STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of South Gate	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not accommodate the preference to use a urinal for one of 19 sampled residents (Resident 1). This deficient practice resulted in Resident 1 wearing and voiding into an incontinence brief despite being continent, removing his ability to void in a dignified manner. Cross-reference: F-tags F657, F690Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/15/2025. Resident 1's admitting diagnoses included pleural effusion (a collection of fluid around your lungs) and pneumonia (lung inflammation caused by infection). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 did not have cognitive impairments, and was dependent on staff for showering, and required substantial to maximal assistance from staff for mobility while in and out of bed. During a review of Resident 1's admission Nursing Assessment, dated 5/15/2025, the assessment indicated Resident 1 was incontinent bladder. The assessment was documented by Registered Nurse (RN) 2. During a review of Resident 1's care plan titled The resident has bladder incontinence., dated 5/29/2025, indicated Resident 1 preferred to use a urinal. During an interview on 7/15/2025 at 12:58 p.m. with Resident 1, Resident 1 stated staff kept him in an incontinence brief. Resident 1 stated he was not incontinent and stated the incontinence brief prevented him from being able to use a urinal because he had difficulty removing the brief on his own. Resident 1 stated he would prefer to use a urinal and would feel better if he did not need to void into an incontinence brief. During an interview on 7/17/2025 at 1:15 p.m., with RN 2, RN stated Resident 1's admission Nursing Assessment, dated 5/15/2025, was not accurate, and Resident 1 was not incontinent. RN 2 stated use of an incontinence brief, while continent, was a dignity concern. During an observation on 7/17/2025 at 1:32 p.m., at Resident 1's bedside, no urinal was observed at Resident 1's bedside. During an interview on 7/17/2025 at 1:37 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she assumed Resident 1 was incontinent. CNA 1 stated she did not ask Resident 1 if he could use a urinal or if he wanted to use a urinal. CNA 1 stated it was important to provide a urinal to continent residents, if that was their preference, to help them to maintain their independence and ensure their dignity was maintained. During a concurrent observation and interview on 7/17/2025 at 1:42 p.m., at Resident 1's bedside, with CNA 1, CNA 1 stated Resident 1 did not have a urinal at his bedside. During a review of the facility's policy and procedure (P&P) titled Dignity, revised 1/2025, the P&P indicated staff were to ensure each resident was cared for in a manner that promoted or enhanced their sense of well-being and feelings of self-worth and self-esteem. The P&P indicated individual preferences were to be identified during the assessment process and facility culture was to support dignity and respect for residents by honoring their choices and preferences.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the Responsible Party (RP) 2 prior to administering Depakote (an anticonvulsant medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions) and placing the bed against the wall for one of five sampled residents (Resident 37).This deficient practice resulted in the facility obtaining informed consent from Resident 37, who did not have the capacity to understand and make decisions, and resulted in Resident 37 making uninformed decisions regarding her care and unable to understand the risks and benefits of her treatment.Findings:a. During a review of Resident 37's admission Record (Face Sheet), the Face Sheet indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (decrease in muscle mass that can cause a decline in muscle strength and function), bipolar disease (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). The Face Sheet indicated RP 2 listed as Resident 37's emergency contact.During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 5/18/2025, the MDS indicated Resident 37's cognition (process of thinking) was severely impaired. The MDS indicated Resident 37 used mobility devices such as a walker and wheelchair. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) with bathing, dressing, and personal hygiene. The MDS indicated Resident 37 took anticonvulsant medication in the facility.During a review of Resident 37's Order Summary Report, order date 8/12/2024, the Order Summary Report indicated to give Depakote 250 milligrams (mg, a unit of measurement), by mouth two times a day for bipolar disorder manifested by Resident 37 being calm to yelling.During an interview on 7/17/2025 at 8 a.m., with Registered Nurse (RN) 1, RN 1 stated informed consent should only be obtained from the resident if the resident had the mental capacity to understand and make medical decisions. RN 1 stated if the resident did not have the mental capacity to understand and make medical decisions, informed consent would be obtained from the RP. RN 1 stated Resident 37 was on Depakote to treat behavioral symptoms manifested by her bipolar disorder. RN 1 stated prior to administering Depakote, Resident 37's physician was responsible for explaining the use of the medication, the side effects, and the risks and benefits to ensure an informed decision could be made.During a concurrent interview and record review on 7/17/2025 at 8:05 a.m., with RN 1, Resident 37's Informed Consent, dated 8/13/2024, was reviewed. The Informed Consent indicated informed consent for the use of Depakote 250 mg was obtained from Resident 37. RN 1 stated, on 8/13/2024, she verified informed consent was obtained from Resident 37. During a concurrent interview and record review on 7/17/2025 at 8:07 a.m., with RN 1, Resident 37's History and Physical (H&P), dated 7/10/2024, was reviewed. The H&P indicated Resident 37 could make needs known but could not make medical decisions. RN 1 stated when Resident 37 was admitted to the facility, Resident 37's medical documents from her previous facility were faxed on 7/31/2024. RN 1 stated Resident 37 did not have the capacity to make medical decisions, therefore could not fully understand the use of Depakote, the side effects, and the risk and benefits. RN 1 stated informed consent should have been obtained from RP 2 to ensure an informed decision was made. During an interview on 7/18/2025 at 8:45 a.m., with the Director of Nursing (DON), the DON stated informed consent for the use of Depakote should have been obtained from RP 2 instead of Resident 37. The DON stated allowing RP 2 to make an informed decision would ensure RP 2 was aware of all treatments administered to Resident 37 and to make any necessary decisions thereafter. b. During an observation on 7/15/2025 at 9:54 a.m., in Resident 37's room, Resident 37 was lying in bed, and the left side of the bed was against the wall. During a review of Resident 37's Order Summary Report, order date 8/12/2024, the Order Summary Report indicated Resident 37 could have the bed against the wall, per Resident 37's request. During a review of Resident 37's Care Plan titled, At risk for Self-Injury Related to the Bed Against the Wall, dated 6/11/2025, the Care Plan's interventions indicated to allow Resident 37 to make an informed choice by explaining the risks, benefits, and alternatives. During a concurrent interview and record review on 7/17/2025 at 8:16 a.m., with RN 1, Resident 37's Informed Consent, dated 6/11/2025, was reviewed. The Informed Consent indicated informed consent for the bed against the wall was obtained

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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. Based on observation, interview, and record review, the facility failed to ensure the call light (a device that residents use to request assistance from staff) was within reach for one of six sampled residents (Resident 82). This deficient practice had the potential to result in delay or an inability for Resident 82 to obtain necessary care and services as needed. Findings:During concurrent observation and interview on 7/15/2025 at 11:14 a.m., in Resident 82's room, with Resident 82, observed Resident 82 lying in bed. Resident 82's call light was observed on the left side of the resident's bed. Resident 82's call light was not within reach. Resident 82 stated she needed assistance with personal care and was not able to reach the call light to call for assistance. During a review of Resident 82's admission Record, the admission Record indicated the facility admitted Resident 82 on 7/14/2025 with diagnoses including seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and acute respiratory failure (a critical condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 82's History and Physical (H&P), dated 6/5/2025, the H&P indicated Resident 82's cognition (ability to think, remember, and reason) was intact. During a review of Resident 82's admission Nursing Assessment, dated 7/14/2025, the admission Nursing Assessment indicated Resident 82 was dependent (helper does all the effort) on staff for activities of daily living (ADLs-routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of Resident 82's care plan titled Resident at risk for falling, date initiated 7/15/2025 indicated the facility would keep call light within the resident's reach. During a concurrent observation and interview on 7/15/2025 at 11:24 a.m., in Resident 82's room, with Registered Nurse (RN) 1, Resident 82 was observed lying in bed. RN 1stated Resident 82's call l light was hanging on the left side of the resident bed not within reach. RN 1 stated Resident 82's call light should have been within reach for the resident to be able to call for assistance when needed. RN 1 stated the call light not within reach was a resident's safety issue, and placed Resident 82 at risk for fall and injury. During a review of the facility's policy and procedure (P&P) titled Call light/Bell, undated, the P&P indicated the facility would provide the resident with the call light and would be placed within reach when resident in bed.

