32's falls. During an interview on 5/30/2024 at 10:42 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the care plan must be reviewed and/or revised when residents have a change of condition, and/or new physician order. The ADON stated Resident 32's care plan should have been revised to address Resident 32's fall preventions, care needs, and prevention from falls reoccurring. The ADON stated Resident 32's care plan should have been undated to include the use of physical restraints. A review of facility's Policy and Procedure (P&P) titled Policy and Procedure - Care Plan, revised 9/2009, the P&P indicated a care plan is the summation of the resident concerns, goals, approaches, and interventions to meet the goals and help minimize if not totally eradicate residents' problems. The P&P indicated the resident care plan is developed within seven (7) days upon residents' admission, reviewed quarterly, annually, or as often as there is a change of condition. During a review of facility's P&P titled Policy and Procedure on Restraint, revised 7/2012, the P&P indicated: 1. Physical restraint will never be used for the convenience of the staff. 2. Residents are to be evaluated regarding safety measures, including the use of physical restraint. 3. Based on the assessment result if physical restraint is needed consent will be obtained by the doctor from the resident/ resident representative or both of use of such restraint. 4. All necessary and possible human approaches should be implemented before the use of restraint. A review of facility's P&P titled Use of Restraints, revised 12/2014, the P&P indicated, Physical Restraints are defined as any manual method of physical device, which restricts freedom of movement. The P&P indicated the following: 1. Restraint shall be only used for the safety and well-being of the resident(s). 2. If the resident cannot remove a device in which the staff applied it given that resident's physical condition (side rails are put back down, rather that climbed over), that device is considered a restraint. 3. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and /or responsible party. 4. Family and /or responsible party members may not give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary. 5. Facility staff will not use a restraint based solely of family request.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 During an observation, interview, and record review the facility failed to ensure the staff provided the necessary care and services to one out of eight sampled residents (Resident 27) that promoted residents well-being by failing to: 1. Ensure Certified Nursing Assistant (CNA 1) offered assistance to Resident 27, to clean up his bed that had a large amount of feces (stool). 2. Ensure CNA 1 gave Resident 27 had ice water when requested. 3. Ensure Resident 27 had a working call light to communicate his needs to staff. These deficient practices had the potential to have a negative impact on Resident 27's quality of life and caused Resident 27 needs not to be met like toileting, bathing receiving drinking water. Findings: A review of Resident 27's Admission Record, the admission record indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and heart failure (progressive heart disease that affects pumping action of the heart muscles that caused fatigue and shortness of breath). A review of Resident 27's History and Physical (H&P) dated 6/22/2023, the H&P indicated Resident 27 had the capacity to understand and make medical decisions. A review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/25/2024, the MDS indicated that Resident 27's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 27 needed supervision (the helper provides verbal cues, touching contact as resident completes activity) for toileting hygiene, dressing, and for showers/baths. The MD indicated Resident 27 needed supervision for toilet transfer (the ability to get on and off a toilet or commode), to move from sit to stand position, and to walk for at least 10 feet. During an observation on 5/30/2024 at 8:18 a.m., in the hallway outside of Resident 27's room, there was a foul odor of feces. Resident 27 was observed in bed with his pants above his knees and there was a large amount of feces on Resident 27's bed, located under Resident 27's buttocks. It was observed that feces were on Resident 27's floor by his bedside. During an observation on 5/30/2024 at 10:47 a.m., in Resident 27's room, it observed Resident 27 was lying on his right-side body with a large amount of feces on Resident 27's bed, located under Resident 27's buttocks and on the floor in the room. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/30/2024 at 11:50 a.m., in Resident 27's room, it was observed Resident 27 was lying on his right-side body with a large amount of feces on Resident 27's bed, under Resident 27's buttocks and on the floor in the room. During an observation on 5/30/2024 at 12:33 p.m., in Resident 27's room, it was observed Resident 27 was lying on his right-side body with a large amount of feces on Resident 27's bed, under Resident 27's buttocks and on the floor in the room. During an interview on 5/30/2024 at 12:38 p.m., with Resident 27 at his bedside, Resident 27 stated he pushed his call light to be cleaned earlier but no one came to his room to assist him. Resident 27 stated he needed some help with something but now it was too late. During an interview on 5/30/2024 at 1:25 p.m. with CNA 1, in the hallway, the CNA 1 stated it was her responsibility to check on her resident's call lights and make sure they were accessible and working. CNA 1 stated she had checked Resident 27's call light today and it was working, but it was not working. During a concurrent observation and interview on 5/30/2024 at 1:31 p.m. with CNA 1, in Resident 27's room, Resident 27 was lying on his right side of the body and had a large amount of feces on his bed, directly beside his buttocks. CNA 1 stated that she was not aware that Resident 27 had feces on his bed. CNA 1 stated she had gone into Resident 27's room today a couple of times but never seen the feces on his bed or on the floor and she did not smell the feces. CNA 1 stated it was her job to check Resident 27's environment and assist him with anything he needed. CNA 1 stated it was the CNA job to notice Resident 27 was sitting on feces but she did not. CNA 1 stated it was important not to have a resident sitting on his feces to prevent skin damage, sickness, infections and for hygiene purposes. During an interview on 5/30/2024 at 3:14 p.m. with Licensed Vocational Nurse (LVN1) LVN 1 stated she had gone to Resident 27's room for medication administration two times, once in the morning and after lunch. LVN 1 stated two times she went to Resident 27's room she did not smell or see the feces on Resident 27's bed or floor. The LVN 1 stated it was important not to have a resident sitting on their feces to prevent skin irritation and skin prevent skin breakdown. LVN 1 stated anyone that went into Resident 27's room should have noticed the feces on the bed and on the floor, but no one did. LVN 1 stated it was important to continuously check on residents' well-being too prevent injuries and to assist residents with their needs. During a concurrent observation and interview on 5/31/2024 at 8:17 a.m. with Resident 27, in Resident 27's room, the Resident 27 pushed his call light and the call light did not light up in the room, outside of the room and it did not make a noise. Resident 27 stated he couldn't believe that the call light was not working. Resident 27 stated maybe that was the reason why staff did not come to his room to assist him. Resident 21 stated if he needed help, how would he get it if his call light did not work. Resident 27 stated he asked CNA 1 for ice water but CNA 1 never gave him the ice water. Resident 27 stated he had been pushing his call light, but no one came to his room to help him. During an interview on 5/31/2024 at 10:22 a.m. with CNA 1, CNA 1 stated she had checked on resident 27's environment, his bed and checked his call light today and everything looked good and call light did work. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/31/2024 at 10:29 a.m. with CNA 1, in Resident 27's room, Resident 27 pushed his call light and his call light did not turn on inside the room or outside the room and it did not make any noise to indicate call light was working. CNA 1 stated the call light should light up inside the room and outside the room but it was not working. CNA 1 stated that it was her job to check if Resident 27 had a working call light. CNA 1 stated it was important to have a working call light because it was the way the residents communicated their needs. CNA 1 stated she wanted to be truthful and say that she did not check his call light today and did not remember when the last time she actually checked to see if the call light worked. Resident 27 stated he was still waiting for CNA 1 to bring him some ice water. During a review of facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting, undated, the P&P indicated the facility would provide support and assistance with hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), and dining (meals and snacks). The P&P indicated a resident's ability to perform ADLS will be measured using clinical tools, including the MDS.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide treatment and services to maintain or improve the ability to perform activities of daily living (ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) for one of four sampled residents (Resident 53) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility by failing to transfer Resident 53 out of the bed daily. This deficient practice resulted in Resident 53, who had a history of depression, to experience limited social interaction and a decline in ROM, mobility, ADLs, affecting Resident 53's quality of life. Cross reference F656, F688, and F825. Findings: A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's Activity Attendance Record for 12/2023, indicated Resident 53 was seen for room visits from 12/1/2023 to 12/31/2023. A review of Resident 53's Documentation Survey Report (record of nursing tasks) for 12/2023, indicated Resident 53 was totally dependent for locomotion off unit (movement to different locations of the facility) on 12/3/2023, 12/5/2023, 12/9/2023, 12/13/2023, 12/14/2023, 12/18/2023, 12/19/2023, 12/20/2023, and 12/21/2023. A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 1/2/2024, indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember) and did not have any ROM impairments to both arms and both legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. A review of Resident 53's Activity Attendance Record for 1/2024, indicated Resident 53 was seen for room visits from 1/1/2024 to 1/31/2024. A review of Resident 53's Documentation Survey Report for 1/2024, indicated Resident 53 was totally dependent for locomotion off unit on 1/1/2024, 1/2/2024, 1/8/2024, 1/9/2024, and 1/17/2024. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's Activity Attendance Record for 2/2024, indicated Resident 53 was seen for room visits from 2/1/2024 to 2/29/2024. A review of Resident 53's Documentation Survey Report for 2/2024, indicated Resident 53 was totally dependent for locomotion off unit on 2/1/2024, 2/3/2024, 2/13/2024, 2/14/2024, 2/19/2024, 2/20/2024, 2/26/2024, 2/27/2024, and 2/28/2024. A review of Resident 53's Activity Attendance Record for 3/2024, indicated Resident 53 was seen for room visits from 3/1/2024 to 3/12/2024 and 3/21/2024 to 3/31/2024. The Activity Attendance record indicated Resident 53 was hospitalized from 3/13/2024 to 3/20/2024. A review of Resident 53's general acute care hospital (GACH) History and Present Illness (H&P), indicated Resident 53 presented to the emergency roiaognom on [DATE] crying due to ongoing pain and found to have fecal impaction (occurs when hard mass of stool gets makes it difficult to have a bowel movement). A review of Resident 53's Documentation Survey Report for 3/2024, indicated Resident 53 was totally dependent for locomotion off unit on 3/1/2024, 3/5/2024, 3/6/2024, 3/7/2024, 3/8/2024, 3/12/2024, 3/21/2024, 3/25/2024, and 3/28/2024. A review of Resident 53's care plan, initiated on 3/26/2024, indicated Resident 53 had constipation related to decrease physical activity. A review of Resident 53's Documentation Survey Report for 4/2024, indicated Resident 53 was totally dependent for locomotion off unit on 4/1/2024. A review of Resident 53's MDS, dated [DATE], indicated Resident 53 had severely impaired cognition and did not have any ROM impairments to both arms and both legs. The MDS indicated Resident 53 was dependent for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene, showering/bathing, and dressing. A review of Resident 53's care plan, initiated 4/5/2024, indicated Resident 53's activity participation was complicated due to body weakness. The care plan interventions indicated to provide sensory stimulation (activation of one of more senses including taste, smell, vision, vision, and touch) daily. A review of Resident 53's Activity Attendance Record for 4/2024, indicated Resident 53 was seen for room visits from 4/1/2024 to 4/7/2024 and from 4/10/2024 to 4/30/2024. The Activity Attendance Record indicated Resident 53 was hospitalized from 4/8/2024 to 4/9/2024. A review of Resident 53's nursing Progress Notes, dated 4/8/2024 at 7:52 p.m., indicated Resident 53 had persistent crying and screaming in bed. Resident 53's physician was notified and ordered for Resident 53's transfer to the GACH. A review of Resident 53's Activity Attendance Record for 5/2024, indicated Resident 53 was seen for room visits from 5/1/2024 to 5/6/2024, 5/9/2024 to 5/26/2024, and participated in the activity room on 5/27/2024 for a coffee social. The Activity Attendance Record indicated Resident 43 was in the hospital from 5/7/2024 to 5/8/2024. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's Documentation Survey Report for 5/2024, indicated Resident 53 was totally dependent for locomotion off unit on 5/5/2024, 5/10/2024, 5/18/2024, 5/28/2024, and 5/30/2024. During an observation on 5/28/2024 at 9:38 a.m., in Resident 53's room, Resident 53 was observed awake while lying in bed and started crying, moaning, and screaming. Resident 53 was unable to communicate Resident 53's feelings. During an observation on 5/29/2024 at 8:13 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the head-of-bed (HOB) elevated. A bed sheet was covering Resident 53's legs. Resident 53 smiled but did not speak. During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the HOB elevated. During an observation on 5/29/2024 at 1:12 p.m., in Resident 53's room, Certified Nursing Assistant (CNA) 8 was observed cleaning Resident 53 while lying in bed. During an observation on 5/29/2024 at 2:27 p.m., in Resident 53's room, Resident 53 was observed lying awake in bed. During an observation on 5/29/2024 at 4:28 p.m., in Resident 53's room, Resident 53 was observed lying awake in bed. During an observation on 5/30/2024 at 8:40 a.m., in Resident 53's room, Resident 53 was observed lying in bed. During an observation on 5/30/2024 at 3:20 p.m., in Resident 53's room, Resident 53 was observed lying in bed. During a concurrent interview and record review on 5/31/2024 at 8:37 a.m. with the Activity Director (AD), Resident 53's Activity Attendance Records from 12/2023 to 5/2024 were reviewed. The AD stated Resident 53 was alert but could not vocalize Resident 53's needs. The AD stated Resident 53 received sensory stimulation and participated in a coffee social on 5/27/2024. The AD reviewed Resident 53's Activity Attendance Records and stated Resident 53 was seen for activities inside the room from 12/2023 to 5/27/2024 except during hospitalization s and on 5/27/2024. During an observation on 5/31/2024 at 9:01 a.m., in Resident 53's room, Resident 53 was observed awake while lying in bed and yelling. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 05/31/2024
NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of South Gate		STREET ADDRESS, CITY, STATE, ZIP CODE 8455 State Street South Gate, CA 90280	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/31/2024 at 9:12 a.m. with the Assistant Director of Nursing (ADON) and the MDS Coordinator (MDS 1), Resident 53's physician orders, care plans, Activity Attendance Records, Documentation Survey Reports, and the facility's policy and procedure (P&P) were reviewed. The MDS 1 stated the residents (in general) should be getting out of bed daily to prevent skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), prevent depression, promote movement, and prevent lung problems. ADON and MDS 1 reviewed Resident 53 physician orders and stated there was no physician orders preventing Resident 53 from getting out of bed daily. MDS 1 stated Resident 53 went to the shower on Mondays and Thursdays. MDS 1 stated Resident 53 did not have a care plan for ADLs but had a care plan for constipation. ADON stated movement assisted in preventing constipation. ADON and MDS 1 reviewed Resident 53's Activity Attendance Records from 12/2023 to 5/2024 and stated Resident 53 was seen inside the room for the past six months except for 5/27/2024. ADON and MDS 1 reviewed Resident 53's Documentation Survey Report and stated Resident 53 was transferred out of the room nine times in 12/2023, five times in 1/2024, nine times in 2/2024, nine times in 3/2024, one time in 4/2024, and five times in 5/2024. ADON and MDS 1 reviewed the facility's P&P titled, Activities of Daily Living (ADLs), Supporting, and stated the facility was not providing services to maintain Resident 53's ADLs. A review of the facility's undated policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, indicated the facility will provide care and services for residents who were unable to carryout ADLs independently in accordance with the care plan, including assistance with mobility, which included transfers.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review the facility failed to provide treatment and services for two out of three residents (Resident 35 and Resident 53) by failing to: a. Document Resident 53's hypoglycemic (low blood sugar) episode. This deficient practice had the potential to cause miscommunication of Resident 35's negative health trends and medication adjustments of insulin. b. Ensure Resident 53 who had range of motion (ROM, full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns) were properly assessed for the provision and application of elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to both arms, including the determination of Resident 53's splint wear time (length of time the splint was applied) of four to six hours in accordance with professional standards of practice for Occupational Therapy (OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]). Cross reference F825. This deficient practice had the potential to damage Resident 53's skin integrity (relating to skin health), including but not limited to redness, bruising, swelling, and development of pressure sores (injuries to the skin and underlying tissue caused by prolonged pressure on the skin). Findings: a. A review of Resident 35's Admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnosis included type II diabetes mellitus (a chronic metabolic condition where the body has trouble regulating sugar as fuel). A review of Resident 35's History and Physical (H&P), undated, indicated Resident 35 had fluctuating capacity to understand and make decisions. A review of Resident 35's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/14/2024, indicated Resident 35 was mildly cognitively impaired (ability to think and reason). The MDS indicated Resident 35 required substantial assistance (helper does more than half the effort) with toileting hygiene, showering, dressing the lower body, and putting on footwear. A review of Resident 35's Physicians Orders, dated 4/5/2024, indicated Resident 35 was to received Insulin Lispro (a fast-acting insulin used to treat high blood sugar) per sliding scale (a scale used to determine how much insulin to give based on blood sugar results) for type 2 diabetes mellitus. During an observation on 5/28/2024 at 9:25 a.m., Resident 35 was observed awake, sitting up in bed. Resident 35 reported feeling dizzy and pushed the call light. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/28/2024, at 9:28 a.m., the Assistant Director of Nursing (DON) answered Resident 35's call light. Resident 35 stated she felt dizzy. The ADON asked Licensed Vocational Nurse (LVN) 5 to obtain Resident 35's blood sugar. Resident 35's blood sugar level was 56 milligrams per deciliter (mg/dl, unit of measurement, Normal Reference Range between 70 mg/dl and 100 mg/dl. A review of Resident 35's Weights and Vitals Summary, dated 5/1/2024 through 5/31/2024 indicated Resident 35's had a hypoglycemic (low blood sugar) episode on 5/28/2024 at 9:35 a.m. Resident 35's blood sugar level was 56 mg/dl. A review of Resident 35's progress notes, dated 5/28/2024 through 5/31/2024 indicated there was no documentation of Resident 35's hypoglycemic episode on 5/28/2024 at 9:35 a.m. A review of Resident 35's medical record indicated there was no change of condition note for Resident 35's hypoglycemic episode on 5/28/2024 at 9:35 a.m. During an interview at 5/28/2024, at 10:05 a.m., LVN 5 stated she gave Resident 35 some food and juice since Resident 35 refused glucagon (a sugar pill used for hypoglycemia). LVN 5 stated she did not have an order to administer glucagon at the time anyway. LVN 5 stated she had retaken Resident 35's blood sugar which was 87 mg/dl. During an interview on 5/31/2024, at 9:45 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated Resident 35's hypoglycemic episode on 5/28/2024 at 9:35 a.m. was considered a change of condition which should have been documented. The IPN stated abnormal blood sugar levels should be documented in the resident's chart so that the resident could be properly monitored, and medication could be adjusted accordingly. A review of the facility policy and procedure (P&P) titled Management of Hypoglycemia, undated, indicated hypoglycemic events should be documented, including interventions, level of consciousness, and provider instructions upon notification. A review of the facility P&P titled Change of Condition, dated 7/2012, indicated the purpose of the policy was to clearly define guidelines for timely notification of a change in resident condition for immediate intervention. The P&P indicated all nursing actions, physician orders/instructions, and resident assessment information will be documented in the nursing progress notes. The P&P indicated the licensed nurse is responsible for the resident and will continue assessment and documentation on every shift for seventy-two (72) hours or until condition has stabilized. 