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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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely notify one of three sampled residents' (Resident 81) physician of significant weight loss on 3/17/2025 and 6/3/2025.This deficient practice resulted in a delay in care and services and had the potential to result in further weight loss. Cross Reference F692. Findings:During a review of Resident 81's admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included multiple myeloma (a type of blood cancer that affects white blood cells), cauda equina syndrome (a rare but serious condition where the nerve roots at the bottom of the spinal cord, called the cauda equina, are compressed), and chronic kidney disease (a type of blood cancer that affects).During a review of Resident 81's Minimum Data Set (MDS- a resident assessment tool), dated 6/27/2025, the MDS indicated Resident 81's cognition (process of thinking) was severely impaired. The MDS indicated Resident 81 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, and lower body dressing. During a review of Resident 81's History and Physical (H&P), dated 6/14/2025, the H&P indicated Resident 81 had fluctuating capacity to understand and make decisions.During an interview on 7/17/2025 at 11:27 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated the RNAs were responsible for weighing the residents based on the physician's order. RNA 1 stated residents were weighed upon their admission to the facility then weekly for a total of four weeks. RNA 1 stated unless the resident's physician orders for more frequent weights, the residents would then be weighed once a month. RNA 1 stated any fluctuations in a resident's weight had to be reported timely to the licensed nurse. During a concurrent interview and record review on 7/17/2025 at 11:36 a.m., with RNA 1, Resident 81's Weights, dated 3/21/2025 through 6/20/2025, were reviewed. The Weights indicated on 03/21/2025, Resident 81 weighed 166 lbs. and on 03/27/2025, Resident 81 weighed 139 lbs. which was a 16.27 percent (%) weight loss. The Weights indicated on 05/03/2025, Resident 81 weighed 147 lbs. and on 06/03/2025, Resident 81 weighed 136 lbs. which was a 7.48% weight loss. RNA 1 stated Resident 81 had weight loss indicated on 3/27/2025 and 6/3/2025 and should have been reported to the licensed nurse on duty. During an interview on 7/17/2025 at 12:10 p.m., with Registered Nurse (RN) 1, RN 1 stated the RNAs were responsible for weighing the residents per the physician's order and report any weight changes to the Director of Nursing (DON) and licensed nurses. RN 1 stated reporting the weight changes were essential for timely physician notification and implementation of interventions to prevent further weight loss. During a concurrent interview and record review on 7/17/2025 at 12:13 p.m., with RN 1, Resident 81's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/27/2025 through 6/26/2025, were reviewed. The SBARs did not indicate Resident 81's physician was notified of his weight loss on 3/27/2025 and 6/3/2025. The SBAR, dated 3/31/2025, indicated Resident 81 had poor oral intake (not eating and/or drinking enough food and liquids to meet the body's needs) but did not indicate Resident 81's weight loss. RN 1 stated once there was knowledge of a resident's weight loss, the resident's physician had to be notified as soon as possible to obtain new orders to prevent further weight loss. During an interview on 7/18/2025 at 9:11 a.m., with the DON, the DON stated when a resident had unplanned weight loss, the RNAs and licensed nurses were responsible for informing her. The DON stated she would collaborate with the licensed nurse to inform the resident's physician and obtain new orders such as a change in diet, nourishment snacks, and/or new medications. The DON stated timely physician notification was necessary to treat the resident right away and not delay care. During a concurrent interview and record review on 7/18/2025 at 9:15 a.m., with the DON, Resident 81's Weight Management Review, dated 4/8/2025 and 6/23/2025, were reviewed. The Weight Management Review, dated 4/8/2025, indicated Resident 81's physician was notified of significant weight loss due to recent hospitalizations and poor oral intake and new orders were given. The Weight Management Review, dated 6/23/2025, indicated Resident 81's physician was notified of Resident 81's fluctuating weight gain and weight loss and new order was given to administer Megace (medication to increase appetite). The DON stated she was not made aware of Resident 81's weight loss on 3/27/2025 and 6/3/2025, thus Resident 81's weight loss was not addressed until Resident 81's monthly Weight Management Review on 4/8/2025 and 6/23/2025. The DON stated the delay in physician notification resulted in the delay of implementing orders and additional interventions to prevent further weight loss. During a review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of financial liability (Skilled Nursing Facility Advance Beneficiary Notice- SNF ABN) to two out of three sampled residents (Resident 13 and Resident 23) when Medicare Part A coverage ended and the residents chose to continue receiving skilled nursing services. This failure had the potential to result in unexpected pay charges for Resident 13 and Resident 23.Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 13's Minimum Data Set ([MDS], a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 13's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 13 required substantial assistance (helper does more than half of the effort) when toileting and lower body dressing. During a review of Resident 13's History and Physical (H&P), dated 3/21/2025, the H&P indicated Resident 13 had the capacity to understand and make decisions. During a review of the facility's Beneficiary Notice List of Resident discharged Within the Last Six Months Worksheet, dated 7/16/2025, the Worksheet indicated Resident 13's Medicare Part A coverage ended on 4/9/2025 and remained in the facility. During a review of Resident 13's SNF Beneficiary Notification Review form, dated 7/16/2025, the form indicated the facility or provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. b. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), chronic pain syndrome, and lack of coordination. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognitive skills were moderately impaired. The MDS indicated Resident 23 was entirely dependent on staff for toileting hygiene, bathing, lower body dressing, and taking off footwear. During a review of the facility's Beneficiary Notice List of Resident discharged Within the Last Six Months Worksheet, dated 7/16/2025, the Worksheet indicated Resident 23's Medicare Part A coverage ended on 7/4/2025 and remained in the facility. During a review of Resident 23's SNF Beneficiary Notification Review form, dated 7/16/2025, the form indicated the facility or provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. During an interview on 7/17/2025 at 12:22 p.m. with the Business Office Manager (BOM), the BOM stated the SNF ABN form was normally provided to Medicare Part A residents that had benefit days remaining and chose to stay in the facility. The BOM stated Resident 13 and 23 should have received the SNF ABN form. The BOM stated she did not provide the SNF ABN form to Resident 13 and Resident 23 because she mistakenly believed the SNF ABN form was replaced by the Detailed Explanation of Non-Coverage (DENC- explains the specific reasons for the end of covered services) form based on an email sent by corporate. The BOM stated she misread the email and did not provide the form to residents since 1/2025. The BOM stated failing to provide the SNF ABN form to Resident 13 and Resident 23 violated resident rights to be made aware of services not covered by Medicare. During a review of the facility's Policy and Procedure (P&P), titled, Medicare Advanced Beneficiary Notice (undated), the P&P indicated the facility was to ensure residents are informed in advance when changes will occur to their bills. The P&P indicated if the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) was notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). The P&P indicated the facility issued the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care was considered not medically reasonable and necessary, or custodial. The P&P indicated the resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) assessments for two of 19 sampled residents (Residents 71 and 81) were accurate. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 71 and 81's health status. This deficient practice also created the potential for Residents 81 and 71 to not receive the care and interventions needed to reach their highest practicable physical and psychosocial well-being.Findings: 1. During a review of Resident 71’s admission Record, the admission Record indicated the facility originally admitted Resident 71 on [DATE], and most recently re-admitted Resident 71 on [DATE]. Resident 71’s admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and obstructive sleep apnea (a sleep disorder characterized by repeated pauses in breathing during sleep due to a blockage in the upper airway). During a review of Resident 71’s Discharge MDS, dated [DATE], the MDS indicated Resident 71 was independent with cognitive skills (the mental abilities used in thinking, learning, remembering, and problem-solving) for daily decision making. The MDS indicated Resident 71 was dependent on staff for all mobility while in and out of bed. The MDS did not indicate Resident 71 required oxygen therapy (a medical treatment that involves administering supplemental oxygen to individuals with breathing difficulties or low blood oxygen levels). During a review of Resident 71’s physician order, dated [DATE], the order indicated Resident 71 was to receive oxygen therapy at two (2) liters per minute (L/min, a unit for measuring oxygen delivery rate) as needed. During a review of Resident 71’s oxygen saturation monitoring flowsheet, dated 6/2025, the flowsheet indicated Resident 71 received oxygen therapy from [DATE] to [DATE]. During an interview on [DATE] at 2:19 p.m. with the Director of Nursing (DON), the DON stated the lookback period when coding for oxygen therapy in a discharge MDS was three (3) days. During a concurrent interview and record review, on [DATE] at 2:21 p.m., with the DON, Resident 71’s oxygen saturation monitoring flowsheet dated 6/2025, and MDS dated [DATE], were reviewed. The DON stated the oxygen saturation flowsheet indicated Resident 71 received oxygen therapy from [DATE] to [DATE]. The DON stated the MDS did not indicate Resident 71 required oxygen therapy. The DON stated the MDS should have reflected Resident 71’s oxygen therapy. During an interview on [DATE] 2:27 p.m., with the DON, the DON stated it was important for the MDS to be accurate because the MDS guided the resident’s plan of care. During a concurrent interview and record review, on [DATE] 2:28 p.m., with the DON, Resident 71’s current care plans were reviewed. The DON stated Resident 