36943 b. A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 53's physician orders, dated 3/25/2024, indicated for the Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) to provide passive range of motion (PROM, movement of joint through the ROM with no effort from the person) on both arms and both legs, followed by the application of both elbow splints for four to six hours (4-6 hours), three to five times per week. A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 4/2/2024, indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember) and did not have any ROM impairments to both arms and both legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. A review of Resident 53's quarterly Rehab Screening Form, dated 4/9/2024, indicated Resident 53 did not have any contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), did not have any ROM impairments in both arms, but had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue RNA ROM exercise program. During an observation on 5/29/2024 at 8:13 a.m., in Resident 53's room, Resident 53 was observed wearing a hospital gown while lying awake in bed with the head-of-bed (HOB) elevated. A bed sheet was covering Resident 53's legs. Resident 53 smiled but did not speak. Resident 53's body twitched (short, jerky sudden movements) intermittently (did not happen continuously) and both elbows were in a bent position. Resident 53 was not wearing any splints on both arms. During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the HOB elevated. Resident 53's elbows were in a bent position. Restorative Nursing Assistant (RNA) 3 performed ROM exercises on Resident 53's left arm, including shoulder abduction (lifting the arm away from the body) and adduction (returning the arm toward the body), shoulder rotation (circular motion) in clockwise and counterclockwise directions, shoulder flexion (lifting the arm upward) and extension (returning the arm downward), elbow flexion (bending) and extension (straightening), and then applied an elbow extension splint (splint that prevents the resident from bending at the elbow) on the left arm. RNA 3 performed ROM exercises on Resident 53's right arm, including shoulder abduction and adduction, shoulder rotation in clockwise and counterclockwise directions, shoulder flexion and extension, elbow flexion and extension, and then applied an elbow extension splint on the right arm. RNA 3 then performed ROM exercises to both legs. During an interview on 5/29/2024 at 9:37 a.m. with RNA 3, RNA 3 stated she performed PROM on both of Resident 53's arms and legs and applied both elbow extension splints. During a concurrent observation and interview on 5/29/2024 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 53's room, Resident 53 was observed crying and yelling while lying in bed. LVN 3 stated Resident 53 was yelling either due to psychosis or Resident 53 did not like the splints the RNAs just applied to both elbows. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/24/2024 at 2:27 p.m., in Resident 53's room, RNA 1 removed Resident 53's elbow splints after approximately five hours. Resident 53's skin was slightly red on the areas where the splint was applied on both arms, but Resident 53's skin was intact without pressure areas. During a concurrent interview and record review on 5/29/2024 at 4:06 p.m. with the Director of Rehabilitation (DOR), Resident 53's Rehab Screening Form, dated 4/9/2024 and the facility's Rehabilitation electronic documentation were reviewed. The DOR reviewed Resident 53's Rehab Screening Form and stated Resident 53 did not have any ROM issues but provided both elbow splints to prevent elbow contractures. The DOR reviewed the facility's Rehabilitation electronic documentation and stated Resident 53 has never received therapy services, including OT. The DOR stated OT did not complete a written assessment indicating Resident 53 needed both elbow splints and did not have any document evidence Resident 53 tolerated the elbow splints for 4-6 hours. The DOR stated the RNAs (unspecified) were instruction on how to apply both elbow splints on Resident 53's arms when the splints arrived at the facility. The DOR stated the OT profession's standard of practice for providing a splint to a resident included applying the splint and determining the resident's splint wear time. The DOR stated there was no documented evidence the DOR followed the OT profession's standard of practice. The DOR stated splints could cause skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) or pressure areas if an assessment was not done. During an interview on 5/30/2024 at 10:20 a.m. with the Physical Therapist (PT 1), PT 1 stated splint (also known as orthotics) training was a skilled treatment requiring an evaluation, recommendations of the splint, adjusting the splints, and determine the splint wear time. PT 1 stated the determination of splint wear time included applying the splint for 15 to 30 minutes and then gradually increasing the splint application time. During an interview on 5/30/2024 at 12:12 p.m. with the DOR, the DOR stated the provision of a splint was skilled service that required an evaluation, adjustment of the splint, and skin checks for the tolerance. The DOR stated the splint was applied and adjusted on both of Resident 53's elbows but the RNAs were experienced to check the skin for any pressure areas. The DOR stated the facility did not have any documented evidence the OT performed an evaluation for Resident 53's elbow splints and determined the splint wear time for Resident 53. During an observation on 5/31/2024 at 9:01 a.m., in Resident 53's room, Resident 53 was observed lying in bed yelling while both elbow splints were applied to the arms. A review of a textbook titled, Occupational Therapy for Physical Dysfunction, fifth edition, published 2002, page 316, indicated the OT's role is to evaluate the need for a splint clinically and functionally; to select the most appropriate splint; to provide or fabricate (make) the splint; to assess the fit of the splint; to teach the patient and caregivers the purpose, care, and use of the splint. The Occupational Therapy for Physical Dysfunction textbook, page 316, further indicated the OT must consider, carefully monitor, and teach the patient and caregiver to report any of these problems related to orthotic use, including impaired skin integrity, pain, and swelling.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 During an observation, interview, and record review the facility failed to practice pressure related injury preventive practices for two out eight residents (Resident 3 and Resident 26) when the facility failed to: 1.Ensure a low air mattress (LAM) was set according to Resident 26's weight of 255 pounds and the LAM was set to 350 pounds. 2. Ensure the LAM was set according to Resident 3's weight of 161 pounds and LAM was set to 180 pounds. 3. Assess and prevent a pressure injury over Resident 3's ears. These deficient practices placed Resident 3 and Resident 26 at a higher risk of developing a pressure injury due to incorrect weight setting on the LAM and caused Resident 3 to develop a pressure injury on right ear due to prolonged use of medical device. Findings: 1. A review of Resident 3's Admission Record, the admission record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of kidney failure (occurs when kidneys suddenly become unable to filter waste products from the blood, kidneys lose their filtering ability, dangerous levels of wastes may accumulate, and blood's chemical makeup may get out of balance) and myocardial infarction (A heart attack, occurs when a blood clot blocks blood flow to the heart). A review of Resident 3's History and Physical (H&P) dated 10/23/2023, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. A review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/30/2024, the MDS indicated Resident 3 had an unclear speech. The MDS indicated that Resident 3's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for all activities of daily living. The MDS indicated Resident 3 was dependent on staff for moving from left to right in the bed, from sitting to lying positioning, and for chair/bed -to-chair transfer. A review of Resident 3's physician orders, dated 10/29/2023, the physician orders indicated to change oxygen tubing on every Sunday. 2. A review of Resident 26's Admission Record, the admission record indicated Resident 26 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (condition caused by a brain injury, that results in a varying degree of weakness, stiffness, and lack of control in one side of the body) and kissing spine (close approximation of adjacent spinous processes due to degenerative changes of the spine). (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 26's History and Physical (H&P) dated 5/6/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions. A review of Resident 26's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/4/2024, the MDS indicated Resident 26 cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 26 needed substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene, shower/baths, and lower body dressing. During an observation on 5/28/2024 at 9:10 a.m. in Resident 26 room, Resident 26's LAM was set to 350 pounds. During an observation on 5/28/2024 at 9:14 a.m. in Resident 3's room, Resident 3 was lying on a LAM that was set to 180 pounds. During an observation on 5/31/2024 at 11:52 a.m. in Resident 3's room, Resident 3 was sitting on a wheelchair and did not have a nasal cannula on. Resident 3 was observed with blood over his right ear and redness over his left ear. During an interview on 5/31/2024 at 12:30 p.m. with Licensed Vocational Nurse (LVN 3), in Resident 26's and 3's room, LVN 3 stated residents that are bedbound use the LAM to prevent skin breakdown. LVN 3 stated he did not know the LAM was not set to correct residents' weight. LVN 3 stated he could not adjust the LAM to the correct weight because he did not know how to do that. LVN 3 stated the Maintenance Supervisor (MS) was responsible for setting the LAM and the MS is called for all LAM troubleshooting. LVN 3 stated if LAM was overinflated it can cause resident to be uneven in the bed or the mattress could possibly pop. LVN 3 stated it was important to set the LAM with correct weight to prevent pressure injuries, for safety and for comfort. During a concurrent observation and interview on 5/31/2024 at 12:42 a.m. with LVN 3, in Resident 3's room, the Resident 3 had blood over his right ear and redness to his left ear. LVN 3 stated he did not know that Resident 3's ear had been bleeding. LVN 3 assessed Residents 3's right ear, blood oozed out and Resident 3 grimaced. LVN 3 stated Resident 3 got the pressure injury due to prolonged use of a nasal cannula. LVN 3 stated that staff should have noticed the pressure injury during shower time, diaper change, skin treatments or when they provide medications to Resident 3. LVN 3 stated it was important to continuously assess residents with medical devices to prevent skin injuries. During an interview on 5/31/2024 at 2:36 p.m. with MS in Resident 26's and Resident 3's room, the MS stated he was responsible to set up the LAM according to resident's weight. The MS stated the nurses inform him of resident's weight and he uses that weight to set up the LAM. The MS stated the LAM for Resident 26 and Resident 3 have been set to the same weight since he initially set it up. The MS stated he had not been notified if Resident 26 or Resident 3's weight had changed. The MS stated it was important to have a LAM with the correct weight to prevent skin injuries. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/2024 at 2:59 p.m. with Assistant Director of Nursing (ADON), the ADON stated residents that use a medical device should be assessed for pressure injuries due to the use of a medical device. The ADON stated residents that use a nasal cannula (tube placed in the nose to deliver oxygen to the body) should be assessed daily for pressure injuries by the treatment nurse. The ADON stated residents' skin should be assessed when nasal cannula tubing is changed every week. The ADON stated residents develop pressure injuries when they have prolonged use of a medical device and when residents are not assessed accordingly. During an interview on 5/31/2024 at 3:14 p.m. with ADON, the ADON stated residents that are bed bound use [NAME] to prevent skin breakdowns. The ADON stated a licensed nurse and MS are responsible to set the LAM. The ADON stated the MS would assist the licensed nurse to set up the LAM. The ADON stated if the LAM is over inflated it could be uncomfortable and painful for a resident. The ADON stated it was important to set the LAM with correct patient weights to prevent skin pressure injuries, for resident safety and for their comfort. A review of the facility's Policy and Procedure (P&P) titled Air Loss Mattress, dated 07/2012, the P&P indicated facility's purpose was to ensure that residents skin integrity was maintained and to aid in healing decubitus ulcers. The P&P indicated the air pressure of the air loss mattress will be adjusted based on the resident's weight to serve its purpose. A review of facility's Policy and Procedure (P&P) titled Oxygen administration, dated 12/2014, the P&P indicated to provide protection behind the residents' ears, in order to minimize the risk of pressure ulcer development.		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide services to maintain mobility (ability to move) for one of four sampled residents (Resident 53) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility by failing to: 1. Monitor Resident 53's ROM in each joint of both arms and legs upon admission, quarterly, and annually in accordance with the facility's policies and procedures (P&P) titled, Resident Mobility and Range of Motion, which indicated the resident's comprehensive assessment will identify a resident's current range of motion of his or her joints. 2. Provide Resident 53 with active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises from 12/23/2022 (admission assessment) to 5/1/2023 (more than four months) in accordance Resident 53's admission Rehab Screening Form (brief assessment of a resident's abilities) recommendations, dated 12/23/2022. 3. Provide Resident 53 with passive range of motion ([PROM] movement of joint through the ROM with no effort from the person) of the ankles in accordance with physician orders, dated 3/25/2024. 4. Assess and monitor Resident 3, 56, and 61's ROM in each joint of both arms and both legs upon admission, quarterly, and annually in accordance with the facility's policies and procedures (P&P) titled, Resident Mobility and Range of Motion. 5. Provide Resident 3 with PROM of both elbows, wrists, hands, knees, and the left ankle in accordance with physician orders, dated 11/27/2023. 6. Provide Resident 56 with active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) of the right wrist and hand in accordance with physician orders, dated 4/7/2023. These deficient practices resulted in Resident 53 requiring full physical assistance to perform exercises of both arms and legs and Resident 53's development of both ankle contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness). These deficient practices also had the potential for Resident 3, 56, and 61 to experience an undetected decline in ROM and the development of contractures. Cross reference F580, F656, F677, F726, and F825 Findings: (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of South Gate		STREET ADDRESS, CITY, STATE, ZIP CODE 8455 State Street South Gate, CA 90280	
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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 0688 Level of Harm - Actual harm Residents Affected - Few	a. A review of Resident 53's general acute care hospital (GACH) Neurology (branch of medicine concerned with the study and treatment of disorders involving the brain, spinal cord, and nerves) Progress Note, dated 12/18/2022, indicated Resident 53 was fully awake, alert, and followed simple commands. The Neurology Progress Note also included a physical examination, which indicated Resident 53 held the arms and legs against gravity (active movement). A review of Resident 53's Admission Record indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 4/2/2024, indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 53 did not have any ROM impairments to both arms and legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. A review of Resident 53's Progress Note, dated 12/22/2022 timed at 3:00 p.m., indicated Resident 53 was found in the middle of the bed with both legs dangling outside of the bed. The Progress Note indicated Resident 53 was assisted back to bed and repositioned. The Progress Note indicated Resident 53's physician was informed, and a physician order was carried out to place the bed in the lowest position and floor mat. A review of Resident 53's admission Rehab Screening Form, dated 12/23/2022, indicated Resident 53 did not have any contractures or ROM impairments in both arms, but had a ROM impairment in one leg. The Rehabilitation Screening Form indicated Resident 53's left leg was within functional limits ([WFL] sufficient movement without significant limitation) and the right leg (hip) had tightness into flexion (bending the leg at the hip joint toward the body) and abduction (moving the leg away from the body). The Rehab Screening Form indicated to provide Resident 53 with Restorative Nursing Aide ([RNA] Certified Nursing Aide program that help residents to maintain their function and joint mobility) for AAROM exercises on both arms and legs, three to five times per week (3-5x/week) as tolerated. A review of Resident 53's Restorative Flow Sheets (record of RNA sessions) for 12/2022, 1/2023, 2/2023, 3/2023, and 4/2023 indicated AAROM exercises on both arms and legs were not included. A review of Resident 53's quarterly Rehab Screening Form, dated 4/9/2023, indicated Resident 53 did not have any contractures or ROM impairments in both arms. The Screening Form indicated Resident 53 had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue the RNA ROM exercise program. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 53's physician orders, dated 5/1/2023, indicated for the RNA to provide Resident 53 with PROM on both arms and legs, 3-5x/week with one person assist as tolerated. A review of Resident 53's quarterly Rehab Screening Forms, dated 7/9/2023 and 10/10/2023, indicated Resident 53 did not have any contractures or ROM impairments in both arms. The Screening Form indicated Resident 53 had a ROM impairment in one leg. The Rehab Screening Forms indicated Resident 53 had the same level of function without significant decline and to continue the RNA ROM exercise program. A review of Resident 53's annual Rehab Screening Form, dated 1/9/2024, indicated Resident 53 did not have any contractures and did not have any ROM impairments in both arms. The Screening Form indicated Resident 53 had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue the RNA ROM exercise program. A review of Resident 53's physician orders, dated 3/25/2024, indicated for RNA to provide PROM on both arms and legs, followed by the application of both elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours (4-6 hours), 3-5x/week. A review of Resident 53's quarterly Rehab Screening Form, dated 4/9/2024, indicated Resident 53 did not have any contractures or ROM impairments in both arms. The Rehab Screening Form indicated Resident 53 had a ROM impairment in one leg. The Rehab Screening Form indicated Resident 53 had the same level of function without significant decline and to continue the RNA ROM exercise program. During a concurrent interview and record review on 5/28/2024 at 10:48 a.m. with the Director of Rehabilitation (DOR), the facility's Rehab Screening Form was reviewed. The DOR stated the Rehab Screening Form was completed upon a resident's admission, quarterly, change of condition, and annually. The DOR stated ROM was assessed as either having no impairment, impairment on one side, or impairment on both sides. The DOR stated the Rehab Screening Form did not include a ROM assessment for limitations in each joint of the arms (shoulders, elbows, wrists, and hands) and the legs (hips, knees, ankles). The DOR stated RNA services helped residents maintain their ROM and function. During an observation on 5/29/2024 at 8:13 a.m., in Resident 53's room, Resident 53 was lying awake in bed with the head-of-bed (HOB) elevated and a bed sheet covering Resident 53's legs. Resident 53 smiled but did not speak. Resident 53's body twitched (short, jerky sudden movements) intermittently (did not happen continuously) and both elbows were in a bent position. Resident 53's hips and knees were visibly rotated away from the body with the knees bent, resembling a frog-like leg position, despite the presence of the bed sheet over both legs. Resident 53's ankles and feet were not visible. Resident 53 was not wearing any splints on both arms and legs. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying awake in bed with the HOB elevated. Resident 53's elbows were in a bent position. Restorative Nursing Aide (RNA) 3 performed ROM exercises on Resident 53's left arm, including shoulder abduction (lifting the arm away from the body) and adduction (returning the arm toward the body), shoulder rotation (circular motion) in clockwise and counterclockwise directions, shoulder flexion (lifting the arm upward) and extension (returning the arm downward), elbow flexion (bending) and extension (straightening), and then applied an elbow extension splint (splint that prevents the resident from bending at the elbow) on the left arm. RNA 3 performed ROM exercises on Resident 53's right arm, including shoulder abduction and adduction, shoulder rotation in clockwise and counterclockwise directions, shoulder flexion and extension, elbow flexion and extension, and then applied an elbow extension splint on the right arm. Resident 53's legs were rotated away from the body, both knees were bent, and both ankles were positioned in plantarflexion (ankles bent with toes pointing away from the body). RNA 3 performed ROM exercises on Resident 53's right leg, including hip abduction (moving the leg away from the body) and adduction (returning the leg toward the body), hip rotation clockwise and counterclockwise while the knee was extended, hip flexion (bending the leg at the hip joint toward the body) with knee flexion (bending the knee), and ankle rotation. RNA 3 did not move Resident 53's right ankle into dorsiflexion (ankle bent with toes pointing toward the body). RNA 3 performed ROM exercises on Resident 53's left leg, including hip abduction, hip rotation clockwise and counterclockwise with the knee extended, hip flexion with knee flexion, and ankle rotation. RNA 3 did not move Resident 53's left ankle into dorsiflexion. RNA 3 then performed exercises to the left-hand fingers into flexion and extension, left wrist rotation, left wrist flexion and extension, right-hand fingers into flexion and extension, right wrist rotation, and right wrist flexion and extension. During an interview on 5/29/2024 at 9:37 a.m. with RNA 3, RNA 3 stated she performed PROM on both of Resident 53's arms and legs and applied both elbow extension splints. During an interview on 5/29/2024 at 11:36 a.m. with Physical Therapist (PT, professional trained in the restoration, maintenance, and promotion of optimal physical function) 1, PT 1 stated the ROM exercises that the RNAs were expected to perform for each resident's legs included hip flexion and extension, hip abduction and adduction, knee flexion and extension, and ankle dorsiflexion and plantarflexion to prevent contractures. During a concurrent interview and record review on 5/29/2024 at 4:06 p.m. with the DOR, in the presence of the Assistant Director of Nursing (ADON) and the MDS Coordinator (MDS 1), the facility's Rehabilitation electronic documentation (clinical therapy records) for PT, Occupational Therapy [(OT) profession aimed to increase or maintain a person's capability of participating in everyday life activities (occupations)], and Speech Therapy [(ST or SLP) profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) was reviewed. The DOR stated Resident 53 never received any PT, OT, or SLP services while residing in the facility. During a concurrent interview and record review on 5/29/2024 at 4:23 p.m. with the DOR, Resident 53's Rehab Screening Form, dated 12/23/2022, was reviewed. The DOR stated Resident 53 had ROM impairments in the right leg due to tightness in the hip. The DOR stated Resident 53 did not have any contractures in both legs upon admission to the facility. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 5/29/2024 at 4:38 p.m., with Resident 53, in the presence of the DOR, ADON, and MDS 1, in Resident 53's room, Resident 53 was observed lying in bed with a bed sheet covering both legs. The DOR lifted the bed sheet to view both legs. Resident 53 did not have any splints on both legs. Resident 53's ankles were positioned in plantarflexion. The DOR attempted to provide ROM to Resident 53's ankles into dorsiflexion, but Resident 53's ankles remained in plantarflexion. During an interview on 5/29/2024 at 4:43 p.m. with the DOR, ADON, and MDS 1, the DOR, ADON, and MDS 1 stated Resident 53 had plantarflexion contractures of both ankles. MDS 1 stated the ROM assessment in a resident's MDS indicated whether a resident had any ROM limitations but did not indicate which joint had a ROM limitation. The DOR stated the Rehab Screening Form did not include any assessment of a resident's ROM at each joint and the facility was not monitoring each resident's ROM. The ADON stated ROM exercises, movement, proper positioning, and splints assisted in preventing contractures. The ADON stated Resident 53 did not have any splints on both legs. The ADON and MDS 1 stated the facility did not know Resident 53 had both ankle plantarflexion contractures, and therefore, did not know when Resident 53's contractures developed. The ADON stated contractures increased a resident's risk of developing skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and fractures (break in the bone). The ADON and MDS 1 stated Resident 53's plantarflexion contractures in both ankles were preventable. During an interview on 5/30/2024 at 11:11 a.m. with PT 1, PT 1 stated contractures were a fixed positioning of a joint. PT 1 stated contractures were not reversible but could be surgically released. PT 1 stated contractures could be delayed with ROM exercises, proper positioning, and the application of splints. During a concurrent interview and record review on 5/30/2024 at 11:46 a.m. with the DOR, Resident 53's Rehab Screening Forms, dated 12/23/2022 and 4/9/2023, and physician orders dated, 5/1/2023, for RNA were reviewed. The DOR stated the Rehab Screening Form, dated 12/23/2022, included a recommendation for RNA to perform AAROM exercises to both arms and legs. The DOR stated Resident 53 did not receive RNA until the physician orders, dated 5/1/2023, which indicated for the RNA to perform PROM to both arms and legs. The DOR stated Resident 53 did not receive RNA for AAROM exercises from 12/23/2022 to 5/1/2023. The DOR stated the Rehab Screening Form, dated 4/9/2023, indicated to continue the RNA ROM exercise program but the DOR did not verify if Resident 53 was received RNA services. The DOR stated the facility's Rehab Screening Form did not monitor Resident 53's ROM. During an interview on 5/30/2024 at 3:44 p.m. with the DOR, the DOR stated AAROM meant a resident moved as much as possible but required additional help from another person. The DOR stated PROM meant the resident required full physical assistance. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/31/2024 at 10:28 a.m. with the ADON and MDS 1, Resident 53's Rehab Screening Form, dated 12/23/2022, the Restorative Flow Sheets, and physician orders dated, 5/1/2023, for RNA were reviewed. The ADON stated the Rehab Screening Form, dated 12/23/2022, indicated a recommendation for RNA to provide AAROM exercises to both arms and legs. The ADON stated Resident 53 had some movement in both arms and both legs if the recommendation was for AAROM. The ADON and MDS 1 reviewed the Restorative Flow Sheets from 12/2022 to 4/2022 and stated Resident 53 did not receive RNA for AAROM exercises for four months. MDS 1 stated Resident 53 started receiving RNA for PROM exercises to both arms and legs in accordance with the physician order, dated 5/1/2023. MDS 1 stated the physician orders changed from AAROM to PROM which indicated Resident 53 could have declined in the ability to move. The ADON stated the Rehab Screening Form should have indicated Resident 53 was monitored for ROM (at each joint) since the RNAs were not trained to observe ROM. The ADON stated Resident 53's ROM limitations were preventable. b. A review of Resident 3's Admission Record, indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included type 2 diabetes mellitus (high blood sugar), myocardial infarction (heart attack), hemiplegia or hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (stroke, brain damage due to a loss of oxygen to the area) affecting the right dominant (used most often) side, dysphagia (difficulty swallowing), acquired absence of the left toes, and acquired absence of the right leg below the knee. A review of Resident 3's annual Rehab Screening Form, dated 11/6/2023, indicated Resident 3 had a ROM impairment in one arm and a ROM impairment in one leg. The Rehab Screening Form did not indicate which arm and which leg had ROM impairments. The Rehab Screening Form indicated Resident 3 had the same level of function without decline and to continue the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) program. A review of Resident 3's physician orders, dated 11/27/2023, indicated for the RNA to provide PROM on both upper extremities and both lower extremities, 3-5x/week with one person assist as tolerated. A review of Resident 3's quarterly Rehab Screening Form, dated 2/6/2024, indicated Resident 3 had a ROM impairment in one arm and a ROM impairment in one leg. The Rehab Screening Form did not indicate which arm and which leg had ROM impairments. The Rehab Screening Form indicated Resident 3 had the same level of function without decline and to continue the RNA program. A review of Resident 3 MDS, dated [DATE], indicated Resident 3 had severely impaired cognition, had ROM impairments to one arm and one leg, and was dependent for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene, showering/bathing, and dressing. A review of Resident 3's quarterly Rehab Screening Form, dated 5/7/2024, indicated Resident 3 had a ROM impairment in one arm and a ROM impairment in one leg. The Rehab Screening Form did not indicate which arm and which leg had ROM impairments. The Rehab Screening Form indicated Resident 3 had the same level of function without decline and to continue the RNA program. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/28/2024 at 10:48 a.m. with the DOR, the facility's Rehab Screening Form was reviewed. The DOR stated the Rehab Screening Form was completed upon a resident's admission, quarterly, change of condition, and annually. The DOR stated ROM was assessed as either having no impairment, impairment on one side, or impairment on both sides. The DOR stated the Rehab Screening Form did not include a ROM assessment for limitations in each joint of the arms (shoulders, elbows, wrists, and hands) and the legs (hips, knees, ankles). The DOR stated RNA services helped residents (in general) maintain their ROM and function. During an observation on 5/28/2024 at 11:30 a.m., in Resident 3's room, Resident 3 was observed asleep while lying in bed with the HOB elevated and receiving liquid feeding through the G-tube. Resident 3 woke up easily to sound but did not speak. Resident 3 attempted to move the left hand to reach forward but no other active movement was observed in both arms and both legs. During an observation on 5/29/2024 at 8:47 a.m., in Resident 3's room, Resident 3 was observed lying in bed with the HOB elevated receiving liquid feeding through the G-tube. During an observation on 5/29/2024 at 8:53 a.m., in Resident 3's room, the ADON came into Resident 3's room to disconnect the G-tube from the liquid feeding machine. RNA 2 stood on the left side of Resident 3's bed and performed exercises on Resident 3's left arm, including shoulder flexion (lifting the arm upward) and extension (returning the arm downward), shoulder horizontal abduction (lifting the arm from shoulder level in front of the body toward the side and away from the body) and horizontal adduction (lifting the arm from shoulder level on side of the body toward the front of the body), and shoulder rotation (circular motion). RNA 2 did not perform any exercises on the left elbow, wrist, or fingers. RNA 2 walked to the right side of Resident 3's bed and performed exercises on Resident 3's right arm including, shoulder flexion and extension, shoulder horizontal abduction and adduction, and shoulder rotation. RNA 2 did not perform any exercises to Resident 3's right elbow, wrist, and hand. RNA 2 removed the bed sheet over Resident 3's legs. Resident 3 was observed to have the absence of the right lower leg below the knee and a cushioned boot underneath the left foot. RNA 2 performed exercises to the right leg, including hip flexion (bending the leg at the hip joint toward the body) and extension (returning the leg down away from the body), hip abduction (moving the leg away from the body) and adduction (returning the leg toward the body), and hip rotation. RNA did not perform any exercises to the right knee. RNA 2 removed the cushioned boot from the left foot, and Resident 3 was observed with the absence of toes. RNA 2 performed exercises to the left leg, including hip flexion and extension, hip abduction and adduction, and hip rotation. RNA 2 did not perform any PROM to the left knee and left ankle. During an interview on 5/29/2024 at 9:04 a.m. with RNA 2, RNA 2 stated she performed PROM exercises to both arms and both legs. RNA 2 described and demonstrated the ROM exercises performed to Resident 3's arms and legs. RNA 2 stated she moved both of Resident 3's arms at the shoulder joint upward and downward (shoulder flexion and extension), side to side (shoulder horizontal abduction and horizontal adduction), and circles (shoulder rotation). RNA 2 stated she moved both of Resident 3's legs at the hip joint upward and downward (hip flexion and extension), side to side (hip abduction and adduction), and circles (hip rotation). (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/29/2024 at 11:24 a.m. with the DOR, the DOR stated the ROM exercises that the RNAs were expected to perform for each resident's arms included shoulder flexion and extension, shoulder abduction (lifting the arm up and away from the body) and adduction (returning the arm downward to the side of the body), elbow flexion (bending the elbow) and extension (straightening the elbow), wrist flexion (bending the wrist downward) and extension (bending the wrist upward), and finger flexion (bending the fingers toward the palm) and extension (straightening out the fingers). The DOR stated it was important to perform ROM exercises to each joint to improve circulation and prevent stiffness. During an interview on 5/29/2024 at 11:36 a.m. with PT 1, PT 1 stated the ROM exercises that the RNAs were expected to perform for each resident's legs included hip flexion and extension, hip abduction and adduction, knee flexion (bending the knee) and extension (straightening out the knee), and ankle dorsiflexion (bending the ankle toward the body) and plantarflexion (bending the ankle away from the body) to prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness). During a concurrent interview and record review on 5/29/2024 at 12:36 p.m. with the DOR, Resident 3's Rehab Screening Forms were reviewed. The DOR stated Resident 3's Rehab Screening Forms, dated 11/6/2023, 2/6/2024, and 5/7/2024, indicated Resident 3 had a ROM impairment in one arm and ROM impairment in one leg due to Resident 3's hemiplegia affecting the right side of the body. During an interview on 5/29/2024 at 2:36 p.m. with RNA 2, RNA 2 stated she did not perform ROM exercises to both of Resident 3's elbows, wrists, and hands because the physician orders indicated to perform exercises to Resident 3's upper extremity. During an interview on 5/29/2024 at 4:43 p.m. with the DOR, ADON, and MDS 1, MDS 1 stated the ROM assessment in a resident's MDS indicated whether a resident had any ROM limitations but did not indicate which joint had a ROM limitation. The DOR stated the Rehab Screening Form did not include any assessment of a resident's ROM at each joint and stated the facility was not monitoring each resident's ROM. During an interview on 5/31/2024 at 10:28 a.m., with the ADON, the ADON stated the Rehab Screening Form should have monitored a resident's ROM since the RNAs were not trained to observe ROM. c. A review of Resident 56's Admission Record, indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (high blood sugar), hemiplegia or hemiparesis following a cerebrovascular disease affecting the left dominant side, aphasia (loss of ability to understand or express speech as a result of brain damage), and dysphagia (difficulty swallowing). A review of Resident 56's physician orders, dated 4/7/2023, indicated for the RNA to provide AROM on the right arm and right leg and PROM on the left leg, three to five times per week, with one person assist. A review of Resident 56's RNA Referral, dated 4/7/2023, indicated Resident 56 had increased stiffness on the left side of the body and refused to have the left arm touched. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 56's quarterly Rehab Screening Forms, dated 6/22/2023, 9/24/2023, and 12/24/2023, indicated Resident 56 had ROM impairments in both arms and both legs. The Rehab Screening Form indicated Resident 56 had the same level of function without decline and to continue the RNA program. A review of Resident 56's MDS, dated [DATE], indicated Resident 56 had moderately impaired cognition and had ROM impairments to one arm and one leg. The MDS also indicated Resident 56 required substantial/maximal assistance (helper does more than half the effort) for rolling to either side, oral hygiene, showering/bathing, and upper body dressing, and was dependent for chair/bed-to-chair transfers and lower body dressing. A review of Resident 56's annual Rehab Screening Form, dated 3/24/2024, indicated Resident 56 had ROM impairments in both arms and both legs. The Rehab Screening Form indicated Resident 56 had the same level of function without decline and to continue the RNA program. During a concurrent observation and interview on 5/28/2024 at 10:05 a.m., with Resident 56, in Resident 56's room, Resident 56 was observed awake while lying in bed. Resident 56 moved the right arm and right leg without any physical assistance. Resident 56's left arm was positioned with the left shoulder rotated toward the body, the elbow was bent and touching Resident 56's chest, the wrist was bent downward, and the knuckles of each finger were bent toward the palm. Resident 56's left leg was resting on the bed. Resident 56 stated he was unable to move the left side of the body and stated someone (unknown) performed exercises with Resident 56 at least once per day. During a concurrent interview and record review on 5/28/2024 at 10:48 a.m. with the DOR, the facility's Rehab Screening Form was reviewed. The DOR stated the Rehab Screening Form was completed upon a resident's admission, quarterly, change of condition, and annually. The DOR stated ROM was assessed as either having no impairment, impairment on one side, or impairment on both sides. The DOR stated the Rehab Screening Form did not include a ROM assessment for limitations in each joint of the arms (shoulders, elbows, wrists, and hands) and the legs (hips, knees, ankles). The DOR stated RNA services helped residents maintain their ROM and function. During an observation on 5/29/2024 at 10:02 a.m., in Resident 56's room, Resident 56 was observed awake while lying in bed and performed exercises with RNA 1. Resident 56 performed AROM at the shoulder joint to lift the right arm upward (shoulder flexion) to shoulder level and downward (shoulder extension) without any physical assistance. Resident 56 required some physical assistance to perform right shoulder rotation (circular motion) and right elbow flexion (bending) and extension (straightening). Resident 56 did not perform any ROM exercises of the wrist and the hand. Resident 56 required some physical assistance to perform right hip and knee exercises. Resident 56 did not perform any right ankle exercises. RNA 1 performed PROM exercises to Resident 56's left leg, including hip flexion (bending the leg at the hip joint toward the body) and extension (returning the leg down away from the body). RNA did not perform PROM of the left knee and ankle. RNA 1 stated Resident 56 did not have physician orders to perform ROM exercises to the left arm because Resident 56 did not want anyone to touch it. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/29/2024 at 10:10 a.m. with RNA 1, RNA 1 described and demonstrated the ROM exercises performed with Resident 56. RNA 1 stated Resident 56 performed ROM exercises on the right arm, including moving the shoulder joint upward and downward (shoulder flexion and extension) and rotation. RNA 1 stated Resident 56 required some physical assistance to perform some right arm and right leg exercises and could only tolerate left hip flexion exercises due to pain. During an interview on 5/29/2024 at 11:24 a.m. with the DOR, the DOR stated the ROM exercises that the RNAs were expected to perform for each resident's arms included shoulder flexion and extension, shoulder abduction and adduction, elbow flexion and extension, wrist flexion (bending the wrist downward) and extension (bending the wrist upward), and finger flexion (bending the fingers toward the palm) and extension (straightening out the fingers). The DOR stated it was important to perform ROM exercises to each joint to improve circulation and prevent stiffness. During an interview on 5/29/2024 at 2:32 p.m. with RNA 1, RNA 1 stated Resident 56 did not perform any ROM exercises on the right wrist and hand because Resident 56 already used the right hand constantly to eat and reposition the body. RNA 1 stated Resident 56 did not perform any ROM exercises to the right ankle because Resident 56 was starting to have pain in the right leg. During an interview on 5/29/2024 at 4:43 p.m. with the DOR, ADON, and MDS 1, MDS 1 stated the ROM assessment in a resident's MDS indicated whether a resident had any ROM limitations but did not indicate which joint had a ROM limitation. The DOR stated the Rehab Screening Form did not include any assessment of a resident's ROM at each joint and stated the facility was not monitoring each resident's ROM. During a concurrent interview and record review on 5/30/2024 at 1:15 p.m. with the DOR, Resident 56's Rehab Screening Forms, dated 4/7/2023, 6/22/2023, 9/24/2023, 12/24/2024, and 3/24/2024, were reviewed. The DOR stated Resident 56's Rehab Screening Forms did not include any assessment		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to date and input the time of continuous tube feeding administration, the date and time the tube feeding formula per policy and standards of care for three of five sampled residents (Resident 25, Resident 53, and Resident 61). This deficient practice had the potential to cause weight loss or infection. Findings: a. A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61 diagnoses included cerebral palsy (a condition that develops before birth which affects movement and posture with exaggerated reflexes, floppy or rigid limbs, and involuntary motions), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with a single episode of severe psychotic features (seeing or hearing stimuli that is not there, having false beliefs, and confused or disturbed thoughts), gastrostomy status ([G-tube] also known as an enteral tube, and is surgically inserted tube that enters and provides nutritional directly the stomach), and Type II diabetes mellitus (high blood sugar). A review of Resident 61's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated [DATE], indicated Resident 61 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 61 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 61's Physician Orders, dated [DATE] indicated a current order for enteral feeding (nutrition delivered directly to the gut) of Glucerna 1.2 (a type of nutrition for diabetics) at a rate of 50 milliliters ([ml] a unit of measurement) for 20 hours a day. During an observation on [DATE] at 9:16 a.m., Resident 61 was observed awake in bed and non-verbal. Resident 61's tube feeding was not dated to indicate when the feeding was started. Resident 61's water bag (to be infused periodically through the G-tube for hydration) was dated [DATE], at 4:00 p.m. b. A review of Resident 25's Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 25's diagnoses included dysphagia (difficulty swallowing), gastrostomy malfunction, and Type II diabetes mellitus. A review of Resident 25's MDS, dated [DATE], indicated Resident 25 was severely cognitively impaired. The MDS indicated Resident 25 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 25's care plan titled, Risk for Aspiration (choking), dated [DATE] indicated an enteral feeding of Glucerna 1.5 at a rate of 50 ml for 20 hours a day. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE], at 10:12 a.m., Resident 25 was observed asleep. Resident 25's tube feeding was dated [DATE] but did not indicate a time the feeding was started. c. A review of Resident 53's Admission Record indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included encounter for attention to gastrostomy. A review of Resident 53's MDS, dated [DATE], indicated Resident 53 was severely cognitively impaired. The MDS indicated Resident 53 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 53's care plan titled, Maintain Current Body Weight, dated [DATE] indicated to administer enteral feeding of Jevity 1.2 at a rate of 55 ml for 20 hours a day. During an observation on [DATE] at 9:38 a.m., Resident 53 was observed awake in bed verbal with incoherent speech. Resident 53's tube feeding was dated [DATE] but no time was noted to indicate when the feeding was started. Resident 53's water bag was dated [DATE], at 4:00 p.m. During an interview on [DATE], at 2:15 p.m., with the Assistant Director of Nursing (ADON), the ADON stated all tube feedings should have the resident's name, the room, the date and time the feeding was started, and the nurses' initials. The ADON stated it was important to put the date and time to determine the amount the resident received, and to note when to discard the feeding to prevent administering expired food to residents. The ADON stated feedings and water should be discarded every 24 hours to prevent bacterial growth. A review of the facility policy and procedure (P&P) titled Enteral Nutrition: General Guidelines, dated , d+[DATE], indicated: a. All feeding bags/containers (open and closed systems) of formula must be labeled with the Resident's name, date and time hung, and nurse's initials. b. Feeding bags, administration sets and syringes should be changed every 24 hours.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to: 1. Ensure an informed consent was obtained for bed siderail use (a form of physical restraint) for five of five sample residents (Residents 13, 24, 27, 32 84). 2. Ensure Resident 27 had a physician's order for siderails prior to installing bed siderails. 3. Ensure Resident 13's responsible party (RP) was informed about the risk and benefits of bed siderail use. 4. Ensure Residents 84, 24, and 32 were evaluated for alternatives prior to installing bed rails. These deficient practices placed Residents 13, 24, 27, 32 and 84 at risk of inappropriate use of bedrails, placed the residents at risk for unnecessary restraints, and had the potential to violate the residents' rights and responsible party's right of being informed prior to restraint use. Findings: a. During an observation on 5/28/2024 at 11:32 a.m., in Resident 32's room, Resident 32 was observed lying in bed with bilateral bed siderails in upper position. A review of Resident 32's Admission Record (Face Sheet), indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a loss of brain function such as memory, thinking, language, behavior), anxiety (a feeling of worry or fear), hypertension (high blood pressure), and muscle weakness (loss of muscle strength). A review of Resident 32's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 3/15/2024, indicated Resident 32 makes self-understood and understand others. The MDS indicated Resident 32 required maximum assistance (helper does more than half the effort) from staff for toileting hygiene, shower, and personal hygiene. A review of Resident 32's History and Physical (H&P), dated 8/23, indicated Resident 32 did not have the capacity to understand and make decisions. A review of Resident 32's Order Summary Report, dated 9/3/2023, indicated both half (1/2) side rails up when in bed for turning and repositioning as enabler (equipment, devices, or furniture, used with the intention of promoting independence, comfort, and/or safety). (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/28/2024 at 11:34 a.m., in Resident 32's room, with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident 32 gets out of bed often without calling for assistance. CNA 2 stated Resident 32 was at risk for falls and injuries. CNA 2 stated the facility used bed siderails for residents at high risk for falls. CNA 2 stated bed siderails needed to be up when Resident 32 was lying in bed for safety. CNA 2 stated bed siderails were used for assisting Resident 32 to move from side to side with the assistance of staff. CNA 2 stated she was not sure if bed siderails were considered a restraint. During a telephone interview on 5/29/2024 at 8:06 a.m., with Resident 32's family member (FM 3). FM 3 stated when Resident 32 was readmitted to the facility in 8/11/2023, Resident 32's bed had bed siderails already installed. FM 3 stated she did not consent for bed siderails. FM 3 stated staff did not provide her with informed consent for the use of bed siderails, and she was not aware an informed consent was needed for the use of bed siderails. b. During a concurrent observation and interview on 5/28/2024 at 9:43 a.m., in Resident 24's room, Resident 24 was observed lying in bed and had siderails up. Resident 24 stated he was not aware why his bed had siderails. Resident 24 stated staff had not informed him why he needed bed rails. Resident 24 stated he did not need siderails on his bed. A review of Resident 24's Admission Record (Face Sheet), indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including seizure (uncontrolled body movements that occur because of abnormal electric activity in the brain), heart failure, diabetes, and depression. A review of Resident 24's MDS, dated [DATE], indicated Resident 24 makes self- understood and understand others. The MDS indicated Resident 24 required supervision assistance (helper provides verbal cues, and contact guard assistance as resident completes activity) from staff for toileting hygiene, shower, dressing, and walking. A review of Resident 24's History and Physical (H&P), dated 8/20/2023, indicated Resident 24 had the capacity to understand and make decisions. A review of Resident 24's Order Summary Report, dated 7/11/2023, indicated bilateral padded side rails up on the bed for turning and repositioning Resident 24. During a concurrent interview and record review on 5/29/2024 at 11:22 a.m., with the Registered Nurse (RN) 1, Resident 32's and Resident 24's Electronic Medical Record (EMR) was reviewed. RN 1 was not able to provide documentation on least restrictive measures that were implemented prior to placing bed siderails. RN 1 stated there was not an informed consent signed by Resident 24, and Resident 32, or Resident 32's family member for the use of bed rails in the electronic medical record. c. During an observation on 5/28/2024 at 12:25 p.m., in Resident 13's room, Resident 13's bed had bilateral upper bed side rails attached to bed. A review of Resident 13's Admission Record, indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including ischemic heart disease (heart weakening caused by reduced blood flow to your heart) and dysphagia (difficulty or discomfort in swallowing). (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13's H&P dated 8/31/2023, indicated Resident 13 did not have the capacity to understand and make decisions. A review of Resident 13's Minimum MDS, dated [DATE], indicated Resident 13 had an unclear speech, sometimes understood others, sometimes made herself understood, and her vision was impaired. The MDS indicated that Resident 13's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 13 required maximum assistance for all activities of daily living. The MDS indicated Resident 13 required maximum assistance for rolling left to right in bed, from sitting positioning to lying position and from lying position to sitting on the side of the bed. During an interview on 5/30/2024 at 11:45 a.m. with Resident 13's Responsible Party (RP 1), RP 1 stated no one asked him if he wanted bed siderails placed on Resident 13's bed. RP 1 stated he thought all resident beds came with bed siderails. RP 1 stated he did not know what the bed siderails were used for. RP 1 stated he did not give consent for the bed siderails to be placed on Resident 13's bed. d. During an observation on 5/28/2024 at 12:01 p.m., in Resident 27's room, Resident 27's bed had bilateral upper bed siderails attached to bed. A review of Resident 27's Admission Record, indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 27's diagnoses included peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and heart failure (progressive heart disease that affects pumping action of the heart muscles causing fatigue and shortness of breath). A review of Resident 27's H&P dated 6/22/2023, indicated Resident 27 had the capacity to understand and make medical decisions. A review of Resident 27's MDS, dated [DATE], indicated that Resident 27's cognitive skills for daily decision making was intact. The MDS indicated Resident 27 required supervision (the helper provides verbal cues, touching contact as resident completes activity) for toileting hygiene, dressing, and for showers/baths. The MDS indicated Resident 27 required supervision for toilet transfer (the ability to get on and off a toilet or commode), to move from sit to stand position, and to walk for at least 10 feet. A review of Resident 27's EMR indicated there was no order for bilateral upper side rails for restraints. During an interview on 5/30/2024 at 12:33 p.m. with Resident 27, in Resident 27's room, Resident 27 stated the facility staff did not ask him if he wanted the siderails on the bed. Resident 27 stated he thought the bed came like that and that all residents had siderails on their bed. Resident 27 stated he did not use the side rails on the bed at all. Resident 27 stated it would have been nice if the facility staff informed him of the purpose for the siderails and asked Resident 27's if he wanted the siderails. Resident 27 stated this was his home and he should be able to choose what he wants or did not want. Resident 27 stated he did not give his consent for the siderail use. Resident 27 stated he had been at facility for years and no one had taken the time to check if he needed the siderails. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/2024 at 12:44 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated residents in this facility do get upper siderails on the bed but it was not considered a restraint. LVN 3 stated when a bed had upper and lower siderails they are restrictive and considered a restraint. LVN 3 stated he did not know if an informed consent. LVN 3 stated he never verified with residents or their responsible parties if they consented for siderails. During an interview on 5/31/2024 at 2:58 p.m. with the Assistant Director of Nursing (ADON), the ADON stated residents that had siderails were residents who need assistance with repositioning or at risk for falls. The ADON stated a siderail was considered a restraint and it was used as a last resort for safety. The ADON stated prior to siderail use, a resident must have a doctor's order and an informed consent. The ADON stated a resident's bed should not have siderails if there was no order or an informed consent for siderails. The ADON stated if a resident or responsible party are not informed of the risk and benefits of siderail use, they will feel that information was not communicated to them because it was withheld from them. The ADON stated siderails did not create a homelike environment and created an institutionalized environment (an environment experience by people admitted to prison, a mental asylum, or an orphanage). e. A review of Resident 84's Admission Record, dated 5/30/2024, indicated Resident 84 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included left hip fracture (a partial or complete break of the thigh bone, where it meets the pelvic bone), syncope and collapse (fainting or a temporary loss of consciousness with a quick recovery), hypertension (high blood pressure), and osteoarthritis (inflammation and swelling that occurs in the joints when the flexible tissue at the ends of bones begin to wear down over time). A review of Resident 84's H&P dated 4/24/2024, indicated that Resident 84 had the capacity to understand and make decisions. A review of Resident 84's MDS dated [DATE], indicated Resident 84 had no cognitive impairment. The MDS also indicated Resident required minimal assistance with eating, partial assistance with oral and personal hygiene. A review of Resident 84's Order Summary Report, dated 4/24/2024, indicated an active order for both half side rails up when in bed for turning and repositioning as an enabler. A review of Resident 84's Informed Consent for Physical Restraint, dated 4/3/2024, indicated the facility obtained an informed consent for Resident 84 for the use of physical restraints (both half side rails for turning and repositioning), however the informed consent was not signed by Resident 84 or the physician. A review of Resident 84's care plan dated 5/30/2024, indicated a new care plan was initiated for Resident 84's physician order for both half side rails to be up when in bed for turning and repositioning. A review of Resident 84's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Care Conference Notes, dated 4/8/2024, indicated that Resident 84 used both half siderails as enablers for turning and repositioning. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/31/2024 at 9:35 a.m. with LVN 4, it was observed the upper bed siderails raised on both sides of Resident 84's bed. LVN 4 stated, The side rails are left up. LVN 4 stated when side rails are up, it is considered a restraint to the resident. LVN 4 stated that Resident 84 should have a doctor's order and an informed consent to use the siderails for safety. During a concurrent interview and record review on 5/31/2024 at 9:43 a.m. with Registered Nurse (RN 1), Resident 84's medical record was reviewed. RN 1 stated Resident 84 had a doctor's order for half side rails up when in bed for turning and repositioning. RN 1 stated Resident 84 should also have an informed consent for siderail orders. RN 1 stated the copy in the electronic medical record (EMR) was not signed by Resident 84 or the physician. During an interview and record review on 5/31/2024 at 10:40 a.m. with the Medical Records Director (MRD), Resident 84's medical records were reviewed. The MRD stated that a paper copy of Resident 84's informed consent for restraints for the use of bed siderails should be in the chart and available for signature by the doctor. The MRD was unable to provide a signed copy of a consent for restraints by the physician. During a concurrent interview and record review on 5/31/2024 at 2:46 p.m. with the ADON, Resident 84's electronic medical record was reviewed. The ADON stated all informed consents for restraints should be signed by the physician, resident, or responsible party. The ADON stated an evaluation for restraints must be done on resident before placing the bed siderails upon admission. The ADON stated that other interventions should be tried on residents before placing bed siderails. The ADON stated half bed siderails are considered a restraint and need an informed consent to be placed in the EMR resident's chart. The ADON stated that the paper copy of the informed consent must be signed by the doctor and the resident before initiating the bed siderails/restraints. During a review of facility's Policy and Procedure (P&P) titled Policy and Procedure on Side Rails, revised 5/2012, indicated: 1. Medical Director (MD) should obtain informed consent from resident, resident representative, or both before an order for a physical restraint such as side rails could be carried out by the licensed nurses. 2. Licensed nurse receiving the order from MD should verify from resident or resident representative or both that consent was obtained by the MD from him/her. 3. Documentation of the reason for side rails implementation with the obtained consent of MD from resident, resident representative, or both. A review of the facility's P&P titled, Policy and Procedure on Restraint, dated 7/2012, indicated if the restraint is needed, it has to indicate the medical necessity due to resident physical condition or psychosocial problem. The P&P indicated except for an emergency situation that threatens residents' and others' health and safety, restraint will not be used. The P&P indicated that based on the assessment result if either a physical/chemical restraint is needed, consent will be obtained by the doctor from the resident/resident representative or both of the use of such restraint. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Use of Restraints, dated 12/2014, indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. The P&P indicated that practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted such as using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed. The P&P indicated that restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by a less restrictive intervention. The P&P stated that prior to placing a resident in restraints, a pre-restraining assessment and review is done to determine the need for restraints. A review of the facility's P&P titled, Informed Consent and Chemical Restraints, revised 1/2024, indicated the facility must have an informed consent prior to initiation of Chemical/Physical treatment or procedure. 45009 48343		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure four of four Restorative Nursing Aides (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) received an evaluation of competence (possession of sufficient knowledge or skill) as evidenced by: a. Four of four sampled residents (Resident 53, 3, 56, and 61) with range of motion [ROM, full movement potential of a joint (where two bones meet)] and mobility (ability to move) concerns did not receive ROM exercises to each joint of both arms and both legs in accordance with physician orders and the facility's job description titled, Restorative Nursing Assistant. b. Four of four RNAs (RNA 1, RNA 2, RNA 3, and RNA 4) did not have an evaluation indicating each RNA was proficient (able to do something to a higher than average standard) to provide RNA services in accordance with the facility's policy titled, Competency of Nursing Staff. These deficient practices resulted in Resident 53, 3, 56, and 61 receiving incomplete ROM exercises to both arms and both legs, placing the residents at risk for loss of motion and the development of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness). Cross reference F688. Findings: 1a. A review of Resident 53's Admission Record, indicated the facility originally admitted Resident 53 on 12/21/2022 and readmitted Resident 53 on 3/20/2024. The Admission Record indicated Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's physician orders, dated 3/25/2024, indicated for RNA to provide passive range of motion ([PROM] movement of joint through the ROM with no effort from the person) on both arms and both legs, followed by applying both elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours (4-6 hours), three to five times per week (3-5x/week). (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 4/2/2024, indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember) and was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed while lying awake in bed with the head of bed (HOB) elevated and did not speak. Resident 53's elbows were in a bent position. Restorative Nursing Aide (RNA) 3 performed ROM exercises on Resident 53's left arm, including shoulder abduction (lifting the arm away from the body) and adduction (returning the arm toward the body), shoulder rotation (circular motion) in clockwise and counterclockwise directions, shoulder flexion (lifting the arm upward) and extension (returning the arm downward), elbow flexion (bending) and extension (straightening), and then applied an elbow extension splint (splint that prevents the resident from bending at the elbow) on the left arm. RNA 3 performed ROM exercises on Resident 53's right arm, including shoulder abduction and adduction, shoulder rotation in clockwise and counterclockwise directions, shoulder flexion and extension, elbow flexion and extension, and then applied an elbow extension splint on the right arm. Resident 53's legs were rotated away from the body, both knees were bent, and both ankles were positioned in plantarflexion (ankles bent with toes pointing away from the body). RNA 3 performed ROM exercises on Resident 53's right leg, including hip abduction (moving the leg away from the body) and adduction (returning the leg toward the body), hip rotation clockwise and counterclockwise while the knee was extended, hip flexion (bending the leg at the hip joint toward the body) with knee flexion (bending the knee), and ankle rotation. RNA 3 did not move Resident 53's right ankle into dorsiflexion (ankle bent with toes pointing toward the body). RNA 3 performed ROM exercises on Resident 53's left leg, including hip abduction and adduction, hip rotation clockwise and counterclockwise with the knee extended, hip flexion with knee flexion, and ankle rotation. RNA 3 did not move Resident 53's left ankle into dorsiflexion. RNA 3 then performed exercises to the left-hand fingers into flexion (bending the fingers toward the palm) and extension (straightening out the fingers), left wrist rotation, left wrist flexion (bending the wrist downward) and extension (bending the wrist upward), right-hand fingers into flexion and extension, right wrist rotation, and right wrist flexion and extension. b. A review of Resident 3's Admission Record, indicated the facility originally admitted Resident 3 on 12/18/2018 and readmitted Resident 3 on 10/23/2023. The Admission Record indicated Resident 3's diagnoses included type 2 diabetes mellitus (high blood sugar), myocardial infarction (heart attack), hemiplegia or hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (stroke, brain damage due to a loss of oxygen to the area) affecting the right dominant (used most often) side, dysphagia (difficulty swallowing), acquired absence of the left toes, and acquired absence of the right leg below the knee. A review of Resident 3's physician orders, dated 11/27/2023, indicated for the RNA to provide PROM on both upper extremities (arms) and both lower extremities (legs), 3-5x/week with one person assist as tolerated. A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had severely impaired cognition and was dependent for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene, showering/bathing, and dressing. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/29/2024 at 8:53 a.m., in Resident 3's room, RNA 2 stood on the left side of Resident 3's bed and performed exercises on Resident 3's left arm, including shoulder flexion and extension, shoulder horizontal abduction (lifting the arm from shoulder level in front of the body toward the side and away from the body) and horizontal adduction (lifting the arm from shoulder level on side of the body toward the front of the body), and shoulder rotation. RNA 2 did not perform any exercises on the left elbow, wrist, or fingers. RNA 2 walked to the right side of Resident 3's bed and performed exercises on Resident 3's right arm including, shoulder flexion and extension, shoulder horizontal abduction and adduction, and shoulder rotation. RNA 2 did not perform any exercises to Resident 3's right elbow, wrist, and hand. RNA 2 removed the bed sheet over Resident 3's legs. Resident 3 was observed to have the absence of the right lower leg below the knee and a cushioned boot underneath the left foot. RNA 2 performed exercises to the right leg, including hip flexion and extension, hip abduction and adduction, and hip rotation. RNA did not perform any exercises to the right knee. RNA 2 removed the cushioned boot from the left foot, and Resident 3 was observed with the absence of toes. RNA 2 performed exercises to the left leg, including hip flexion and extension, hip abduction and adduction, and hip rotation. RNA 2 did not perform any PROM to the left knee and left ankle. During an interview on 5/29/2024 at 2:36 p.m. with RNA 2, RNA 2 stated she did not perform ROM exercises to both of Resident 3's elbows, wrists, and hands because the physician orders indicated to perform exercises to Resident 3's upper extremity. c. A review of Resident 56's Admission Record, indicated the facility admitted Resident 56 on 3/5/2023 with diagnoses including diabetes mellitus, hemiplegia or hemiparesis following a cerebrovascular disease (affecting the blood flow of the brain) affecting the left dominant side, aphasia (loss of ability to understand or express speech as a result of brain damage), and dysphagia. A review of Resident 56's physician orders, dated 4/7/2023, indicated for the RNA to provide active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) on the right arm and right leg and PROM on the left leg, 3-5x/week, with one person assist. A review of Resident 56's RNA Referral, dated 4/7/2023, indicated Resident 56 had increased stiffness on the left side of the body and refused to have the left arm touched. A review of Resident 56's MDS, dated [DATE], indicated Resident 56 had moderately impaired cognition, had ROM impairments to one arm and one leg, and required substantial/maximal assistance (helper does more than half the effort) for rolling to either side, oral hygiene, showering/bathing, and upper body dressing, and was dependent for chair/bed-to-chair transfers and lower body dressing. During an observation on 5/29/2024 at 10:02 a.m., in Resident 56's room, Resident 56 was observed awake while lying in bed and performed exercises with RNA 1. Resident 56 performed AROM at the shoulder joint to lift the right arm upward (shoulder flexion) to shoulder level and downward (shoulder extension) without any physical assistance. Resident 56 required some physical assistance to perform right shoulder rotation and right elbow flexion and extension. Resident 56 did not perform any ROM exercises of the wrist and the hand. Resident 56 required some physical assistance to perform right hip and knee exercises. Resident 56 did not perform any exercises on the right ankle. RNA 1 performed PROM exercises to Resident 56's left leg, including hip flexion and extension. RNA did not perform PROM of the left knee and ankle. RNA 1 stated Resident 56 did not have physician orders to perform ROM exercises to the left arm because Resident 56 did not want anyone to touch it. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/2024 at 2:32 p.m. with RNA 1, RNA 1 stated Resident 56 did not perform any ROM exercises on the right wrist and hand because Resident 56 already used the right hand constantly to eat and reposition the body. RNA 1 stated Resident 56 did not perform any ROM exercises to the right ankle because Resident 56 was starting to have pain in the right leg. d. A review of Resident 61's Admission Record, indicated the facility originally admitted Resident 61 on 9/26/2023 and readmitted Resident 61 on 10/10/2023. The Admission Record indicated Resident 61's diagnoses included cerebral palsy (condition marked by impaired muscle coordination and/or other disabilities, typically caused by damage to the brain before or at birth), diabetes mellitus, contractures of both knees, muscle weakness, and attention to the G-tube. A review of Resident 61's physician orders, dated 11/20/2023, indicated for RNA to provide PROM with 10 repetitions to both arms and both legs followed by applying splints to both elbows and both knees for 4-6 hours, five times per week. A review of Resident 61's MDS, dated [DATE], indicated Resident 61 was severely impaired for daily decision making, had ROM impairments to both arms and both legs, and was dependent for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene, showering/bathing, and dressing. During an observation on 5/29/2024 at 9:42 a.m., in Resident 61's room, Resident 61 was observed awake while lying in bed. RNA 1 was standing on the left side of Resident 61's bed and provided PROM to Resident 61's left arm, and RNA 3 was standing on the right side of Resident 61's bed and provided PROM to Resident 61's right arm. RNA 1 and RNA 3 provided PROM to both of Resident 61's arms at the same time but each RNA was performing different types of PROM on different joints. RNA 1 applied an elbow splint to the left arm, and then RNA 3 applied an elbow splint to the right arm. Resident 61 did not receive any PROM to both wrists and hands. Resident 61's bed sheet was removed from both legs. Resident 61's hips were pressed together and bent upward toward Resident 61's body while the knees were almost completely bent downward. RNA 3 and RNA 1 attempted to move both of Resident 61's legs away from each other. RNA 3 held the right leg away from the body while RNA 1 straightened and bent the left hip and knee. RNA 1 then held the left leg away from the body while RNA 3 straightened and bent the right hip and knee. Resident 61 moaned and was loudly breathing during the leg exercises. RNA 3 stated Resident 61 was probably feeling slight discomfort from the PROM exercises on the legs. RNA 3 and RNA 1 then applied both knee splints. Resident 61 did not receive any PROM to both ankles. During an interview on 5/29/2024 at 9:58 a.m., RNA 1 and RNA 3 stated they performed PROM exercises to both arms and both legs at the same time since Resident 61 was very stiff. During an interview on 5/29/2024 at 11:24 a.m. with the DOR, the DOR stated the ROM exercises that the RNAs were expected to perform for each arm included shoulder flexion and extension, shoulder abduction and adduction, elbow flexion and extension, wrist flexion and extension, and finger flexion and extension. The DOR stated it was important to perform ROM exercises to each joint to improve circulation and prevent stiffness. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/2024 at 11:36 a.m. with Physical Therapist 1 (PT 1), PT 1 stated the ROM exercises that the RNAs were expected to perform for each leg included hip flexion and extension, hip abduction and adduction, knee flexion and extension, and ankle dorsiflexion and plantarflexion to prevent contractures. A review of the facility's undated Job Description and Performance Standards tilted, Restorative Nursing Assistant, indicated responsibilities included providing restorative nursing care as outlined by the physician orders. 2. A review of RNA 1's personnel file indicated a document titled, Certified Nursing Assistant Skills Competency Review, dated 5/12/2023. A review of RNA 2's personnel file indicated a document titled, Certified Nursing Assistant Skills Competency Review, dated 10/20/2023. A review of RNA 3's personnel file indicated a document titled, Certified Nursing Assistant Skills Competency Review, dated 5/19/2023. A review of RNA 4's personnel file indicated a document titled, Certified Nursing Assistant Skills Competency Review, dated 5/19/2023. During a concurrent interview and record review on 5/31/2024 at 11:12 a.m. with the Director of Staff Development (DSD), RNA 1, RNA 2, RNA 3, and RNA 4's personnel files were reviewed. The DSD stated RNAs were Certified Nursing Assistants (CNAs) with more specific job duties which included weighing each resident, applying splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), performing ROM exercises, assisting the CNAs to transfer residents, and assisting with mobility, like ambulation (the act of walking) and sit to stand transfers. The DSD stated competency evaluations for nursing staff occurred annually to ensure the staff was qualified to perform job duties and responsibilities and ensure safety for the residents. The DSD reviewed all four personnel files and stated RNA 1, RNA 2, RNA 3, and RNA 4 had a Certified Nursing Assistant (CNA) Skills Competency Review since they were also CNAs. The DSD stated the competency skills to apply splints and obtain weights was not included in the CNA Skills Competency Review. The DSD reviewed all four RNA personnel files and stated all four RNAs did not a competency skill evaluation specific to the RNA job duties. A review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, revised 10/2017, indicated nursing assistants employed by the facility will demonstrate specific competencies and skills sets deemed necessary to care for the needs of residents. The P&P also indicated competency evaluations will include the ability to use tools, devices, or equipment used to care for residents.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review the facility failed to monitor behaviors and provide non-pharmacological behavioral interventions for antipsychotic medication (a type of psychotropic psychiatric medication used to treat psychotic disorders) use for one out of five residents (Resident 61). This deficient practice had the potential to cause Resident 61 extrapyramidal side effects (a series of potentially irreversible psychiatric drug induced movement disorders) and potentially prevent Resident 61 from functioning at her highest practicable physical, mental, and psychosocial well being. Findings: A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's admitting diagnose included cerebral palsy (a condition that develops before birth which affects movement and posture with exaggerated reflexes, floppy or rigid limbs, and involuntary motions) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with a single episode of severe psychotic features (seeing or hearing stimuli that is not there, having false beliefs, and confused or disturbed thoughts). A review of Resident 61's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/22/2024, indicated Resident 61 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 61 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 61's Physician Orders, dated 1/25/2024 indicated a current and renewed order to monitor for any adverse side effects (an undesired and harmful effect resulting from medication) of tardive dyskinesia (repetitive, involuntary movements, such as grimacing and eye blinking), cognitive impairment, akathisia (inability to remain still), and pseudo-parkinsonism (a reaction to medications that manifests as tremors) for antipsychotics. A review of Resident 61's Physician Orders, dated 3/6/2024 indicated a current and renewed order for Seroquel (an antipsychotic medication) oral tablet 50 milligrams ([mg] a unit of measurement] via G-tube ([gastrostomy] a tube is inserted through the belly that brings nutrition directly to the stomach) at bedtime related to major depressive disorder with a single episode of severe psychotic features manifested by crying. A review of Resident 61's Physician Orders, dated 3/6/2024, indicated a current and renewed order to monitor for behavior episodes of depression manifested by crying every shift related to major depressive disorder with a single episode of severe psychotic features. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 61's Gradual Dose Reduction (GDR, is federally required guidelines that required skilled nursing facilities to evaluate resident psychotropic medications on a routine basis, in an attempt to taper off completely or provided the smallest therapeutic dose possible to prevent adverse reactions, and with detailed documentation justifying the continued use) Request & Risk Versus Benefit Statement, dated 3/14/2024, indicated Resident 61 was not a candidate for GDR and was contraindicated because the benefits outweigh the risks, and that the GDR would likely cause psychiatric instability but did not indicate the benefits or the risks. A review of Resident 61's Medication Administration Record (MAR) dated 3/2024 indicated Resident 61 received Seroquel 50 mg every day for crying. The MAR indicated Resident 61 manifested behaviors of crying on 3/23/2024, 3/25/2024, 3/26/2024, 3/27/2024, and 3/29/2024, for a total of 10 episodes crying. A review of Resident 61's MAR dated 4/2024 indicated Resident 61 received Seroquel 50 mg every day for crying. The MAR indicated Resident 61 manifested behaviors of crying on 4/5/2024, 4/6/2024, 4/12/2024, 4/15/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/25/2024, 4/28/2024, 4/30/2024 for a total of 5 episodes crying. A review of Resident 61's MAR dated 5/2024 indicated Resident 61 received Seroquel 50 mg every day for crying. The MAR indicated Resident 61 manifested behaviors of crying on 5/7/2024, 5/8/2024, 5/10/2024, 5/13/2024, 5/14/2024, 5/16/2024, 5/17/2024, 5/19/2024, 5/20/2024, 5/21/2024, and 5/24/2024 for a total of 11 episodes crying. During an observation on 5/28/2024, at 9:20 a.m., Resident 61 was observed lying in bed, non-verbal and had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of both arms and legs. During an observation on 5/28/2024, at 12:10 p.m., Resident 61's knees were observed flexed (bent) towards the chest in a fixed position. Resident 61 did not respond to verbal stimuli. During an observation on 5/29/2024, at 8:05 a.m., Licensed Vocational Nurse (LVN) 3 was observed obtaining a radial (wrist) blood pressure due to Resident 61 having contractures on both arms. During an interview on 5/30/2024, at 8:47 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 61 was receiving Seroquel 50 mg at night because the resident would cry, scream, and meow at night which disrupted the sleeping pattern of other residents. The ADON stated when residents were receiving antipsychotic medications the nurses would monitor Resident 61's crying behavior in the MAR, but no other behaviors such as screaming, meowing, or sleep disruption was being monitored. The ADON stated that non-pharmacological interventions were not charted by nursing when behaviors were noted. The ADON stated antipsychotics could lead to irreversible effects for Resident 61, and the risks versus benefits should be weighed. During an interview on 5/30/2024, at 11:22 a.m., with Psychiatrist (MD) 1, MD 1 stated she started Resident 61 on Seroquel 50 mg in December 2023 for crying and responding to internal stimuli such as auditory or visual hallucinations (hearing and seeing things that are not there). MD 1 stated Resident 61 would not sleep at night which would not allow other residents to sleep at night. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/30/202, at 1:56 p.m., Certified Nursing Assistant (CNA) 6, CNA 6 was observed communicating to Resident 61 by meowing at her. During an interview on 5/30/2024, at 3:49 p.m., with CNA 5, CNA 5 stated she would hear Resident 61 meow at times, but when Resident 61 meowed she was not distraught or crying. During an interview on 5/31/2024, at 4:25 p.m., with Registered Nurse (RN) 2, RN 2 stated she witnessed Resident 61 meow, laugh alone sometimes, and meow in a howling voice that sounded like crying. During an interview on 5/31/2024, at 4:32 p.m., with CNA 4, CNA 4 stated she never witnessed Resident 61 crying when assigned to her care. A review of the facility Policy and Procedure (P&P) titled Psychotropic Medication Use, undated, indicated: a. Consideration of the use of psychotropic medication is based on a comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. b. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. c. Residents on psychotropic medications receive gradual dose reductions (couple with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. d. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts an evaluation of the resident to clarify other causes for symptoms have been ruled out and signs and symptoms are clinically significant enough to warrant medication therapy. A review of the facility P&P titled Restraints-Chemical, dated 1/2001, indicated a chemical restraint is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms. The P&P indicated chemical restraints will not be used to limit or control resident behavior for the convenience of the staff. A review of the facility P&P titled Charting and Documentation, dated 7/2017, indicated the purpose of the policy was for all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The P&P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to ensure residents were free from medication error rates below 5% for one out of five residents (Resident 61). This deficient practice had the potential for residents to be at risk for medication errors. Findings: A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's admitting diagnosis included cerebral palsy (a condition that develops before birth which affects movement and posture with exaggerated reflexes, floppy or rigid limbs, and involuntary motions) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with a single episode of severe psychotic features (seeing or hearing stimuli that is not there, having false beliefs, and confused or disturbed thoughts). A review of Resident 61's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/22/2024, indicated Resident 61 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 61 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 61's Physician Order, dated 10/10/2023, indicated to administer Ferrous Sulfate (an iron supplement) liquid 5 milligrams ([mg] a unit of liquid measurement) in 20 milliliters ([ml] a unit of liquid measurement) via the gastrostomy ([G-tube] a surgically inserted tube that provides nutrition directly to the stomach) twice a day. During an observation on 5/29/2024 at 8:05 a.m., in Resident 61's room, Licensed Vocational Nurse (LVN) 3 was observed taking Resident 61's blood pressure while wearing gloves. LVN 3 put his hand in his pocket with contaminated gloves that came into contact with his clothing. LVN 3 did not check Resident 61's gastrostomy ([G-tube] a surgically inserted tube that provides nutrition directly to the stomach) placement (a procedure to verify that the G-tube has not been dislodged to prevent infection and choking) prior to administering drugs. LVN 3 administered Ferrous Sulfate 300 milligrams ([mg] a unit of weight measurement) in 5 ml but the order was to give Ferrous Sulfate 5 mg/20 ml. After LVN 3 left the room, LVN 3 put on another pair of gloves, decontaminated his equipment (blood pressure cuff) using disinfectant wipes but did not perform hand hygiene after cleaning contaminated equipment. LVN 3 proceeded to use his computer with contaminated hands. During an interview on 5/30/2024, at 3:36 p.m. with the Assistant Director of Nursing (ADON), the ADON stated G-tube placement should be checked prior to every medication administration to prevent aspiration (choking) or infection. The ADON stated medication orders should be checked and verified prior to administering medications to residents to prevent medication errors, and if there was a discrepancy the physician should be called to clarify the order. The ADON stated medication errors could cause adverse reactions (harmful side effects) if the medication was too much and ineffective therapeutic levels (medication doses that provide benefits as intended) if the medication was not enough. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024, at 3:34 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated when staff enter a contact isolation room contaminated gloves should be discarded first, then hand hygiene performed before putting hands into the pocket or touching clothing or non-contaminated surfaces to prevent the spread of infection. The IPN stated after disinfecting contaminated equipment hand hygiene should be performed to prevent the spread of infection to other residents or staff. A review of facility policy and procedure (P&P) titled Enteral Nutrition: General Guidelines, dated 7/2012, indicated tube placement will be verified prior to medication administration via enteral tubes (tubes that bypass nutrition orally and is inserted directly into the gut). A review of the facility P&P titled Medication Administration, dated 7/2013, indicated drugs must be administered in accordance with the written orders of the attending physician (5 rights), and should there be any doubt of administering medication, the physician should be notified to verify the order.