71 did not have a current care plan for oxygen therapy and stated there should be one. The DON stated that if the MDS were accurate, it would have prompted staff to create a care plan for Resident 71’s oxygen therapy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 81’s admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included multiple myeloma (a type of blood cancer that affects white blood cells), cauda equina syndrome (a rare but serious condition where the nerve roots at the bottom of the spinal cord, called the cauda equina, are compressed), and chronic kidney disease (a type of blood cancer that affects).During a review of Resident 81’s Discharge MDS, dated [DATE], the MDS indicated Resident 81’s cognition (process of thinking) was severely impaired. The MDS indicated Resident 81 was dependent on staff’s assistance with eating, oral hygiene, toileting, bathing, and lower body dressing. During a review of Resident 81’s History and Physical (H&P), dated [DATE], the H&P indicated Resident 81 had fluctuating capacity to understand and make decisions.During a concurrent interview and record review on [DATE] at 9:18 a.m., with the DON, Resident 81’s Weights, dated [DATE] through [DATE], were reviewed. The Weights indicated Resident 81’s weights on the following days:- [DATE], 147 pounds (lbs, unit of weight measurement)- [DATE], 135 lbs- [DATE], 148 lbs- [DATE], 136 lbs The DON stated Resident 81 had fluctuating weight loss and weight gain in one month. During a concurrent interview and record review on [DATE] at 9:20 a.m., with the DON, Resident 81’s Discharge MDS, dated [DATE], was reviewed. The MDS did not indicate Resident 81 had a loss of five percent (5%) or more in the last month. The DON stated Resident 81’s MDS was not accurate due to Resident 81’s weight loss. The DON stated Resident had a weight loss from [DATE] through [DATE]. The DON stated the assessment should have been based on Resident 81’s most current weight prior to discharge. 3. During a review of Resident 81’s Weekly Skin Integrity Assessment for Pressure Sore (localized damage to the skin and/or underlying tissue usually over a bony prominence), dated [DATE], the Weekly Skin Integrity Assessment indicated Resident 81 had a stage 4 pressure sore (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) to the sacral coccyx (area of the lower back near the tailbone)During a concurrent interview and record review on [DATE] at 9:20 a.m., with the DON, Resident 81’s Discharge MDS, dated [DATE], was reviewed. The MDS did not indicate Resident 81 had an unhealed pressure sore. The DON stated Resident 81’s MDS was not accurate because Resident 81 had a stage 4 pressure sore upon his discharge to the hospital. The DON stated an accurate MDS was important to show Resident 81’s “whole picture” and to develop and revise care plans to attend to Resident 81’s needs. The DON stated Resident 81’s Discharge MDS would be reviewed whether Resident 81 returned to the facility, transferred to another facility, or discharged home. The DON stated an inaccurate MDS had the potential to affect the care given to Resident 81.During a review of the facility’s policy and procedure (P&P) titled “Resident Assessments,” revised 1/2025, the P&P indicated all persons who completed the MDS were to attest to its accuracy.During a review of the facility’s P&P titled “Charting and Documentation,” revived 4/2025, the P&P indicated all services provided to the resident were to be documented in the resident’s medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of South Gate	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	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** Based on observation, interview, and record review, the facility failed to ensure care plans were developed and interventions implemented for three of 19 sampled residents (Residents 71, 37, and 67). This deficient practice placed Residents 71, 37, and 67 at risk for not receiving the necessary interventions for the services and/or treatments they were receiving.Findings: 1. During a review of Resident 71’s admission Record, the admission Record indicated the facility originally admitted Resident 71 on 12/23/2024, and most recently re-admitted Resident 71 on 6/16/2025. Resident 71’s admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and obstructive sleep apnea (a sleep disorder characterized by repeated pauses in breathing during sleep due to a blockage in the upper airway). During a review of Resident 71’s Minimum Data Set (MDS, a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 71 was independent with cognitive skills (the mental abilities used in thinking, learning, remembering, and problem-solving) for daily decision making. The MDS indicated Resident 71 was dependent on staff for all mobility while in and out of bed. During a review of Resident 71’s physician order, dated 6/16/2025, the order indicated Resident 71 was to receive oxygen therapy (a medical treatment that involves administering supplemental oxygen to individuals with breathing difficulties or low blood oxygen levels) at two (2) liters per minute (L/min, a unit for measuring oxygen delivery rate) as needed. During an observation on 7/15/2025 at 11:33 a.m., at Resident 71’s bedside, Resident 71 was observed receiving oxygen therapy via nasal cannula (a small plastic tube, which fits into the person’s nostrils for providing supplemental oxygen). During an observation on 7/16/2025 at 8:54 a.m., at Resident 71’s bedside, Resident 71 was observed receiving oxygen therapy via nasal cannula. During an interview on 7/16/2025 2:27 p.m., with the DON, the DON stated there should be a care plan oxygen administration for residents on oxygen therapy. The DON stated it would include interventions such as keeping the resident’s head elevated for ease of breathing and monitoring the resident’s oxygen levels. During a concurrent interview and record review, on 7/16/2025 2:28 p.m., with the DON, Resident 71’s current care plans were reviewed. The DON stated Resident 71 did not have a current care plan for oxygen therapy and stated there should be one. The DON stated that if the MDS were accurate, it would have prompted staff to create a care plan for Resident 71’s oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 7/15/2025 at 9:54 a.m., 7/15/2025 at 1:16 p.m., and 7/16/2025 at 9:45 a.m., in Resident 37’s room, Resident 37 was lying in bed, and one floor mat was observed folded up and set against a wheelchair.During a review of Resident 37’s admission Record (Face Sheet), the Face Sheet indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (decrease in muscle mass that can cause a decline in muscle strength and function), bipolar disease (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 37’s MDS, dated [DATE], the MDS indicated Resident 37’s cognition (process of thinking) was severely impaired. The MDS indicated Resident 37 used mobility devices such as a walker and wheelchair. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) with bathing, dressing, and personal hygiene. The MDS indicated Resident 37 had a fall with no injury since her admission to the facility. The MDS indicated Resident 37 took anticonvulsant medication (medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions) in the facility. During a review of Resident 37’s History and Physical (H&P) dated 8/15/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37’s Fall Risk Assessment, dated 6/14/2025, the Fall Risk Assessment indicated Resident 37 was at a high risk for falls. During a review of Resident 37’s Order Summary Report, order dated 7/8/2025, the Order Summary Report indicated to place a floor mat (cushioned floor pad designed to help prevent injury should a person fall) on the right side of Resident 37’s bed. During a concurrent observation and interview on 7/17/2025 at 8:57 a.m., with Certified Nursing Assistant (CNA) 5 in Resident 37’s room, Resident 5 was observed lying in bed, and one floor mat was folded up against the wall. CNA 5 stated she was aware Resident 5 was a fall risk and assisted Resident 5 to the restroom. CNA 5 stated after she assisted Resident 5 back to bed, she did not place the floor mat on the right side of Resident 37’s bed. CNA 5 stated due to Resident 37’s risk for falls, placing the floor mat was necessary to prevent injuries.During a concurrent interview and record review on 7/17/2025 at 9:55 a.m., with Registered Nurse (RN) 1, Resident 37’s Care Plan titled, “At Risk for Falls”, revised 6/16/2025, was reviewed. The Care Plan interventions indicated to place a floor mat to the right side of the bed. RN 1 stated all care plan interventions were created as a guide to provide the best care to Resident 37. RN 1 stated when Resident 37 was in bed, the floor mat was supposed to be placed on the right side of the bed. RN 1 stated when a staff member assisted Resident 37 back to bed, they were responsible for placing the floor mat. RN 1 stated the purpose of the floor mat was to decrease the risk of injury if Resident 37 were to fall from her bed. RN 1 stated without the floor mat in place, Resident 37 was at risk of sustaining an injury from a fall such as a bruise, a skin tear, or a fracture.During an interview on 7/18/2025 at 8:54 a.m., with the DON, the DON stated Resident 37 had recurrent falls and the care plan was revised to include interventions to decrease the risk of falls and injuries. The DON stated the floor mat was to be placed on Resident 37’s right side any time Resident 37 was in bed. The DON stated without the floor mat placement, if Resident 37 fell out of bed, Resident 37 could sustain an injury. During a review of the facility’s P&P titled, “Safety and Supervision of Residents”, revised 4/2025, the P&P indicated, “Implementing interventions to reduce accident risks and hazards shall include the following:a. Communicating specific interventions to all relevant staff;b. Assigning responsibility for carrying out interventions;c. Provide training, as necessary; d. Ensuring that interventions are implemented; ande. Documenting interventions.”3. During a review of Resident 37’s Order Summary Report, order date 8/12/2024, the Order Summary Report indicated to give Depakote (an anticonvulsant) 250 milligrams (mg, a unit of measurement), by mouth two times a day for bipolar disorder manifested by Resident 37 being calm to yelling. During a concurrent interview and record review on 7/17/2025 at 8:12 a.m., with RN 1, Resident 37’s Care Plans, dated 8/12/2024 through 7/17/2025, were reviewed. The Care Plans did not address the use of Depakote to treat Resident 37’s bipolar disorder as manifested as being calm to yelling. RN 1 stated a care plan to address Resident 37’s use of Depakote and the behavioral manifestations of Resident 37’s bipolar disorder should have been developed. RN 1 stated the care plan would address the use of Depakote, non-pharmacological

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	056458	A. Building B. Wing	07/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to revise the incontinence care plan for one out of 19 sampled residents (Resident 1). This deficient practice placed Resident 1 at risk of not receiving interventions to maintain his continence and dignity. Cross-reference: F-tags F690 and F550Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/15/2025. Resident 1's admitting diagnoses included pleural effusion (a collection of fluid around your lungs) and pneumonia (lung inflammation caused by infection). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 did not have cognitive impairments, and was dependent on staff for showering, and required substantial to maximal assistance from staff for mobility while in and out of bed. During a review of Resident 1's admission Nursing Assessment, dated 5/15/2025, the assessment indicated Resident 1 was incontinent bladder. The assessment was documented by Registered Nurse (RN) 2. During a review of Resident 1's care plan titled The resident has bladder incontinence., dated 5/29/2025, indicated staff were to apply incontinence briefs and change them every 2 hours and as needed. During an interview on 7/15/2025 at 12:58 p.m. with Resident 1, Resident 1 stated staff kept him in an incontinence brief. Resident 1 stated he was continent and stated the incontinence brief prevented him from being able to use a urinal because he had difficulty removing the brief on his own. Resident 1 stated he would prefer to use a urinal. During an interview on 7/17/2025 at 1:15 p.m., with RN 2, RN stated Resident 1's admission Nursing Assessment, dated 5/15/2025, was not accurate. RN 2 stated Resident 1 was continent, and he directly observed Resident 1 request a urinal to void and use it without issue when he was first admitted . RN 2 stated the assessment should have been revised because it was not accurate. During an interview on 7/18/2025 at 9:33 a.m., with the Director of Nursing (DON), the DON stated any licensed nurse was capable of revising and updating resident care plans. The DON stated that if the resident's current care plan was not accurate, the care should be revised. During a concurrent interview and record review, on 7/18/2025 at 9:34 a.m., with the DON, Resident 1's care plan titled The resident has bladder incontinence., dated 5/29/2025 was reviewed. The DON stated the care plan was initiated on 5/16/2025 and revised on 5/29/2025. The DON stated the care plan still indicated Resident 1 was incontinent after the revision. The DON stated the care plan should have been revised. The DON stated revisions would allow for different care interventions to promote Resident 1's dignity and continence. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered revised 4/2025, the P&P indicated resident assessments were ongoing and care plans were to be revised as information about the resident changed.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to clarify hold parameters (specific instructions that accompany a medication order for safe and effective drug administration) for amlodipine (medication to lower blood pressure) and lisinopril (medication to lower blood pressure) for one of seven sampled residents (Resident 19).This deficient practice had the potential to result in Resident 19 experiencing bradycardia (heart rate less than 60 beats per minute [bpm], a normal heart rate is between 60 to 100 bpm) with symptoms of dizziness, fatigue, chest pain, and/or fainting.Findings:During a review of Resident 19's admission Record (Face Sheet), the Face Sheet indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (elevated blood pressure). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 7/1/2025, the MDS indicated Resident 19's cognition (process of thinking) was intact. The MDS indicated Resident 19 was independent in eating, oral hygiene, toileting, and personal hygiene.During a review of Resident 19's Order Summary Report, order date 3/18/2025, the Order Summary Report indicated to:1. Give amlodipine 5 milligrams (mg, unit of measurement) by mouth, once a day for hypertension. Hold medication if systolic blood pressure (SBP- pressure in the arteries when the heart beats) less than 110 millimeters of mercury (mmHg, unit of blood pressure measurement).2. Give lisinopril 5 mg by mouth, once a day for hypertension. Hold if SBP less than 110 mmHg.During a concurrent interview and record review on 7/17/2025 at 11:06 a.m., with Registered Nurse (RN) 3, Resident 19's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/1/2025 through 7/31/2025, was reviewed. The MAR indicated Resident 19 had the following pulse rates less than 60 bpm:- 7/1/2025, 54 bpm, amlodipine and lisinopril administered- 7/2/2025, 58 bpm, amlodipine and lisinopril administered- 7/3/2025 58 bpm, amlodipine and lisinopril administered- 7/4/2025, 58 bpm, amlodipine and lisinopril refused by Resident 19- 7/6/2025, 54 bpm, amlodipine and lisinopril administered- 7/7/2025, 54 bpm, amlodipine and lisinopril administered- 7/8/2025, 54 bpm, amlodipine and lisinopril administered- 7/10/2025, 56 bpm, amlodipine and lisinopril held due to pulse less than 60 bpm- 7/12/2025, 54 bpm, amlodipine and lisinopril administered- 7/14/2025, 54 bpm, amlodipine and lisinopril administered- 7/16/2025, 56 bpm, amlodipine and lisinopril held due to pulse less than 60 bpm- 7/17/2025, 56 bpm, amlodipine and lisinopril held due to pulse less than 60 bpmRN 3 stated their electronic MAR (eMAR) prompted the licensed nurse to check Resident 19's blood pressure and pulse rate prior to administering amlodipine and lisinopril. RN 3 stated it was standard practice to hold these medications when the pulse rate was less than 60 bpm. RN 3 stated she held Resident 19's amlodipine and lisinopril on 7/10/2025, 7/16/2025, and 7/17/2025 because Resident 19's pulse rate was less than 60 bpm. RN 3 stated Resident 19's orders did not specify hold parameters for pulse rate. RN 3 stated the licensed nurses, including herself, who administered Resident 19 his amlodipine and lisinopril, should have informed Resident 19's physician of Resident 19's pulse rate below 60 bpm. RN 3 stated informing the physician would result in clarification of the orders or change in medication. RN 3 stated continuing to administer Resident 19 amlodipine and lisinopril with his pulse rate below 60 bpm placed him at risk of bradycardia which could cause dizziness, chest pain, fainting, and/or fatigue. During an interview on 7/18/2025 at 9:01 a.m. with the Director of Nursing (DON), the DON stated Resident 19's order for amlodipine and lisinopril to reflect parameters to hold the medications if Resident 19's pulse rate was below 60 bpm. The DON stated amlodipine and lisinopril had the potential to lower Resident 19's even more and clarifying the orders was important to ensure those medications were held appropriately. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 1/2025, the P&P indicated, Medications are administered in a safe and timely manner.During a review of the facility's P&P titled, Medication and Treatment Orders, revised 1/2025, the P&P indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents' (Resident 67) low air loss mattress ([LALM], a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) was accurately set to Resident 67's weight.This deficient practice had the potential to cause the avoidable development and/or worsening of pressure ulcers (PU, localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and the complications associated with impaired skin integrity.Findings:During an observation on 7/15/2025 at 9:34 a.m., 7/15/2025 at 1:21 p.m., and 7/16/2025 at 9:46 a.m., in Resident 67's room, Resident 67 was observed lying on a Tuffcare brand LALM. The weight setting on the pump to inflate the LALM indicated the LALM was set for an individual who weighed 305 pounds (lbs, a unit of measurement).During a review of Resident 67's admission Record (Face Sheet), the Face Sheet indicated Resident 67 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 67's Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 67's cognitive skills (process of thinking) for daily decision making was moderately impaired. The MDS indicated Resident 67 was dependent on staff's assistance with toileting, bathing, and dressing. During a review of Resident 67's Weekly Skin Integrity Assessment for Pressure Sore (also known as pressure ulcer), dated 7/14/2025, the Weekly Skin Integrity Assessment indicated Resident 67 had a stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the sacral coccyx (area of the lower back near the tailbone).During a review of Resident 67's Order Summary Report, order dated 6/15/2025, the Order Summary Report indicated to use a LALM for wound healing. During a review of Resident 67's Care Plan titled, Sacral-coccyx Stage 4 Pressure Ulcer, dated 6/15/2025, the Care Plan interventions indicated to use a LALM for wound healing.During a concurrent observation and interview on 7/17/2025 at 10:47 a.m., with Treatment Nurse (TN) 1, in Resident 67's room, Resident 67 was observed lying on the LALM with the weight setting on the pump set to 305 lbs. TN 1 stated the LALMs were set according to each resident's weight. TN 1 stated the LALM were used to redistribute pressure on Resident 67's body. TN 1 stated the higher the number, the firmer the mattress became.During a concurrent interview and record review on 7/17/2025 at 10:49 a.m., with RN 1, Resident 67's Weight, dated 7/5/2025, was reviewed. The Weight indicated Resident 67 weighed 100 lbs. TN 1 stated Resident 67 had a stage 4 PU and utilized the LALM to reduce the amount of pressure, not only on her sacral coccyx area, but for the rest of her body. TN 1 stated 305 lbs was too high for Resident 67 which meant the LALM was too firm. TN 1 stated utilizing the LALM at a too high of a weight setting put Resident 67 at risk for developing new PUs and for her current PU to worsen. During an interview on 7/18/2025 at 8:39 a.m., with the Director of Nursing (DON), the DON stated LALM were utilized as a PU management and prevention intervention. The DON stated in addition to other interventions, such as position changes, the LALM assisted in reducing the amount of pressure placed on Resident 67's body. The DON stated the higher the weight setting, the firmer the LALM became. The DON stated the LALM setting had to reflect Resident 67's weight because too high of a weight would increase the amount of pressure on Resident 67's existing wound and to the rest of her body. The DON stated this additional pressure put Resident 67 at risk of delay wound healing, worsening of the existing PU, and development of additional PUs. During a review of the facility's Policy and Procedure (P&P) titled, Pressure-Reducing Mattresses, revised 1/2025, the P&P indicated, It is the policy of this facility to reduce pressure or relieve pressure, reduce skin irritation, and prevent break in skin integrity.During a review of the facility's document titled, Tuffcare Comfy Aire Series Air Mattress System User Manual, undated, the document indicated to adjust the pressure setting according to the individual's weight.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility applied an incontinence brief and failed to allow use of a urinal for one of 19 sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for being unable to void with dignity into a urinal and maintain his continence (the ability to control movements of the bowels and bladder).Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/15/2025. Resident 1's admitting diagnoses included pleural effusion (a collection of fluid around your lungs) and pneumonia (lung inflammation caused by infection). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 did not have cognitive impairments, and was dependent on staff for showering, and required substantial to maximal assistance from staff for mobility while in and out of bed. During a review of Resident 1's admission Nursing Assessment, dated 5/15/2025, the assessment indicated Resident 1 was incontinent bladder. The assessment was documented by Registered Nurse (RN) 2. During an interview on 7/15/2025 at 12:58 p.m. with Resident 1, Resident 1 stated staff kept him in an incontinence brief. Resident 1 stated he knew when he needed to void (urinate), and stated the incontinence brief prevented him from being able to use a urinal because he had difficulty removing the brief on his own. Resident 1 stated he would prefer to use a urinal. During an interview on 7/17/2025 at 1:15 p.m., with RN 2, RN stated Resident 1's admission Nursing Assessment, dated 5/15/2025, was not accurate. RN 2 stated Resident 1 was continent, and he directly observed Resident 1 request a urinal to void and use it without issue when he was first admitted . RN 2 stated the application of an incontinence brief on a continent resident could cause them to become incontinent. RN 2 stated voiding into an incontinence brief also placed Resident 1 at risk for skin breakdown and injury. During an observation on 7/17/2025 at 1:32 p.m., at Resident 1's bedside, no urinal was observed at Resident 1's bedside. During an interview on 7/17/2025 at 1:37 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she assumed Resident 1 was incontinent. CNA 1 stated she did not ask Resident 1 if he could use a urinal or if he wanted to use a urinal. CNA 1 stated it was important to provide a urinal to continent residents, if that was their preference, to help them to maintain their independence. During a concurrent observation and interview on 7/17/2025 at 1:42 p.m., at Resident 1's bedside, with CNA 1, CNA 1 stated Resident 1 did not have a urinal at his bedside. During an interview on 7/17/2025 at 1:46 p.m., with Registered Nurse (RN) 1, RN 1 stated it was important to accurately assess a resident's continence to ensure appropriate interventions were provided, including providing the required level of assistance and/or equipment. RN 1 stated that asking a resident to use an incontinence brief, or placing them in an incontinence brief, if not needed, increased their risk for sustaining skin breakdown, and also placed them at risk of developing incontinence. During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting, revised 1/2024, the P&P indicated staff were to be provided with care that ensured their activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) did not diminish unless unavoidable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of South Gate	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to reweigh one of three sampled residents (Resident 81) to confirm Resident 81's significant weight loss on 3/27/2025 and 6/3/2025. This deficient practice had the potential to result in improper management of Resident 81's weight.Cross Reference F580.Findings:During a review of Resident 81's admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included multiple myeloma (a type of blood cancer that affects white blood cells), cauda equina syndrome (a rare but serious condition where the nerve roots at the bottom of the spinal cord, called the cauda equina, are compressed), and chronic kidney disease (a type of blood cancer that affects).During a review of Resident 81's Minimum Data Set (MDS- a resident assessment tool), dated 6/27/2025, the MDS indicated Resident 81's cognition (process of thinking) was severely impaired. The MDS indicated Resident 81 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, and lower body dressing. During a review of Resident 81's History and Physical (H&P), dated 6/14/2025, the H&P indicated Resident 81 had fluctuating capacity to understand and make decisions.During an interview on 7/17/2025 at 11:27 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated the RNAs were responsible for weighing the residents based on the physician's order. RNA 1 stated residents were weighed upon their admission to the facility then weekly for a total of four weeks. RNA 1 stated unless the resident's physician orders for more frequent weights, the residents would then be weighed once a month. RNA 1 stated if a resident lost five pounds (lbs, unit of measurement) or more, the RNAs were responsible for reweighing the resident to confirm the weight loss. RNA 1 stated to confirm a resident's weight loss, the RNA would reweight the resident the same day or the same time the following day. RNA 1 stated the purpose of reweighing the resident was to confirm the weight loss was accurate and to report timely to the licensed nurse. RNA 1 stated when a resident was reweighed, the weight should be documented on the resident's Weights.During a concurrent interview and record review on 7/17/2025 at 11:36 a.m., with RNA 1, Resident 81's Weights, dated 3/21/2025 through 6/20/2025, were reviewed. The Weights indicated on 03/21/2025, Resident 81 weighed 166 lbs. and on 03/27/2025, Resident 81 weighed 139 lbs. which was a 16.27 percent (%) weight loss. The Weights indicated on 05/03/2025, Resident 81 weighed 147 lbs. and on 06/03/2025, Resident 81 weighed 136 lbs. which was a 7.48% weight loss. RNA 1 stated Resident 81 had weight loss indicated on 3/27/2025 and 6/3/2025 and Resident 81 was not reweighed to confirm the weight loss. RNA 1 stated Resident 81 should have been reweighed the day of the weight loss or the following day. RNA 1 stated confirming weight loss was essential in notifying the licensed nurse timely to help prevent further weight loss.During an interview on 7/18/2025 at 9:07 a.m., with the Director of Nursing (DON), the DON stated RNAs were responsible for weighing the residents according to the physician's orders. The DON stated any change in a resident's weight required a confirmation weight by reweighing the resident with the same weighing method. The DON stated Resident 81 should have been reweighed on 3/27/2025 and 6/3/2025 to confirm the weight loss and allow timely notification of Resident 81's physician and implementation of necessary interventions. The DON stated without confirming Resident 81's weight loss, Resident 81's care could have been mismanaged and inappropriate interventions could have been implemented.During a review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention, revised 9/2016, the P&P indicated, Any weight change of five pounds or 5% or greater within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician and an interdisciplinary team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents), then meeting with weight variance will be started.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen therapy (a medical treatment that provides extra oxygen to breathe, typically prescribed for individuals with conditions causing low blood oxygen levels) was administered as ordered by the physician for two of 19 sampled residents (Residents 71 and 1). This deficient practice placed Resident 71 and Resident 1 at risk of sustaining complications of not receiving enough or receiving too much supplemental oxygen.Findings: 1. During a review of Resident 71's admission Record, the admission Record indicated the facility originally admitted Resident 71 on 12/23/2024, and most recently re-admitted Resident 71 on 6/16/2025. Resident 71's admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and obstructive sleep apnea (a sleep disorder characterized by repeated pauses in breathing during sleep due to a blockage in the upper airway). During a review of Resident 71's Discharge MDS, dated [DATE], the MDS indicated Resident 71 was independent with cognitive skills (the mental abilities used in thinking, learning, remembering, and problem-solving) for daily decision making. The MDS indicated Resident 71 was dependent on staff for all mobility while in and out of bed. During a review of Resident 71's physician order, dated 6/16/2025, the order indicated Resident 71 was to receive oxygen therapy at two (2) liters per minute (L/min, a unit for measuring oxygen delivery rate) as needed. During an observation on 7/15/2025 at 11:33 a.m., with Resident 71, Resident 71 was observed receiving oxygen therapy at a rate of 4 L/min. During an observation on 7/16/2025 at 8:54 a.m., with Resident 71, Resident 71 was observed receiving oxygen therapy at a rate of 4 L/min. During an interview on 7/17/2025 12:25 p.m., with Registered Nurse (RN) 1, RN stated staff routinely check the oxygen flow rate for residents on oxygen therapy. RN 1 stated the purpose of checking the flow rate was to ensure the residents were receiving oxygen at the flow rate ordered by the physician. During a concurrent interview and record review, on 7/17/2025 at 12:27 p.m., with RN 1, Resident 71's physician order for oxygen therapy, dated 6/16/2025, was reviewed. The order indicated Resident 71 was to receive oxygen therapy at a fixed rate of 2 L/min. RN 1 stated that anytime Resident 71 was receiving oxygen therapy, the rate should only be set to 2 L/min. RN 1 stated it was important to administer oxygen therapy as ordered because residents can develop complications from excessive oxygen administration. 2. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/15/2025. Resident 1's admitting diagnoses included pleural effusion (a collection of fluid around your lungs) and pneumonia (lung inflammation caused by infection). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 did not have cognitive impairments, and was dependent on staff for showering, and required substantial to maximal assistance from staff for mobility while in and out of bed. During a review of Resident 1's physician order, dated 5/16/2025, the order indicated Resident 1 was to receive oxygen therapy at a rate of 2 L/min, with the option to increase the rate up to 5 L/min. During an observation on 7/15/2025 at 1:12 p.m. , with Resident 1, Resident 1 was observed receiving oxygen therapy at 1.5 L/min. During a concurrent interview and record review, on 7/17/2025 at 12:29 p.m., with RN 1, Resident 1's physician order for oxygen therapy, dated 5/16/2025, was reviewed. RN 1 stated Resident 1's oxygen therapy should be administered at a rate of at least 2 L/min. RN 1 stated that the purpose of Resident 1's oxygen therapy was to ensure his blood oxygen levels were maintained at 90% or above (normal oxygen saturation typically ranges from 95% to 100%) and stated his blood oxygen levels could be impacted if he did not receive the oxygen therapy as ordered by the physician. During a review of the facility's policy and procedure (P&P) titled Oxygen Therapy, revised 1/2024, the P&P indicated staff were to ensure oxygen therapy was administered as ordered by the physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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	056458	A. Building B. Wing	07/18/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure (P&P) titled Usage of bedside rails revised 1/2024, which indicated consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for side rail use would be obtained from the resident and/or responsible party (RP-a person who has been legally authorized to act on behalf of a resident in matters to care within the facility), after presenting potential benefits and risks for one of six sampled residents (Resident 12).This deficient practice had the potential to result in inappropriate use of side rails for Resident 12 and could lead to injury. Findings: During a review of Resident 12's admission Record, the admission Record indicated the facility originally admitted Resident 12 on 6/6/2023 and readmitted on [DATE]. Resident 12's admitting diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anxiety (a feeling of fear), and hypertension (HTN-high blood pressure).During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 12's cognition (process of thinking) was severely impaired. The MDS indicated Resident 12 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 12's Order Summary Report, dated 7/17/2025, the Order Summary Report indicated on 1/30/2025, Resident 12's attending physician ordered bilateral side rails for turning and repositioning and for prevention of injury.During a review of Resident 12's care plan, titled Resident uses side rails for turning and repositioning., revised on 1/30/2025, the care plan interventions indicated the facility would explain to the resident or RP the risks and benefits of side rails use and would allow the resident or RP to make an informed decision regarding their use. During an observation on 7/15/2025 at 10:03 a.m., and 2:14 p.m., in Resident 12's room, the resident was observed lying in bed with bilateral side rails in the upright position during both observations. During a telephone interview on 7/16/2025 at 7:35 a.m., with RP 1, RP 1 stated when Resident 12 was readmitted to the facility in 2024, the bed provided already had side rails installed. RP 1 stated no one from the facility explained anything about the risks or benefits of the side rails. RP 1 stated she was not asked to sign an informed consent, she assumed the side rails were part of the standard bed setup. During a concurrent interview and record review on 7/16/2025 at 2;10 p.m., with Registered Nurse (RN) 1, Resident 12's available informed consent for the use of side rails and clinical records, were reviewed. RN 1 stated side rails were used for residents who need assistance turning or repositioning in bed. RN 1 the facility required to explain the risks-such as entrapment, falls, or injury and obtain informed consent before applying them. RN 1 stated the discussion should be documented in the resident's medical records and signed by either the resident or their RP. RN 1 stated Resident 12's clinical records did not contain a completed or signed informed consent for the use of side rails. RN 1 stated as a result of an uncompleted informed consent form for side rails, Resident 12 and/or her RP 1 were not provided with the opportunity to make an informed decision about whether to accept or refuse the side rails use.During a review of the facility's P&P titled Usage of bedside rails, revised 1/2024, the P&P indicated the facility would assess every resident admitted to the facility for proper use of bed side rails. The P&P indicated For any purpose of bedside rails usage, it is a must to have consent of the resident/resident's representative or both.During a review of the facility's P&P titled Informed Consent of Physical and Chemical Restraints, revised 1/2025, the P&P indicated:1. The facility would have an informed consent prior to initiation of physical treatment such as side rails.2. The facility would not apply physical restraints (side rails) until the informed consent was given by the resident and/or resident representative.

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	056458	A. Building B. Wing	07/18/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Registered Nurse (RN) 3 documented on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) immediately after administering medications to one of seven sampled residents (Resident 19).This deficient practice had the potential to result in double administration of medication to Resident 19 which could lead to liver and kidney damage. Findings:During a review of Resident 19's admission Record (Face Sheet), the Face Sheet indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (elevated blood pressure). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 7/1/2025, the MDS indicated Resident 19's cognition (process of thinking) was intact. The MDS indicated Resident 19 was independent in eating, oral hygiene, toileting, and personal hygiene.During a review of Resident 19's Order Summary Report, active orders dated 7/17/2025, the Order Summary Report indicated to:1. Give amlodipine (medication to lower blood pressure) 5 milligrams (mg, unit of measurement) by mouth, once a day for hypertension. Hold medication if systolic blood pressure (SBP- pressure in the arteries when the heart beats) less than 110 millimeters of mercury (mmHg, unit of blood pressure measurement).2. Give ClearLax (medication to produce a bowel movement) oral powder, one scoop of 17 grams (g, unit of measurement) by mouth, once a day for constipation (difficulty having a bowel movement). 3. Give Paxlovid (medication to treat Coronavirus 2019 [COVID-19, a contagious respiratory virus) 150 mg/100mg by mouth two times a day, for five days, related to COVID-19.During a review on 7/16/2025 at 11:14 a.m., Resident 19's MAR, dated 7/1/2025 through 7/31/2025, the MAR indicated Resident 19's amlodipine, ClearLax, and Paxlovid were due for administration at 9 a.m. and did not have any documentation to indicate whether the medications were given. During an interview on 7/16/2025 at 11:20 a.m., with RN 3, RN 3 stated Resident 19 received his medications that were due at 9 a.m.During an interview on 7/16/2025 at 11:25 a.m., with Resident 19, Resident 19 stated he received his medications while he ate breakfast.During a concurrent interview and record review on 7/17/2025 at 11:03 a.m., with RN 3, Resident 19's Medication Administration Audit Report, dated 7/16/2025, was reviewed. The Audit report indicated the following:- Amlodipine 5mg was held by RN on 7/16/2025 at 8:05 a.m. due to Resident 19's pulse rate being less than 60 beats per minute (bpm) and documented on the MAR on 7/16/2025 at 2:55 p.m.- ClearLax 17g was refused by Resident 19 on 7/16/2025 at 8:56 a.m. and documented on the MAR on 7/16/2025 at 2:56 p.m.- Paxlovid 150mg/100mg was administered on 7/16/2025 at 8:05 a.m. and documented on the MAR on 7/16/2025 at 2:56 p.m.RN 3 stated when administering medications, the process was pour, pass, document, meaning she was responsible for pouring the medication into the medication cup, administer the medication to the resident, and immediately document on the MAR. RN 3 stated she did not follow that process after administering Resident 19's medication on 7/16/2025. RN 3 stated immediately documenting on the MAR was a communication tool indicating the medications Resident 19 did and did not receive. RN 3 stated by not marking Resident 19's MAR, it appeared that Resident 19 had not received his scheduled medications. RN 3 stated this put Resident 19 at risk of double dosing on the Paxlovid which could affect the liver and kidneys. During an interview on 7/18/2025 at 8:57 a.m., with the Director of Nursing (DON), the DON stated after administering medications to a resident, the licensed nurse was responsible for documenting immediately whether the medications were given, held, or refused. The DON stated documentation was the licensed nurse's signature of care provided to the residents. The DON stated by not documenting immediately after administration and waiting hours later, placed Resident 19 at risk of a medication error such as double administration. The DON stated another licensed nurse could take over Resident 19's care and may think the scheduled medications were not given and decide to administer another dose. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 1/2025, the P&P indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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	056458	A. Building B. Wing	07/18/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for side effects for one of five sampled residents (Resident 67), who was on Cymbalta (medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] and chronic pain). This deficient practice had the potential to result in undetected side effects, delay in physician notification of a change of condition, and a delay in providing necessary care and services to Resident 67.Findings:During a review of Resident 67's admission Record (Face Sheet), the Face Sheet indicated Resident 67 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 67's Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 67's cognitive skills (process of thinking) for daily decision making was moderately impaired. The MDS indicated Resident 67 was dependent on staff's assistance with toileting, bathing, and dressing. The MDS indicated Resident 67 took antidepressant medication. During a review of Resident 67's Order Summary Report, order dated 6/15/2025, the Order Summary Report indicated to give Cymbalta (an antidepressant medication), by mouth in the morning related to type 2 diabetes mellitus with diabetic polyneuropathy.During a concurrent interview and record review on 7/17/2025 at 8:21 a.m., with Registered Nurse (RN) 1, Resident 67's Orders, dated 7/17/2025, were reviewed. The Orders did not indicate side effects monitoring for Resident 67's use of Cymbalta. RN 1 stated Resident 67 took Cymbalta to treat her neuropathy pain, however, Cymbalta was classified as an antidepressant. RN 1 stated Cymbalta had side effects that the licensed nurses had to monitor for. RN 1 stated if Resident 67 experienced any side effects of Cymbalta, the licensed nurse was responsible for notifying her physician.During an interview on 7/18/2025 at 8:31 a.m., with the Director of Nursing (DON), the DON stated monitoring Resident 67 for side effects from Cymbalta was important to assess how Resident 67 tolerated taking the medication. The DON stated monitoring every shift for side effects would allow the licensed nurses to identify the change of condition and notify Resident 67's promptly. The DON stated without proper monitoring, the side effects such as nausea and vomiting, diarrhea, and dry mouth would go undetected, which would result in delay in physician notification and treatment.During a review of the facility's Policy and Procedure (P&P) titled, The Use of Psychotropic Medication (medication that affect the brain to treat mental health disorders), revised 6/2013, the P&P indicated the licensed nurses were responsible for monitoring psychotropic drug use for any side effects.