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for the lunch menu was followed on 5/28/2024 when the following occurred: 1. Ten residents receiving a puree diet (foods that do not require chewing and are easily swallowed, all foods should be smooth and pureed to the consistency of pudding) received lasagna in a texture or form that met their needs. The pureed lasagna was lumpy, not smooth and had large pieces of pasta present requiring chewing before swallowing. 21 residents receiving a mechanical soft diet (provides foods that are easily chewed) received toasted garlic bread with a hard crust per the spreadsheet (food portion and serving guide) and menu. 2. Ensure staff followed food production recipes for the dysphagia diet (foods that are moist, mechanically altered requiring little chewing and does not fall apart when swallowed) during lunch preparation and tray line observation. Two residents on a Dysphagia diet received chopped lasagna instead of the ground turkey patty with chopped pasta and green beans cut to 1/2 inch. 3. Follow the lunch menu and portion sizes as written for residents on a pureed diet. 10 residents on a pureed diet received 1/2 cup of lasagna instead of 1 cup per the food portion and serving guide. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake, weight loss, and increased choking risk for 10 residents who were receiving a pureed diet, and 21 residents receiving a mechanical soft diet. Findings: 1. During an observation on 5/28/2024 at 11:30 AM, in the kitchen, Dietary Aide (DA) 2 was preparing garlic bread. DA 2 spread butter, garlic powder, parmesan cheese and seasonings on sliced white bread, then placed the garlic bread in the hot oven. DA 2 stated garlic bread was served with the lasagna for lunch. During an observation of the lunch tray line service on 5/28/2024 at 11:55 AM, the pureed lasagna was dry and not smooth. The garlic bread when removed from the oven, was light brown in color, dry and toasted. When DA 2 sliced the bread in half using a knife, there was a crunch sound. During the same observation for lunch service on 5/28/2024 at 11:55 AM, residents receiving a regular diet and mechanical soft diet received the same dry and toasted garlic bread. During an interview with DA 2 on 5/28/2024 at 12:30 PM, DA 2 stated she was making more garlic bread. DA 2 stated some of the garlic bread was dry. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/28/2024 at 12:45 PM with the Dietary Supervisor (DS) and [NAME] 1, [NAME] 1 stated pureed food should be the consistency of mashed potatoes. [NAME] 1 stated it was important to make the food smooth, so residents were able to swallow. [NAME] 1 stated the pureed lasagna served for lunch did not look smooth because there were pieces of noodles. The DS stated the garlic bread was left in the oven for too long and became dry. The DS stated residents receiving a mechanical soft diet, should receive soft bread per the menu because they could have problems with eating the dry bread. During a subsequent interview and taste tray test of the pureed lasagna on 5/28/2024 at 12:45 PM, with the DS and [NAME] 1, the pureed lasagna was thick with lumpy texture. There were some chunky pieces that required chewing and moving around in the mouth before swallowing. The DS stated the consistency of the pureed lasagna was not smooth and there were large pieces of noodles requiring chewing before swallowing. The DS stated residents receiving a pureed diet could have difficulty swallowing. [NAME] 1 stated the pureed lasagna should have been blended longer for a smooth texture. A review of the facility policy and procedure (P&P) titled Pureed Diet, dated 2018 indicated the puree diet provides foods that do not require chewing and are easily swallowed. The P&P indicated all foods should be smooth and pureed to the consistency of pudding. A review of the facility policy titled Mechanical soft diet (dated 2018) indicated, diet proved foods that are easily chewed. It is appropriate for individuals who have chewing problems, poor dentures, and minor swallowing problems. Foods suggested soft breads. A review of facility spreadsheet for lunch (portion and serving guide) on 5/28/2024 indicated for mechanical soft diet: Zesty Lasagna no hard edges, Italian [NAME] beans (soft), Garlic Bread (soft no hard crust), Peanut butter cookies (soft). Pureed diet: Zesty Lasagna pureed (1 cup), Italian green beans pureed, garlic bread pureed. 2. A review of the Lunch Menu for Dysphagia Mechanical diet dated 5/28/2024, indicated the following ground turkey patties served with #10 scoop yielding 3 ounces (oz., unit of measurement) moist with 1 oz. sauce, pasta 1/2 cup chopped 1/2 mash would be served. During an observation of the lunch tray line service on 5/28/2024, at 11:55 AM, [NAME] 1 served lasagna and regular green beans for the residents who were receiving a dysphagia diet (finally chopped to prevent choking). During a concurrent review of the Menu and interview on 5/28/2024 at 12:45 PM, with [NAME] 1, [NAME] 1 stated she made a mistake and did not follow the menu for the dysphagia mechanical diet (finally chopped/minced). [NAME] 1 stated the residents receiving a dysphagia diet should receive ground turkey with sauce and chopped pasta on the side. During a subsequent interview on 5/28/2024 at 12:45 PM, with the DS, the DS stated the cooks should always follow the menu for the different therapeutic diets (diets that are modified per physician's orders). A review of the Turkey Patties Recipe indicated, for Dysphagia diets, grind the turkey patties and serve with gravy to moisten. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the lunch menu for the pureed diet dated 5/28/2024, indicated 1 cup of pureed zesty Lasagna; 1/2 cup of Italian green beans; parsley garnish flakes; pureed garlic bread; and pureed peanut butter cookies were to be served. During an observation of the lunch tray line service on 5/28/2024, at 11:55 AM, [NAME] 1 was observed serving pureed lasagna using #8 scoop yielding 1/2 cup instead of 1 cup for residents who were receiving a pureed diet. During a concurrent interview and review of the menu on 5/28/2024 at 12:45 PM, with [NAME] 1 and the DS, [NAME] 1 stated she served the wrong scoop size and served less food to residents who received a pureed diet. [NAME] 1 stated it was important to make sure the correct amount was served because serving less food to the residents could result in weight loss. The DS stated the cooks should always follow the menu and the serving guide to serve the correct amount. The DS stated not serving the correct portion, could result in residents not receiving the right calories and protein. A review of facility menu and spreadsheet dated 5/28/2024, indicated to serve 1 cup of pureed lasagna for residents receiving a pureed diet.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure a therapeutic mechanical soft (texture-modified [moist and soft] foods for people who have difficulty chewing and swallowing) diet was served as prescribed by the physician for one of two sampled residents (Resident 42). This deficient practice had the potential to cause Resident 84 to choke on food that was too difficult to chew or swallow. Findings: A review of Resident 42's Admission Record, dated 5/30/2024, indicated Resident 42 was initially admitted to the facility on [DATE]. Resident 42's diagnoses included altered mental status (AMS - disruption in how the brain works that causes a change in behavior), metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), hyponatremia (abnormally low level of sodium in the blood), and dehydration (a harmful reduction in the amount of water in the body). A review of Resident 42's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/6/2024, indicated Resident 42 had a Brief Interview for Mental Status (BIMS - a screening tool used to identify the cognitive condition of residents upon admission into a long-term care facility) of six (severe impairment, normal BIMS score is 13-15). The MDS indicated Resident 42 required maximal assistance (helper does more than half the effort) with toileting and bathing and moderate assistance (helper provides less than half the effort) with eating. A review of Resident 42's History and Physical (H&P), dated 9/21/2023, indicated Resident 42 did not have the capacity to understand and make decisions. A review of Resident 42's Order Summary Report, dated 4/24/2024, indicated a no added salt diet (NAS), mechanical soft texture, thin liquids consistency, fresh fruit only as a dessert starting on 2/24/2023. A review of Resident 42's Quarterly Nutritional Assessment, dated 3/6/2024, indicated Resident 42 was receiving a mechanical altered diet and had chewing problems. A review of the facility's Spring Menu - Week 1, dated 5/27/2024 through 6/2/2024, indicted that zesty lasagna, Italian green beans, garlic bread and a peanut butter cookie would be served for lunch on 5/28/2024. The menu also indicated the peanut butter cookie should be served soft for the mechanical soft diet. A review of the facility's kitchen instructions titled Comparison of IDDSI Level #6 - Soft and Bite Size to Healthcare Menu Direct, LLC's Mechanical Soft Diet, dated 2023, indicated that residents receiving a mechanical soft diet may have soft cookies, cake, pies, puddings. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Health Menus Direct, LLC Recipe for Peanut Butter Cookies, dated 2024, indicated instructions to bake cookies for 10 - 14 minutes at 375 degrees Fahrenheit and do not over bake. The recipe instructions also indicated that for mechanical soft diets the cookie may be given soft. During the lunch dining observation on 5/28/2024 at 12 :40 p.m., in Resident 42's room, observed Resident 42's sitting in his bed. Resident 42 did not appear to have upper or lower teeth or dentures. Observed Resident 42's meal tray which displayed a diet card that indicated Resident 42 was to receive a mechanical soft regular diet with no added sodium (salt). Resident 42 was assisted with feeding by Certified Nursing Assistant (CNA) 3. Observed Resident 42's tray to have chopped lasagna, green beans, toasted bread cut into wedges and one cookie and a carton of reduced fat milk. Upon observation, the cookie appeared hard with darkened outer edges. During a concurrent observation and interview on 5/28/2024 at 1:15 p.m. with CNA 3, observed Resident 42's tray after eating. CNA 3 stated that Resident 42 had eaten approximately 30 percent (%) of his meal. CNA 3 stated Resident 42 tended to spit out food that he did not like. Observed that Resident 42 had eaten most of the cookie on the tray. Asked CNA 3 how Resident 42 was able to eat the cookie since he did not have teeth or dentures, and CNA 3 replied that she had to soften the cookie with the Resident 42's milk because the cookie was too hard and dry for the resident to eat. During an interview on 5/31/2024 at 11:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that the dietary staff prepared the meal trays and placed them on the cart. LVN 2 stated that the CNAs would then distribute the trays to the residents from the cart. LVN 2 stated that the diet type should be on a card located on each resident's tray when being served by the CNAs. LVN 2 stated that the charge nurses should visibly look at the meal to make sure the food on the tray matched the resident's diet on the meal card. LVN 2 stated that residents who were receiving a mechanical soft diet had a hard time swallowing or chewing food and a resident with missing or no teeth would have a difficult time chewing a hard cookie. LVN 2 stated that a resident who was ordered a mechanical soft diet could choke or aspirate (when food, liquid, or other material enters a person's airway) hard cookie. During an interview on 5/31/2024 at 11:36 a.m. with the Dietary Supervisor (DS), the DS stated that when residents were admitted to the facility, the physician's diet order was sent to the kitchen by the nursing staff. The DS stated that he reviewed the therapeutic menus to ensure that the residents were being served the proper diet. The DS stated that it was the responsibility of the kitchen to follow the diet order as written. The DS stated that for a mechanical soft diet a cookie should be served soft and should not have been served if it was too hard. The DS also stated that he followed the recipe for the peanut butter cookies served for lunch on 5/28/2024. The DS stated that he was aware that residents receiving a mechanical soft diet could have cookies that were served soft. The DS stated he could add more butter to the cookie recipe or reduce the cooking time to ensure the cookies remained soft, but he did not do that for that cookie recipe. The DS stated that if the cookies were cooked too long, they would get too hard and could not be served for a mechanical soft diet. During an interview on 5/31/2024 at 2:46 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that residents receiving a mechanical soft diet should have food that was finely chopped to make sure the resident did not aspirate especially if they have missing teeth. The ADON stated that the treatment nurse should check the trays before giving to the residents. The ADON also stated that a resident receiving a mechanical soft should not be given a hard cookie because they could aspirate. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Therapeutic Diet, revised on 12/2024, indicated that a therapeutic diet will be served to residents who have a therapeutic diet order by the attending physical. The P&P indicated that mechanically altered diets as well as diets modified for medical or nutritional needs will be considered a therapeutic diet. The P&P also indicated that the DS would establish a tray identification system to ensure each resident receives his/her diet as ordered by the physician.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when: 1. One staff working in the dish washing area did not wash their hands before removing the clean and sanitized dishes from the dish machine. 2. Expired food brought to residents from outside of the facility were stored in the resident food refrigerator. There was coffee from staff stored in the refrigerator. The refrigerator had no thermometer and monitoring system for the refrigerator temperatures. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 67 out of 74 residents who received food from the facility, including residents who had food stored in the resident refrigerator. Findings: 1. During an observation on [DATE] at 8:45 AM, in the dishwashing area, DA 1 was observed rinsing soiled dishes and loading the dirty dishes in the dish machine while wearing gloves. DA 1 dipped his hands in a bucket filled with water located inside the manual dishwashing sink next to the dishwashing machine. DA 1 shook the excess water off his hands while still wearing the same gloves and proceeded to remove the clean and sanitized dishes from the dish machine. During an interview on [DATE] at 9:00 AM, with DA 1, DA 1 stated there was usually two people working in the dish machine area to help remove the clean and sanitized dishes. DA 1 stated he was cleaning his gloves in the sanitizer water before removing the clean dishes. DA 1 stated he should remove the dirty gloves, wash his hands, and then replace the gloves before touching the clean and sanitized dishes. DA 1 stated it was important to his wash hands to not contaminate the clean dishes. During an interview on [DATE] at 9:10 AM, with the DS, the DS stated the dishwasher should wash their hands and replace their gloves after working with the dirty dishes and before removing the clean and sanitized dishes. A review of facility's P&P titled, Glove Use Policy, dated 2023, indicated gloved hands are considered a food contact surface that can get contaminated or soiled. The P&P indicated disposable gloves are a single use item and should be discarded after each use. The P&P indicated to wash hands when changing to a fresh pair when gloves need to be changed, before beginning a different task, and as soon as they become soiled. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on [DATE] at 11:30 AM, of the resident refrigerator located in the activity room, there was no thermometer. There was one large container of cold coffee with no label or date. There was a box with 5 small bottles of expired liquid turmeric health tonics (herbal drinks) with a use by date of [DATE]. There were 5 yogurt containers and 10 applesauce individual containers with manufacture expiration date of [DATE]. During a concurrent interview on [DATE] at 11:30 AM, with the Activity Director (AD), the AD stated the nurses checked the resident's food brought from outside. The AD stated if there was left over food, staff brought the food to the activity room for storage in the resident refrigerator. The AD stated she labeled and dated the food. The AD stated that she had not checked the temperature of the refrigerator since there was no thermometer. The AD stated the coffee belonged to the staff and should not be in the resident refrigerator. The AD stated the resident's family brought the yogurt and applesauce recently and she did not check the dates. The AD verified that the yogurt, applesauce, and turmeric herbal drinks were expired and removed them from the refrigerator. The AD stated it was important that the temperature of the refrigerator was monitored to make sure the food was safely stored. A review of facility's P&P titled, Foods Brought by Family/Visits, revised ,d+[DATE], indicated food brought by family/visitors that is left with the resident to consume later is labeled and stored in manner that it is clearly distinguishable from facility prepared food. The P&P indicated perishable foods are stored in resealable containers with tightly fitting lids in a refrigerator. The P&P indicated containers are labeled with the resident's name, the item, and the use by date. The P&P indicated nursing staff will discard perishable foods on or before the use by date.		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]), Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function), and Speech Therapy ([ST or SLP] profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) to one of four sampled residents (Resident 53), who had range of motion (ROM, full movement potential of a joint [where two bones meet]) mobility (ability to move) and swallowing problems. The facility failed to: 1. Provide Resident 53 with PT and OT evaluations upon admission to the facility in accordance with physician orders, dated 12/21/2022. 2. Provide Resident 53 with PT and OT evaluations upon admission to the facility in accordance admission notes, dated 12/22/2022. 3. Provide Resident 53, who received gastrostomy (G-tube- tube placed directly into the stomach for feeding and medication administration) feedings with a SLP evaluation in accordance with the physician orders, dated 12/27/2022. 4. Provide PT, OT, and SLP services consistent with the facility's job descriptions and the facility's policy and procedure (P&P) titled, Skilled Nursing Rehabilitation Services. 5. Provide Resident 3 PT and OT evaluations in accordance with the physician orders, dated 9/5/2022 and 10/23/2023, the facility's job descriptions for PT and OT, and the facility's P&P titled, Skilled Nursing Rehabilitation Services. These deficient practices resulted in Resident 53 not receiving any interventions to improve speech, cognition (ability to think, understand, learn, and remember), the ability to eat by mouth, mobility, and activities of daily living (ADLs), resulting in Resident 53's dependence on staff for mobility and ADLs and a decline in the resident's physical and psychosocial well-being. These failures also had the potential to prevent Resident 3 from improving mobility, ADLs, and overall physical and psychosocial well-being. Cross reference F677, F684, and F688. Findings: a. A review of Resident 53's GACH Neurology (branch of medicine concerned with the a. study and treatment of disorders involving the brain, spinal cord, and nerves) Progress Note, dated 12/18/2022, indicated Resident 53's overall mental status appeared to be improving. The Neurology Progress Note indicated Resident 53 was fully awake, alert, followed simple commands, and held the arms and legs against gravity (active movement). (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 0825 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 53's Admission Record, indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 53's diagnoses included psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), major depressive disorders (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness), starvation (suffering caused by hunger), and attention to gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding). A review of Resident 53's physician orders, dated 12/21/2022 timed at 11:41 p.m., indicated to provide PT and OT evaluation/consult as needed. A review of Resident 53's Admission Progress Note, dated 12/22/2022 timed at 1:02 a.m., indicated Resident 53 was admitted to the facility on [DATE] at 11:25 p.m. under skilled level of care, for PT and OT evaluation. The Admission Progress Note indicated Resident 53 was alert with episodes of confusion, able to make needs known, was striking out at staff, resisted care while cleaning and changing, and kept moving the arm (unspecified). A review of Resident 53's Progress Note, dated 12/22/2022 timed at 3:00 p.m., indicated Resident 53 was found in the middle of the bed with both legs dangling outside of the bed. The Progress Note indicated Resident 53 was assisted back to bed and repositioned. The Progress Note indicated Resident 53's physician was informed, and a physician order was carried out to place the bed in the lowest position and floor mats. A review of Resident 53's physician orders, dated 12/27/2022 timed at 2:20 p.m., indicated to provide a SLP evaluation and treatment as indicated. A review of Resident 53's physician orders, dated 12/29/2022 timed at 4:32 p.m., indicated PT and OT evaluation/consult as needed was discontinued. A review of Resident 53's physician orders, dated 2/22/2023 timed at 4:44 p.m., indicated discontinue speech therapy evaluation and treatment as indicated. A review of Resident 53's physician orders, dated 3/25/2024, indicated for Restorative Nursing Aide ([RNA] Certified Nursing Aide program that helps residents to maintain their function and joint mobility) to provide passive range of motion ([PROM] movement of joint through the ROM with no effort from the person) on both arms and both legs, followed by the application of both elbow splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours, three to five times per week. A review of Resident 53's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 4/2/2024, indicated Resident 53 had severely impaired cognition. The MDS indicated Resident 53 did not have any ROM impairments to both arms and legs. The MDS indicated Resident 53 was dependent (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. (continued on next page)		

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 05/31/2024
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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/2024 at 10:48 a.m. with the Director of Rehabilitation (DOR), the DOR stated therapy services helped residents regain ability and function. During an observation on 5/29/2024 at 8:13 a.m., in Resident 53's room, Resident 53 was observed lying in bed, awake, with the head-of-bed (HOB) elevated and a bed sheet covered Resident 53's legs. Resident 53 smiled but did not speak and was receiving feeding through a G-tube. Resident 53 did not actively move either arms or legs upon request. Resident 53's body twitched (short, jerky sudden movements) intermittently (did not happen continuously) and both elbows were in a bent position. Resident 53's hips and knees were visibly rotated away from the body with the knees bent, resembling a frog-like leg position, despite the presence of the bed sheet over both legs. Resident 53's ankles and feet were not visible. During an observation on 5/29/2024 at 9:09 a.m., in Resident 53's room, Resident 53 was observed lying in bed, alert, with the HOB elevated. Resident 53's elbows were in a bent position. Restorative Nursing Aide (RNA) 3 performed ROM exercises on Resident 53's left arm and then applied an elbow extension splint (splint that prevents bending at the elbow) on the left arm. RNA 3 performed ROM exercises on Resident 53's right arm and then applied an elbow extension splint on the right arm. Resident 53's legs were rotated away from the body, both knees were bent, and both ankles were positioned in plantarflexion (ankles bent with toes pointing away from the body). RNA 3 performed ROM exercises on both of Resident 53's legs. During an interview on 5/29/2024 at 9:37 a.m. with RNA 3, RNA 3 stated she performed PROM on both of Resident 53's arms and legs and applied elbow extension splints on the resident's elbows. During a concurrent interview and record review on 5/29/2024 at 4:06 p.m. with the DOR in the presence of the Assistant Director of Nursing (ADON) and the MDS Coordinator (MDS 1), the DOR reviewed the facility's Rehabilitation electronic documentation system (clinical therapy records) and stated Resident 53 never received any PT, OT, or SLP services while residing in the facility. During a telephone interview on 5/30/2024 at 9:36 a.m. with Resident 53's family member (FM) 1, FM 1 stated Resident 53 used to walk, dress, and do everything without assistance but had mental health problems. FM 1 stated Resident 53 had gotten worse while residing at the facility since Resident 53 could no longer move and talk. During an interview on 5/30/2024 at 11:32 a.m. with Speech Therapist (SLP) 1, SLP 1 stated a resident with a G-tube did not mean the resident could not chew or swallow. SLP 1 stated a Speech Therapist was the best person to determine whether a resident could swallow. SLP 1 stated the purpose of Speech Therapy included interventions for speech, swallowing, language, and cognition. (continued on next page)		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/2024 at 11:56 a.m. with the DOR, Resident 53's physician orders for PT and OT evaluation, dated 12/21/2022, Admission Progress Note, dated 12/22/2022, and physician orders for SLP evaluation, dated 12/27/2022, were reviewed. The DOR stated Resident 53's Admission Progress Note, dated 12/22/2022, indicated Resident 53 was admitted for skilled level of care, including PT and OT evaluations. The DOR stated the physician orders for PT and OT evaluation were not completed and were discontinued on 12/29/2022 for an unknown reason. The DOR reviewed Resident 53's physician orders, dated 12/27/2022, for a SLP evaluation and treatment. The DOR stated the SLP evaluation was not completed and the SLP evaluation was discontinued on 2/22/2023. The DOR stated the resident's payor source (person, organization, or entity that pays for the care services administered by a health provider) had to be verified prior to evaluating a resident for therapy. The DOR stated the facility did not complete the PT, OT, and SLP evaluations on Resident 53 in accordance with the physician orders. During an interview on 5/30/2024 at 3:44 p.m., the DOR stated the purpose of PT, OT, and SLP were to improve the resident's strength and attempt to return the resident to his/her prior level of function (ability prior to admission to the facility). The DOR stated PT interventions were for the resident's legs, mobility, standing, transfers, and ambulation (the act of walking). The DOR stated OT interventions included interventions to the resident's arms, self-care, and ADLs. During a concurrent interview and record review on 5/31/2024 at 9:49 a.m. with the Assistant Director of Nursing (ADON) and MDS Coordinator (MDS 1), Resident 53's physician orders for PT and OT, dated 12/21/2022, Admission Progress Notes dated, 12/22/2022, physician's orders for SLP, dated 12/27/2022, and job descriptions for PT, OT, and SLP were reviewed. The MDS 1 stated, the admission Progress Note indicated Resident 53 was admitted to the facility for skilled services, including PT and OT. MDS 1 stated Resident 53's physician orders, dated 12/21/2022, for PT and OT evaluation was discontinued on 12/29/2022. The ADON stated the standard of practice for discontinuing physician orders included contacting the physician for an order to discontinue treatment and then the designated staff would carry out the order. MDS 1 reviewed Resident 53's Progress Notes dated 12/2022 and stated there were no nursing notes indicating Resident 53's physician was contacted to discontinue the PT and OT evaluation order. MDS 1 reviewed Resident 53's physician orders, dated 12/27/2022, for SLP evaluation and stated the order was discontinued on 2/22/2023. MDS 1 stated, there were no nursing notes indicating Resident 53's physician was contacted to discontinue the SLP evaluation order. The ADON and MDS 1 stated they did not know the reason Resident 53 did not receive any therapy. The ADON stated Resident 53 should have received PT, OT, and SLP evaluations. The ADON stated the purpose of therapy was for mobility and to regain strength. The ADON and MDS 1 stated facility did not attempt to maintain Resident 53's ability since Resident 53 did not receive any therapy services. The ADON stated she did not know whether Resident 53's mobility, ADLs, speech, and swallow could have improved since Resident 53's physician orders for PT, OT, and SLP were never carried out. The ADON stated according to the facility's job descriptions for PT, OT, and SLP, the facility did not provide therapy to Resident 53 in accordance with the job descriptions. During an interview on 5/31/2024 at 12:45 p.m. with the Acting Administrator (AADM), the AADM stated the facility was responsible for a resident's care, including following the treatment plan and physician orders, upon accepting the resident's admission to the facility. (continued on next page)		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's undated job description titled, Speech Pathologist, indicated the purpose for this position was to evaluate, treat, document and/or facilitate care for residents with impaired ability to swallow or communicate due to disease process. The SLP job description indicated the SLP was authorized to Evaluate resident's functional needs when referred by the resident's attending physician and Follow physician's orders, facility policies and procedures to evaluate and treat residents. A review of the facility's policy and procedure titled, Skilled Nursing Rehabilitation Services, indicated each resident with physician orders for therapy services will receive an assessment. b., A review of Resident 3's Admission Record, indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included type 2 diabetes mellitus (high blood sugar), myocardial infarction (heart attack), hemiplegia or hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (stroke, brain damage due to a loss of oxygen to the area) affecting the right dominant (used most often) side, dysphagia (difficulty swallowing), acquired absence of the left toes, and acquired absence of the right leg below the knee. A review of Resident 3's physician orders, dated 9/5/2022 timed at 4:57 p.m., indicated PT/OT evaluation as needed. A review of Resident 3's physician orders, dated 9/6/2022 timed at 4:53 p.m., indicated the physician orders for PT/OT evaluation as needed, dated 9/5/2022, was discontinued. A review of Resident 3's physician orders, dated 10/23/2023 timed at 8:33 p.m., indicated PT/OT evaluation as needed. A review of Resident 3's physician orders, dated 10/24/2023 timed at 12:43 p.m., indicated the physician orders for PT/OT evaluation as needed, dated 10/23/2023, was discontinued. A review of Resident 3's physician orders, dated 11/27/2023, indicated for the RNA to provide PROM on both arms and both legs, 3-5x/week with one person assist as tolerated. A review of Resident 3 MDS, dated [DATE], indicated Resident 3 had severely impaired cognition, had ROM impairments to one arm and one leg, and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side, transferring from sit to lying, chair/bed-to-chair transfers, oral hygiene (cleaning teeth), showering/bathing, and dressing. During an interview on 5/28/2024 at 10:48 a.m. with the DOR, the DOR stated therapy services helped residents regain ability and function. During an observation on 5/28/2024 at 11:30 a.m., in Resident 3's room, Resident 3 was observed asleep while lying in bed with HOB elevated and receiving liquid feeding through the gastrostomy tube (G-tube, tube placed directly into the stomach for long-term feeding). Resident 3 woke up easily to sound but did not speak. Resident 3 attempted to move the left hand to reach forward but no other active movement was observed in both arms and both legs. (continued on next page)		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an observation on 5/29/2024 at 8:47 a.m., in Resident 3's room, Resident 3 was observed lying in bed with the HOB elevated and receiving liquid feeding through the G-tube. During an observation on 5/29/2024 at 8:53 a.m., in Resident 3's room, the ADON came into Resident 3's room to disconnect the G-tube from the liquid feeding machine. RNA 2 stood on the left side of Resident 3's bed and performed exercises on Resident 3's left shoulder. RNA 2 walked to the right side of Resident 3's bed and performed exercises on Resident 3's right shoulder. RNA 2 removed the bed sheet over Resident 3's legs. Resident 3 was observed to have the absence of the right lower leg below the knee and the absence of toes on the left foot. RNA 2 performed exercises to the right hip and then performed exercises to the left hip. During an interview on 5/29/2024 at 9:04 a.m. with RNA 2, RNA 2 stated she performed PROM exercises to both arms and both legs since Resident 3 did not assist with the exercises. During an interview on 5/29/2024 at 11:36 a.m. with PT 1, PT 1 stated she had never seen Resident 3 for PT services. During a concurrent interview and record review on 5/29/2024 at 11:50 a.m. with the DOR, Resident 3's therapy documentation and physician orders were reviewed. The DOR stated Resident 3 received a PT evaluation on 4/14/2021 and had not received any PT services since 4/14/2021. The DOR stated Resident 3 had never received any OT services. The DOR reviewed Resident 3's physician orders, dated 9/5/2022, for PT/OT evaluation as needed which was discontinued on 9/6/2022. The DOR stated Resident 3 never received PT and OT evaluations in accordance with the physician orders, dated 9/5/2022. The DOR reviewed Resident 3's physician orders, dated 10/23/2023, for PT/OT evaluation as needed which was discontinued on 10/24/2024. The DOR stated never received the PT and OT evaluations in accordance with the physician orders, dated 10/23/2023, but received RNA services to continue to help Resident 3. The DOR stated the facility discontinued the physician orders for PT and OT without completing the evaluation if the PT and OT evaluation was not necessary. During an interview on 5/29/2024 at 3:18 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 3 used to have a leg prosthesis (device designed to replace a missing part of the body or to make a part of the body work better) and stood up with assistance to transfer to the chair despite weakness to one-side of the body. CNA 7 stated Resident 3's abilities changed about two to three years ago but did not know the reason for Resident 3's decline. CNA 7 stated Resident 3 currently had stiffness in both arms and required complete care. During an interview on 5/30/2024 at 11:56 a.m. with the DOR, the DOR stated the resident's payor source (person, organization, or entity that pays for the care services administered by a health provider) had to be verified prior to evaluating a resident for therapy. During an interview on 5/30/2024 at 8:46 a.m. with CNA 4, CNA 4 stated Resident 3's function has been the same for the past two years. CNA 4 stated Resident 3 did not speak, had leg amputations (loss or surgical removal of a body part), required G-tube feeding, and required two people for dressing due to difficulty lifting both arms. (continued on next page)		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/30/2024 at 9:02 a.m. with the MDS 1, MDS 1 stated Resident 3 used to sit up in a wheelchair, had conversational language, and would eat. MDS 1 stated Resident 3 went to the hospital (unknown date) for an unknown reason and returned to the facility (unknown date) requiring total dependence for ADLs and mobility. During an interview on 5/30/2024 at 3:44 p.m. with the DOR, the DOR stated the purpose of OT included intervention to a resident's arms, self-care, and ADLs. The DOR stated the purpose of PT included intervention to a resident's legs, mobility, standing, transfers, and ambulation (the act of walking). The DOR stated the purpose of therapy was to improve a resident's strength and attempt to return the resident to their prior level of function (ability prior to admission to the facility). During an interview on 5/31/2024 at 12:45 p.m. with the AADM, the AADM stated the facility was responsible for a resident's care, including following the treatment plan and physician orders, upon accepting the resident's admission to the facility. During an interview and record review on 5/31/2024 at 4:18 p.m. with Registered Nurse (RN) 1, Resident 3's nursing Progress Notes were reviewed. RN 1 stated the process of discontinuing a physician's order included calling the physician who will decide whether to discontinue the order. RN 1 reviewed Resident 3's nursing Progress Notes for the months of 9/2022 and 10/2023. RN 1 stated there were no nursing progress notes indicating the physician was called to discontinue PT and OT evaluations during the months of 9/2022 and 10/2023. A review of the facility's undated job description titled, Physical Therapist, indicated the purpose of this position was to evaluate, treat, document and/or facilitate care for residents with impaired ability to function at an independent level due to disease process. The PT job description indicated the PT was authorized to evaluate resident's functional needs when referred by the resident's attending physician and follow physician's orders, facility policies and procedures to evaluate and treat residents. A review of the facility's undated job description titled, Occupational Therapist, indicated the purpose of this position was to evaluate, treat, document and/or facilitate care for residents with impaired ability to perform activities of daily living at an independent level due to disease process. The OT job description indicated the OT was authorized to evaluate resident's functional needs when referred by the resident's attending physician and follow physician's orders, facility policies and procedures to evaluate and treat residents. A review of the facility's policy and procedure (P&P) titled, Skilled Nursing Rehabilitation Services, indicated each resident with physician orders for therapy services will receive an assessment.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and complete accurately the Advance Directives Acknowledgement ([ADA]- a form gives you the right to give instructions about your own health care) for three of six sampled residents (Residents 8, 63, and 53). These deficient practices resulted in inaccurate, and incomplete medical records, and had the potential to result in uncertainty in the care and services for residents and placed residents at risk of not receiving care based on their wishes due to inaccurate and incomplete documentation for Residents 8, 63, and 53. Findings: a. A review of Resident 8's Admission Record (Face Sheet), the Face Sheet indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes (high blood sugar), major depressive disorder (a mental health condition that causes loss of interest in activities of daily living), hypertension (high blood pressure), and muscle weakness (loss of muscle strength). A review of Resident 8's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 4/25/2024, the MDS indicated Resident 8 was self-understood and had the ability to understand others. The MDS also indicated Resident 8 was dependent (helper does all the effort) on staff for toileting hygiene, shower, and chair, bed-to-chair transfer. A review of Resident 8's ADA, undated, the ADA form indicated Resident 8's initials, signature, and date was to be notated. The ADA also required facility staff signature, and date on the form. The ADA form was undated, there were no Resident 8's initials, and missing facility staff signature. b. A review of Resident 63's Face Sheet, indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including diabetes, heart failure (a condition when your heart doesn't pump enough blood for your body), and muscle weakness (loss of muscle strength). A review of Resident 63's MDS, dated [DATE], indicated Resident 63 self-understood and had the ability to understand others. The MDS also indicated Resident 8 was dependent from staff for toileting hygiene, shower, and chair, bed-to-chair transfer. A review of Resident 63's History and Physical (H&P) dated 1/16/2024, indicated Resident 63 had fluctuating capacity to understand and make decisions. A review of Resident 63's ADA form indicated, Resident 8's initials, signature, and date next to the signature was required. The ADA form also requires facility staff signature, and date on the form. The ADA form was undated, and there were no initials for Resident 63 on the form. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/30/2024 at 9:01 a.m., with Social Services Director (SSD) Resident 8's and Resident 63's ADA form was reviewed. The SSD stated she was responsible for completing the ADA form. The SSD confirmed that Resident 8's, and Resident 63's ADA form were undated, missing Resident 8's, and Resident 63's initials which meant they were incomplete. The SSD stated the ADA form must be completed accurate per facility policy. The SSD stated it was important the form was accurate to ensure residents received treatment, and services needed. The SSD stated inaccurate ADA forms could lead to actions that could harm residents. During an interview on 5/30/2024 at 10:42 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 8's and Resident 63's ADA form should have been completed accurately. The ADON stated the ADA form was a legal document that reflected the residents' medical needs and wishes and must be completed accurately per facility policy. c. A review of Resident 53's Admission Record indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE], with an admitting diagnosis that included but was not limited to: encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). A review of Resident 53's MDS, dated [DATE], indicated Resident 53 was severely cognitively impaired. The MDS indicated Resident 53 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 53's ADA form, undated, indicated no date next to the signatures, which was required. During an interview on 5/30/2024, at 8:38 a.m., with Registered Nurse (RN 1), RN 1 stated the ADA forms must be signed and dated to legitimize the document. A review of facility's Policy and Procedure (P&P) titled Advance Directives, revised 7/2012, indicated the following: 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 2. Each resident will also be informed that our facility's policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive. 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. A review of facility's P&P titled Charting and Documentation, revised 7/2017, indicated: (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record. 3. Documentation in the medical record will be complete, and accurate. 4. Documentation will include details, including: a) The date and time. b) The name and title of the individual(s). c) The signature and title of the individual(s) documenting. 