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	056458	A. Building B. Wing	07/18/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate the initiation of RNA ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) services with a resident's hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) provider after a resident exhibited documented limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] for one out of five sampled residents. This failure resulted in unmet care needs and placed the resident at increased risk for functional decline. Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (an interruption in blood flow to the brain), fracture (broken bone) of unspecified part of neck of unspecified femur (leg bone), muscle weakness, and history of falling. During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 4/19/2025, the MDS indicated Resident 11's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 11 was entirely dependent on staff to perform Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 11's Care Plan titled, At risk for Further Decline in ADL's Related to Impaired Mobility and Physical Limitations, initiated 1/3/2025, the Care Plan Goals indicated Resident 11 would have less episodes of further decline in ADLs. During a review of Resident 11's Physician Order Summary Report, dated 7/16/2025, the Order Summary Report indicated, on 1/3/2025, Resident 1 was ordered hospice services and, on 4/23/2025, Resident 11 was ordered a hand roll for his left hand. There were no orders for RNA ROM exercises. During observations made on 7/15/2025 at 9:13 a.m. and 7/16/2025 at 2:45 p.m. Resident 11 was in bed, with a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen), with both of his legs bent and his left hand and arm bent inward. During a concurrent record review and interview on 7/16/2025 at 1:40 p.m. with the Director of Rehabilitation (DOR), Resident 11's Rehab Screening Form, dated 4/21/2025, was reviewed. The Rehab Screening Form indicated Resident 11 had the presence of a contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), ROM impairment on the left shoulder, and ROM impairments to both lower extremities. The note indicated the DOR coordinated with the desk nurse to recommend a left-hand roll. The DOR stated the normal practice was to notify the assigned nurses to notify the hospice provider whenever there was a concern, a recommendation or change of condition in the resident. The DOR stated Resident 11 was high risk for ADL decline and the development of contractures. The DOR stated she communicated the need for a hand roll but did not advocate for passive ROM exercises for Resident 11's upper and lower extremities. The DOR stated Resident 11 would have greatly benefitted from passive range of motion exercises for his upper and lower extremities to make him comfortable, maintain integrity of his joints and avoid decline. The DOR stated she did not recommend RNA services because the resident was a hospice resident and left the coordination of ROM exercises to the hospice team. The DOR stated she should have advocated for ROM exercises in addition to the application of the hand roll for Resident 11 regardless of his hospice care status. During a record review and interview on 7/17/2025 at 7:47 a.m. with Registered Nurse (RN) 1, Resident 11's Nursing Progress Notes dated, 4/1/2025 to 7/2025, and all of Resident 11's SBARs, dated in 2025, were reviewed. The Nursing Progress Notes and the SBAR notes indicated there was no communication between licensed nursing staff and Resident 11's hospice provider about Resident 11's range of motion decline. RN 1 stated ROM exercises were important to ensure a resident maximized his or her ROM and to prevent mobility decline. RN 1 stated Resident 11 had known ROM limitations and was at risk for decline in mobility. RN 1 stated the licensed nursing staff should have advocated for ROM exercises and RNA services for Resident 11. RN 1 stated consistent ROM exercises should have been ordered to enhance Resident 11's quality of life, keep him comfortable and lessen the likelihood of the development of contractures. During a record review and interview on 7/17/2025 at 11:26 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 11's Nursing Progress Notes dated, 4/1/2025 to 7/2025, and all of Resident 11's SBARs, dated in 2025, were reviewed. The Nursing Progress Notes and the SBAR notes indicated there was no communication between licensed nursing staff and Resident 11's hospice provider about Resident 11's range of motion decline. LVN 1 stated he noticed Resident 11 had worsening ROM decline since February of 2025. LVN 1 stated he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of South Gate	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control measures were maintained and/or implemented for eight of 19 sampled residents (Residents 71, 70, 74, 1, 18, 52, 5, and 20) when: 1. Signage for enhanced barrier precautions (EBP, infection control measures used to reduce the spread of multidrug-resistant organisms [MDROs], requiring staff to wear a protective gown and gloves during high-contact activity) was not placed outside of Rooms A, B, and C.2. Certified Nursing Assistant (CNA) 2 and CNA 3 did not don the required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) before entering Room D.3. CNA 1 did not don the required PPE before entering Resident 5's room.4. Failed to ensure Resident 20's suprapubic catheter (a tube inserted through the abdomen into the bladder that allows urine to drain from the bladder into a bag) drainage bag was not touching the floor.5. Licensed nursing staff failed to ensure the safe disposal of sharps (devices with sharp points or edges that can puncture or cut skin) containers (containers used to dispose of contaminated sharps) that were overfilled with sharps beyond the manufacturer's fill line for two of three sharps containers attached to medication carts 2 and medication cart 3. These deficient practices placed all facility residents at risk due to transmission of Coronavirus 2019 (COVID-19, a contagious respiratory virus) and/or MDROs from one resident to another, and to other staff. These deficient practices also placed Resident 20 at risk of infection.1.a. During a review of Resident 71’s admission Record, the admission Record indicated the facility originally admitted Resident 71 on 12/23/2024, and most recently re-admitted Resident 71 on 6/16/2025. Resident 71’s admitting diagnoses included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood) and obstructive sleep apnea (a sleep disorder characterized by repeated pauses in breathing during sleep due to a blockage in the upper airway). During a review of Resident 71’s MDS, dated [DATE], the MDS indicated Resident 71 was independent with cognitive skills (the mental abilities used in thinking, learning, remembering, and problem-solving) for daily decision making. The MDS indicated Resident 71 was dependent on staff for all mobility while in and out of bed. During a review of Resident 71’s physician order, dated 7/4/2025, the order indicated staff were to implement EBP due to Resident 71’s multiple open wounds. During a review of Resident 71’s care plan titled “Resident is on Enhanced Barrier Precautions…,” revised 7/4/2025, the care plan indicated staff were to post clear signage outside of Resident 71’s room (Room A) to indicate the type of precaution in place and the required PPE. During an observation on 7/16/2025 at 9:34 a.m., outside of Room A, no EBP signage was observed on the wall or door. Signage for droplet precautions (measures taken to prevent the spread of infection transmitted through respiratory droplets, requiring staff to wear a surgical mask) was observed posted on the wall. During an observation on 7/16/2025 at 2:45 p.m., outside of Room A, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/17/2025 at 8:25 a.m., outside of Room A, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. b. During a review of Resident 70’s admission Record, the admission Record indicated the facility admitted Resident 70 on 1/9/2024. Resident 70’s admitting diagnoses included generalized muscle weakness and presence of a gastrostomy tube (a surgically placed tube that provides a way to deliver nutrition, fluids, and medications directly into the stomach). During a review of Resident 70’s MDS, dated [DATE], the MDS indicated Resident 70 had severe cognitive impairment (a significant decline in mental abilities), and was dependent on staff for toileting hygiene and for showering/bathing. During a review of Resident 70’s physician order, dated 3/21/2025, the order indicated staff were to implement EBP due to Resident 70’s colonization (the presence of microorganisms [i.e., bacteria, viruses, or fungi] within a person, without any apparent symptoms or disease) with an MDRO. During a review of Resident 70’s care plan titled “Resident is on Enhanced Barrier Precautions, ” dated 3/21/2025, the care plan indicated staff were to post clear signage outside of Resident 70’s room (Room B) to indicate the type of precaution in place and the required PPE. During an observation on 7/16/2025 at 2:40 p.m., outside of Room B, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. During an observation on 7/17/2025 at 8:25 a.m., outside of Room B, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. c. During a review of Resident 74’s admission Record, the admission Record indicated the facility originally admitted Resident 74 on 3/13/2024, and most recently re-admitted him on 1/17/2025. Resident 74’s admitting diagnoses included perforation of intestine (a serious medical condition where a hole or tear develops in the wall of the gastrointestinal tract) and generalized muscle weakness. During a review of Resident 74’s MDS, dated [DATE], the MDS indicated Resident 74 had moderate cognitive impairment (a decline in mental abilities, such as memory, thinking, and problem-solving) and required partial or moderate assistance from staff for toileting hygiene and for showering/bathing. During a review of Resident 74’s physician order, dated 3/27/2025, the order indicated staff were to implement EBP due to Resident 74’s colonization with an MDRO. During a review of Resident 74’s care plan titled “Resident is on Enhanced Barrier Precautions, ” dated 3/27/2025, the care plan indicated staff were to post clear signage outside of Resident 74’s room (Room C) to indicate the type of precaution in place and the required PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 1’s admission Record, the admission Record indicated the facility admitted Resident 1 on 5/15/2025. Resident 1’s admitting diagnoses included pleural effusion (a collection of fluid around your lungs) and pneumonia (lung inflammation caused by infection). During a review of Resident 1’s MDS, dated [DATE], the MDS indicated Resident 1 did not have cognitive impairments, and was dependent on staff for showering, and required substantial to maximal assistance from staff for mobility while in and out of bed. During a review of Resident 1’s physician order, dated 7/4/2025, the order indicated staff were to implement EBP due to the presence of Resident 1’s indwelling PleurX catheter (a thin, flexible tube placed in the chest to drain fluid), Resident 1’s colonization with an MDRO, and the presence of an open wound. During a review of Resident 1’s care plan titled “Resident is on Enhanced Barrier Precautions, ” dated 7/4/2025, the care plan indicated staff were to post clear signage outside of Resident 1’s room (Room C) to indicate the type of precaution in place and the required PPE. During a review of Resident 18’s admission Record, the admission Record indicated the facility admitted Resident 18 on 8/14/2024 and most recently re-admitted him on 8/18/2024. Resident 18’s admitting diagnoses included reduced mobility, paraplegia (inability to move the legs and lower body), and a pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of the right buttock. During a review of Resident 18’s MDS, dated MDS 5/25/2025, the MDS indicated Resident 18 had moderate cognitive impairment and was dependent on staff for toileting, showering, and mobility while in and out of bed. During a review of Resident 18’s physician order, dated 3/27/2025, the order indicated staff were to implement EBP due to Resident 18’s colonization with an MDRO. During a review of Resident 18’s care plan titled “Resident is on Enhanced Barrier Precautions, ” dated 3/27/2025, the care plan indicated staff were to post clear signage outside of Resident 18’s room (Room C) to indicate the type of precaution in place and the required PPE. During an observation on 7/16/2025 at 9:37 a.m., outside of Room C, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. During an observation on 07/16/2025 2:34 p.m., outside of Room C, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. During an observation on 7/17/2025 at 8:26 a.m., outside of Room C, no EBP signage was observed on the wall or door. Signage for droplet precautions was observed posted on the wall. During an interview on 7/17/2025 at 11:10 a.m., with Infection Preventionist Nurse (IPN), the IPN stated EBP required staff to wear a protective gown, and droplet precautions only required a surgical mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/17/2025 at 11:19 a.m., with the IPN, the IPN stated it was important to ensure signage for any required precautions was posted for infection control and to prevent transmission of infection. The IPN stated that without clear signage there was potential for the spread of infection. 2. During a review of Resident 52’s admission Record, the admission Record indicated Resident 52 was admitted on [DATE]. Resident 52’s admitting diagnoses included high blood pressure. During a review of Resident 52’s MDS, dated [DATE], the MDS indicated Resident 52 did not have cognitive impairments and required substantial to maximal assistance from staff for toileting, showering, and mobility while in bed. During a review of Resident 52’s progress note, dated 7/11/2025, the progress note indicated Resident 52 tested positive for Covid-19. During a review of Resident 52’s physician order, dated 7/12/2025, the order indicated staff were to implement novel respiratory precautions (an infection control measure requiring staff to put on a disposable gown, eye protection [goggles or face shield], a fit-tested respirator [a mask that protects the wearer from hazardous airborne substances], and gloves) prior to entering Resident 52’s room. During a review of Resident 52’s care plan titled “…On Novel Respiratory Precautions, ” dated 7/11/2025, the care plan indicated staff were to use the required PPE when providing care. During an observation on 7/15/2025 at 3:33 p.m., at Resident 52’s bedside, CNA 2 entered Resident 52’s room and was not wearing a respirator-type face mask, face shield/goggles, or a gown. During an observation on 7/15/2025 at 3:41 p.m., at Resident 52’s bedside, CNA 3 entered Resident 52’s room and was not wearing a respirator-type face mask, face shield/goggles, or a gown. During an interview on 7/15/2025 at 3:52 p.m., outside of Resident 52’s room, with CNA 2, CNA 2 stated he did not see the signage indicating novel respiratory precautions before entering Resident 52’s room. CNA 2 stated he should have put on the required PPE prior to entering Resident 52’s room. CNA 2 stated the importance of putting on the required PPE was to prevent the transmission of Covid-19. During an interview on 7/15/2025 at 3:56 p.m., with CNA 3, CNA 3 stated he did not see the signage indicating novel respiratory precautions before entering Resident 52’s room. CNA 3 stated the failure to use the required PPE created the risk for the spread of Covid-19. During an review of the facility P&P titled Infection Prevention and Control Program dated 2001, the P&P indicated that important facets of infection prevention included instituting measures to avoid complications or dissemination. It also indicated outbreak management procedures included preventing the spread of infection to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During a review of Resident 20’s admission Record, the admission Record indicated the facility originally admitted Resident 20 on 4/29/2022 and readmitted on [DATE]. Resident 20’s admitting diagnoses included urinary tract infection, urogenital implant (catheter), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 20’s admission Nursing Assessment, dated 7/10/2025, the admission Nursing Assessment indicated Resident 20’s cognition was moderately impaired. The admission Nursing Assessment indicated Resident 20 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 20’s Order Summary Report, dated 7/10/2025, the Order Summary Report indicated Resident 20 would have suprapubic catheter, and the facility would provide care every shift. During an observation on 7/15/2025 at 10:27 a.m., and 12:35 p.m., in Resident 20’s room, Resident 20 was observed lying in bed with suprapubic catheter. The catheter drainage bag was observed on the right side of Resident 20's bed, touching the floor during both observations. During an interview on 7/15/2025 at 1:34 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated the catheter bag should be hanging from the side of the resident bed, not on the floor. CNA 4 stated Resident 20’s catheter bag on the floor was not sanitary and could cause infection. During an interview on 7/16/2025 at 4:15 p.m., with the Director of Nursing (DON), the DON stated catheter drainage bag must be secured to the resident’s bed and should never be touching the floor under any circumstances. The DON stated that when the catheter bag touches the floor increases the risk of bacterial contamination, which could potentially place Resident 20 at risk of catheter associated urinary tract infections. During a review of the facility’ policy and procedure (P&P) titled “Catheter Care, Urinary”, undated the facility would maintain the catheter tubing and drainage bag clean and would ensure the catheter tubing and drainage bag were kept off the floor. 5. During an observation on 7/17/2025 at 11:05 a.m., a sharps container was attached to medication cart 2 filled with used needles, lancets and other sharps. The container was observed to be overfilled with sharps that passed the manufacturer’s fill line. During an interview on 7/17/2025 at 11:05 a.m., with Licensed Vocational Nurse, LVN 1 stated, This container is full and does pose an infection control risk to residents. During an observation on 7/17/2025 at 11:19 a.m., a sharps container was attached to medication cart 3 containing needles, lancets and other sharps. The container was observed to be filled beyond the manufacturer’s fill line. During an interview on 7/19/2025 at 12:40 p.m., with Registered Nurse (RN), RN 3 stated, It is an infection control risk having the sharps container filled beyond the fill line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility’s policy and procedure (P&P) titled, “Sharps Disposal”, undated, the P&P indicated, “During use, containers for contaminated sharps will be handled as follows: Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or accidents while attempting to push sharps into the container.”