47092		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 48131 Based on observation, interview, and record review, the facility Quality Assurance and Performance Improvement (QAPI - a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents, families, and nursing home caregivers) committee failed to identify, develop, and implement action plans to ensure: 1. Range of motion (ROM- full movement potential of a joint where two bones meet) was monitored for all residents. (see F-Tag F688) 2. Informed consent for psychotropic medications (drug that affects how the brain works and causes changes in mood) including behavior monitoring and signature verification was done for all residents. (see F-Tag 758) 3. Informed consents were obtained for bed rails. (see F-Tag 700) 4. Physical therapy services were provided per physician's orders. (see F-Tag 825) 5. Restorative Nursing Aide (RNA- assists residents with exercises to improve or maintain mobility and independence) staff were competent to perform their duties as evidenced by: a. Residents with ROM concerns did not receive ROM exercises in accordance with physician orders and the facility's job description titled, Restorative Nursing Assistant. b. Four of four RNAs did not have an evaluation indicating each RNA was proficient (able to do something to a higher than average standard) to provide RNA services in accordance with the facility's policy titled, Competency of Nursing Staff. (F-Tag 726) These deficient practices had the potential to affect the health and safety of the residents. Findings: (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/2024 at 4:30 p.m. with the Acting Administrator (AADM), the AADM verified that the QAPI Committee was unaware of the various facility issues, such as not monitoring ROM for all residents, not obtaining informed consents and behavior monitoring for residents receiving psychotropic medications, not assessing or obtaining informed consents for bed rails, not ensuring the competency of RNA staff, and not providing physical therapy services as ordered by the physician. The AADM stated the issues were not brought up during the QAPI meetings. The AADM stated that these concerns should have been addressed in the QAPI meetings. The AADM stated that patterns of informed consent issues should have been caught by the medical records department during medical record audits and the issue raised in the QAPI meetings. The AADM stated that residents need to be assessed and informed consents must be obtained as well as attempting alternative measures before implementing bed rails. The AADM also stated that if a resident was admitted for physical therapy/occupational therapy (PT/OT), the rehabilitation department must assess the resident. The AADM stated that since there was a concern regarding ROM in 2022, the QAPI Committee should have picked ROM as a QAPI goal. The AADM stated that it was important to identify the issues in QAPI to prevent the decline of residents with issues that were not identified. A review of the facility's policy and procedure (P&P), titled Quality Assurance and Performance Improvement (QAPI) Program, dated 2001 and revised February 2020, indicated the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on the indicators of the outcomes of care and quality of life for our residents. The P&P indicated the QAPI plan describes the process for identifying and correcting quality deficiencies. The P&P indicated key components of the process included: a. tracking and measuring performance, b. establishing goals and thresholds for performance measurement, c. identifying and prioritizing quality deficiencies, d. systematically analyzing underlying causes of systemic quality deficiencies, e. developing and implementing corrective action or performance improvement activities, and f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure standard infection control practices were followed for seven of by failing to: 1. Ensure Resident 22 and Resident 24's oxygen nasal cannula tubing (a device used to deliver supplemental oxygen placed directly in a resident's nostrils) was dated, properly stored when not in use, and was off the floor, and ensure Resident 69's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask was dated, labeled, properly stored when not in use, and was not touching the floor. 2. Ensure the Social Services Director (DSD) and Registered Nurse (RN) 1 removed their gloves when moving between Resident 33 and Resident 274, and Resident 17 and Resident 13. 3. Ensure contact precautions were followed when Licensed Vocational Nurse (LVN) 3 put his hand in his pocket with contaminated gloves, and failed to perform hand hygiene after cleaning a contaminated blood pressure cuff used on Resident 61. These deficient practices had the potential to result in cross-contamination and placed Residents 22, 24, 69, 33, 274, 17, 13, and 61, and all other residents residing in the facility at high risk for the spread of infections. Findings: 1a. During an observation on 5/28/2024 at 10:38 a.m., in Resident 22's room, Resident 22's oxygen nasal cannula was observed touching the floor next to Resident 22's bed. The oxygen tubing was undated. A review of Resident 22's Admission Record (Face Sheet), indicated Resident 22 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]- a lung disease causing restricted airflow and breathing problems), diabetes (high blood sugar), heart failure (a condition when your heart doesn't pump enough blood for your body's needs), and muscle weakness (loss of muscle strength). A review of Resident 22's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 4/21/2024, indicated Resident 22 was self-understood and understand others. The MDS indicated Resident 22 required maximum assistance (helper does more than half the effort) from staff for dressing, toilet use, personal hygiene, and was dependent (helper does all the effort) from staff with transfer, and showers. A review of Resident 22's Order Summary Report dated 11/25/2023, indicated to administer oxygen (O2) at two liters per minute (2LPM) via nasal cannula. b. During an observation on 5/28/2024 at 9:43 a.m., in Resident 24's room, Resident 24's oxygen cannula tubing was observed on the floor under Resident 24's bed. The oxygen tubing was undated. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 24's Admission Record (Face Sheet), indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including seizure (uncontrolled body movements that occur because of abnormal electric activity in the brain), heart failure, and diabetes. A review of Resident 24's MDS, dated [DATE], indicated Resident 24 was self- understood and understand others. The MDS indicated Resident 24 required supervision assistance (helper provides verbal cues, and contact guard assistance as resident completes activity) from staff for toileting hygiene, shower, dressing, and walking. A review of Resident 24's History and Physical (H&P), dated 8/20/2023, indicated Resident 24 had the capacity to understand and make decisions. A review of Resident 24's Order Summary Report dated 7/6/2020, indicated to administer O2 at 2LPM via nasal cannula. c. During an observation on 5/28/2024 at 9:12 a.m., in Resident 69's room, Resident 69's nebulizer mask was observed touching the floor next to Resident 69's bed. The oxygen tubing was undated and the nebulizer machine was unlabeled. A review of Resident 69's Admission Record (Face Sheet), indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition where there's not enough oxygen in your body), diabetes, muscle weakness, and dysphagia (difficulty swallowing). A review of Resident 69's MDS, dated [DATE], indicated Resident 69 was self-understood and usually understand others. The MDS indicated Resident 69 was dependent from staff for toileting hygiene, shower, and require moderate assistance (helper does less than half the effort) for oral, and personal hygiene. A review of Resident 69's Medication Administration Record (MAR), dated 5/2024, indicated was to receive O2 at 2LPM via nasal cannula. A review of Resident 69's care plan initiated 2/19/2024, and revised 2/19/2024, indicated to administer oxygen at 2LPM via nasal cannula. During a concurrent observation and interview on 5/28/2024 at 2:30 p.m., with Resident 69, in Resident 69's room, Resident 69 was observed lying in bed, well groomed, dressed in a hospital gown. Resident 69's nebulizer machine on the top of Resident 69's nightstand by the resident's bed. The undated nebulizer mask was on the floor. Resident 69 stated he had been using the nebulizer machine and nebulizer mask sometimes, not every day. During an interview on 5/29/2024 10:29 a.m., with Registered Nurse (RN 1). RN 1 stated nasal cannula tubing and nebulizer masks should be changed weekly, dated, and placed in a bag next to the residents' bed when not in use. RN 1 stated if the nasal cannula was touching the floor, it was unsanitary and could lead to infection issues. RN 1stated if the nasal cannula and nebulizer mask was not stored properly in the bag it was possible for contamination (making something dirty, containing unwanted substances). RN 1 stated the contamination could produce respiratory problems and place the residents at risk for infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/2024 at 10:42 a.m., with the Assistant Director of Nursing (ADON), The ADON stated the oxygen nasal cannula and nebulizer mask should be dated, changed weekly, and placed in the bag next to the residents' bed. The ADON stated was important that the respiratory equipment was dated, and labeled so staff would know when it was last changed. The ADON stated it was important to place the nasal cannula, and nebulizer mask in the bag to prevent contamination, and respiratory infections. A review of the facility's Policy and Procedure (P&P) titled Policy and Procedure on Nebulizer, revised 7/2012, indicated the nebulizer machine should be labeled and dated of the resident's name using the nebulizer. A review of the facility's Policy and Procedure (P&P), titled Oxygen Administration, revised 12/2014, indicated to store cannula or mask so as not to touch the floor when not in use. A review of facility's P&P, titled Oxygen Therapy, revised 1/2024, indicated oxygen tubing is to be replaced once a week. The P&P indicated oxygen masks or nasal prongs are to be replaced once a week. 45009 2a. A review of Resident 33's Admission Record, indicated Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included legal blindness (when person can see, but only in a very small window in the eye) and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of Resident 33's History and Physical (H&P) dated 1/18/2024, indicated Resident 33 did have the capacity to understand and make decisions. A review of Resident 33's MDS, dated [DATE], indicated Resident 33's vision was severely impaired. The MDS indicated that Resident 33's cognitive skills for daily decision making was intact. The MDS indicated Resident 33 required supervision for eating, oral hygiene and for personal hygiene. b. A review of Resident 274's Admission Record, indicated Resident 274 was admitted to the facility on [DATE]. Resident 274's diagnoses included post laminectomy syndrome (a condition in which the patient continues to feel pain after undergoing back surgery) and overactive bladder (a problem with bladder function that causes the sudden need to urinate). A review of Resident 274's MDS, dated [DATE], indicated Resident 274's cognitive skills for daily decision making was intact. The MDS indicated Resident 274 required supervision for eating, oral hygiene, and personal hygiene. c. A review of Resident 17's Admission Record, indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included hemiplegia (a condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body) and gastrostomy (creation of an artificial external opening into the stomach for nutritional support). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 17's H&P dated 10/15/2023, indicated Resident 17 did not have the capacity to understand and make decisions. A review of Resident 17's MDS, dated [DATE], indicated Resident 17 had unclear speech, had minimal difficulty in hearing, and impaired vision. The MDS indicated Resident 17 rarely understood others and rarely made herself understood. The MDS indicated that Resident 17's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 17 was dependent on staff for all activities of daily living. The MDS indicated Resident 17 was dependent on staff for all movements in bed or transfers. d. A review of Resident 13's Admission Record, indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included dysphagia (difficulty or discomfort in swallowing, as a symptom of disease) and gastrostomy. A review of Resident 13's H&P dated 8/31/2023, indicated Resident 13 did not have the capacity to understand and make decisions. A review of Resident 13's MDS, dated [DATE], indicated Resident 13 had unclear speech, sometimes understood others, sometimes made herself understood, and impaired vision. The MDS indicated that Resident 13's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 13 required maximal assistance for all activities of daily living. The MDS indicated Resident 13 required maximal assistance for rolling left to right in bed, from sitting positioning to lying position and from lying position to sitting on the side of the bed. During an observation on 5/28/2024 at 10:26 a.m., in Resident 33's and Resident 274's room, the SSD entered the room wearing a gown, mask and gloves. The SSD assisted Resident 33 by giving her a yogurt and setting the resident up to eat. The SSD placed a towel under Resident 33's chin and handed her a spoon. The SSD did not remove her gloves or perform hand hygiene and proceeded to assist Resident 274. The SSD went to Residents 274's nightstand and removed a coffee drink from the nightstand and handed the drink to Resident 274. The SSD touched Resident 274's side table and brought it closer to Resident 274. The SSD did not remove her gloves and returned to Resident 274's bedside. The SSD used a towel to clean up the yogurt that Resident 274 had on her face. The SSD touched Resident 274's hair and covered the resident with sheets without performing hand hygiene. During an interview on 5/28/2024 at 10:31 a.m. with the SSD, the SSD stated she put on a gown and gloves to reduce the risk of getting an infection prior to entering the room because the residents were on precautions. The SSD stated it was acceptable to use the same personal protective equipment between residents as long as the residents were in the same room. The SSD stated she forgot to remove her gloves between residents. The SSD stated she should have removed her gloves to prevent the spread of an infection. During an interview on 5/29/2024 at 3:12 p.m. with the Infection Preventionist (IP) Nurse, the IP Nurse stated all staff must remove gloves prior to providing care for another resident. The IP Nurse stated it was unacceptable to use the same pair of gloves when coming in contact with other residents' belongings or providing care to another resident. The IP Nurse stated it was important to remove gloves prior to coming in contact with other residents to prevent the spread of infections. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. During an observation on 5/31/2024 at 8:31 a.m., in Resident 13 and Resident 17's room, RN 1 was observed assisting Resident 13. RN 1 did not remove her gloves after touching Resident 13's privacy curtain. RN 1 then proceeded to Resident 17's bedside and touched Resident 17's gastrostomy tube (G-tube, a tube inserted through the belly that brings nutrition directly to the stomach) equipment. RN 1 did not remove her gloves when she moved from Resident 13 to Resident 17. During an interview on 5/31/2024 at 8:42 a.m. with the IP Nurse, the IP Nurse stated RN 1 should have changed her gloves when touching the resident's G-tube equipment. The IP Nurse stated the gloves should have been changed to prevent the spread of infections. A review of the facility's P&P titled Standard Infection Precautions, dated 6/2012, indicated standard infection precautions will be employed in the care of all residents regardless of their diagnoses or presumed infection status. The P&P indicated staff were to remove gloves immediately after use, before touching non-contaminated items and environmental surfaces, and prior to going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments. A review of the facility's P&P titled Enhanced Barrier Precautions dated 7/12/2022, indicated personal protective equipment is removed before exiting room or before providing care to another resident in same room. 47092 3. A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included cerebral palsy (a condition that develops before birth which affects movement and posture with exaggerated reflexes, floppy or rigid limbs, and involuntary motions) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with a single episode of severe psychotic features (seeing or hearing stimuli that is not there, having false beliefs, and confused or disturbed thoughts). A review of Resident 61's MDS, dated [DATE], indicated Resident 61 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 61 required total dependence for care with nutrition, hygiene, toileting, bathing, dressing, and moving. A review of Resident 61's Physician Orders, dated 11/6/2024 indicated an order for contact precautions (precautions used in the care of patients known or suspected to have a serious illness easily transmitted by direct patient contact or by indirect contact with items in the patient's environment) for Candida Auris ([C. Auris] a fungal infection). During an observation on 5/29/2024 at 8:05 a.m., Licensed Vocational Nurse (LVN) 3 was observed in Resident 61's room taking Resident 61's blood pressure while wearing gloves. LVN 3 then put his gloved hand in his pocket and pulled out a pulse oximetry (a noninvasive small device used in measuring the saturation of oxygen in a person's blood) to take Resident 61's pulse and oxygen saturation (how much oxygen is in the blood). After LVN 3 left the room, he put on another pair of gloves, decontaminated his equipment (blood pressure cuff and pulse oximetry) using disinfectant wipes but did not perform hand hygiene after cleaning the equipment. LVN 3 then proceeded to use his computer. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility P&P titled Handwashing/Hand Hygiene, dated 6/2012, indicated the purpose of the policy was to prevent the spread of infections with hand washing and hand hygiene. The P&P indicated staff were to perform hand washing after contact with the resident's intact skin and after handling contaminated equipment. A review of the facility P&P titled Isolation - Categories of Transmission-Based Precautions, dated 1/2024, indicated contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The P&P indicated staff were to: a. Wear gloves while entering the room. b. Gloves are removed, and hand hygiene performed before leaving the room. c. Staff are to wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to assess the need for modifications to the call light system for one out of eight (8) residents, (Resident 27) by failing to: 1. Ensure the facility the call light for Resident 27 working properly and alarmed when activated by Resident 27. 2. Ensure the Certified Nursing Assistant (CNA 1) reported Resident 27's call light needed repair and was not working to the Maintenance Supervisor (MS). These deficient practices resulted in a delay in obtaining necessary care and services and placed Resident 27 at risk for an accident if called for help. Findings: A review of Resident 27's Admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and heart failure (progressive heart disease that affects pumping action of the heart muscles that causes fatigue, shortness of breath). A review of Resident 27's History and Physical (H&P) dated 6/22/2023, the H&P indicated Resident 27 had the capacity to understand and make medical decisions. A review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/25/2024, the MDS indicated Resident 27's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 27 needed supervision (the helper provides verbal cues, touching contact as resident completes activity) for toileting hygiene, dressing, and for showers/baths. The MDS indicated Resident 27 needed supervision for toilet transfer (the ability to get on and off a toilet or commode), to move from sit to stand position, and to walk for at least 10 feet. During an interview with Resident 27 on 5/30/2024 at 12:38 p.m., in Resident 27's room, Resident 27 stated he pushed his call light earlier, but no one came to his room to assist him. Resident 27 stated he needed some help but now, it was too late. During an interview on 5/30/2024 at 1:25 p.m. with CNA 1, in the hallway, CNA 1 stated it was her responsibility to check on her resident's call lights and make sure they were accessible and working. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/31/2024 at 8:17 a.m. with Resident 27, in Resident 27's room, Resident 27 pushed his call light and the call light did not work. Resident 27 stated he couldn't believe that the call light was not working. Resident 27 stated maybe that was the reason staff did not come to his room to assist him when he called for help. Resident 27 stated if he needed help, how would he get it, if his call light did not work. Resident 27 stated he asked his CNA for ice water, but the CNA never came to give him ice water. Resident 27 stated he had been pushing his call light, but no one came to his room to help him. During a concurrent observation and interview on 5/31/2024 at 10:29 a.m. with CNA 1, in Resident 27's room, Resident 27 call light and his call light did not work. CNA 1 stated the call light should light up inside the room and outside the room, but it was not working. CNA 1 stated that it was her job to check if Resident 27 had a working call light. CNA 1 stated it was important to have a working call light because it was the way residents communicated their needs. CNA 1 stated she wanted to be truthful and say that she did not check his call light today and did not remember when the last time she actually checked the call light to see if it worked. CNA 1 stated she would notify maintenance to fix the call light today, 5/31/2024. During an interview on 5/31/2024 at 2:36 p.m. with the Maintenance Supervisor (MS), in the hallway, the MS stated not all call lights were checked every day. The MS stated he randomly picked three rooms daily and checked their call light system. The MS stated he was not aware that Resident 27's call light was not working. The MS stated the CNA 1 did not inform him that a call light needed to be repaired. The MS stated it was important that every resident had a working call light because that was the way the residents communicated their needs. During a review of facility's Policy and procedure (P&P) titled Call Lights, dated 1/2024, the P&P indicated it was the facility's purpose to provide the residents a means of communication with nursing staff. The P&P indicated if call light was defective, staff must promptly report this information to the unit supervisor for immediate repair or replacement.		