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 _____	C 10/22/2024

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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one Facility Reported Incident numbered CA00924376. The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written for the Facility Reported Incident number CA00924376 (Refer to Ftags F658 F760).	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greenfield Care Center of South Gate does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency(ies). The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency(ies), statements, facts, and conclusions that form the basis for the deficiency(ies).	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy to document the findings related to a change of condition (COC) every shift for two of three sampled residents (Resident 1 and Resident 2). This deficient practice had the potential to result in serious harm such as another episode of aggression towards others, and a delay of necessary treatments. Findings: 1. During a review of Resident 1 ' s Admission	F 658	CORRECTIVE ACTION On 10/22/24, the DON in-serviced licensed nurses on change of condition Q shift monitoring and documentation. IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION Any resident who has a COC is potentially affected. No other residents were identified as being affected by the deficient practice and no further corrective action was needed. MEASURES TO PREVENT RECURRENCE On 10/22/24, the DON in-serviced licensed nurses on change of condition Q shift monitoring and documentation. The medical records director/designee shall conduct daily COC audits to ensure that the facility follows its policies regarding COC monitoring and documentation. The results of these audits shall be presented by the MRD/designee to the DON or	10/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
A. Cuadra	Licensed Nursing Home Administrator	11/07/24

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.

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F 658	Continued From page 1 Record, the Admission Record indicated Resident 1 was originally admitted to facility on 12/21/2016 and re-admitted on 7/6/2020. Resident 1 ' s diagnoses included seizures (a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness), dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental health condition that involved excessive and persistent feelings of fear, dread, and uneasiness), and insomnia (trouble falling asleep or staying asleep). During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/18/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment to both extremities and used a walker and/or wheelchair for mobility. During a review of Resident 1 ' s History and Physical (H&P), dated 9/30/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s care plan titled, "Roommate (Resident 2) hit resident (Resident 1) on right side of the face related altercation regarding television. At risk for pain or discomfort," dated 10/8/2024, the care plan indicated staff would monitor every shift for any change of condition. During a review of Resident 1 ' s Nursing Notes dated 10/8/2024, the nursing notes indicated Resident 1 had an altercation with Resident 2, and the doctor ordered staff to monitor Resident	F 658	designee daily at the morning stand up meeting. Any deficient practices shall be corrected immediately and any corresponding in-service education or systemic change shall be implemented to prevent further deficient practice(s). MONITORING AND INCORPORATION INTO THE QA SYSTEM The MRD/designee shall conduct daily COC audits for four weeks, then monthly for three months, then quarterly for three quarters to monitor licensed staff are in compliance with this identified deficiency. Any deficient findings shall be reported to the DON/designee for implementation of corrective action and/or in-service education. The DON/designee shall present at the quarterly QAPI meeting for three quarters, a summary of the MRD/designee monitoring and the corresponding corrective action(s), if needed. These findings shall be reviewed by the QAPI committee to identify potential trends and/or patterns. Based on this review, the committee shall give guidance on additional monitoring and/or corrective actions to ensure ongoing compliance, if needed. Once compliance has been achieved for 3 quarters, monitoring of this deficient practice will no longer be necessary and the systemic changes will be deemed effective.	

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F 658	Continued From page 2 1. During a concurrent interview and record review on 10/22/2024 at 10:39 AM with Registered Nurse (RN 1), Resident 1 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. RN 1 stated there were no documentations regarding Resident 1 ' s COC for the 11 PM to 7AM (night) shift on 10/8/2024, the 3 PM to 11 PM (evening) shift on 10/9/2024, the evening shift on 10/10/2024, or the night shift on 10/10/2024. RN 1 stated the licensed nurses should document every shift for 72 hours on the nursing note for Resident 1. RN 1 stated it was important to document so nurses could notify the doctor regarding any aftereffects on Resident 1 from the incident, and nurses could provide interventions to address any psychosocial needs. During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the Director of Nursing (DON), Resident 1 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. The DON stated there were no documentation regarding Resident 1 ' s COC for the night shift on 10/8/2024, the evening shift on 10/9/2024, the evening shift on 10/10/2024, or the night shift on 10/10/2024. The DON stated the licensed nurse assigned to Resident 1 should document every shift for 72 hours on the nursing note. The DON stated staff monitored Resident 1 ' s emotions to see if the resident was feeling depressed or happy every shift for three days. The DON stated it was important to document so nurses could know if Resident 1 had any negative outcomes from the incident. 2. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident	F 658		

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F 658	Continued From page 3	F 658		

2 was admitted to the facility on 9/19/2024. Resident 2 ' s diagnoses included hypertension (high blood pressure), Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which caused the heart to not pump the blood efficiently), and cardiomyopathy (a diseases of the heart muscle that made it harder for the heart to pump blood).

During a review of Resident 2 ' s MDS, dated 10/2/2024, the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was mildly impaired. The MDS indicated Resident 5 used a cane/ crutch for mobility.

During a review of Resident 2 ' s H&P, dated 9/2/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions.

During a review of Resident 2 ' s Nursing Notes dated 10/18/2024, the nursing notes indicated Resident 2 had an altercation with Resident 1, and the doctor ordered staff to monitor Resident 2.

During a concurrent interview and record review on 10/22/2024 at 10:39 AM with RN 1, Resident 2 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. RN 1 stated there were no documentation regarding Resident 2 ' s COC for the night shift on 10/9/2024, the night shift on 10/10/2024, or the 7 AM to 3 PM (morning) shift on 10/11/2024. RN 1 stated the licensed nurses should document every shift for 72 hours on the nursing note for Resident 2. RN 1 stated it was important to document so nurses could notify the doctor regarding any aftereffects on Resident 2 from the incident, and nurses could

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F 658	Continued From page 4 provide interventions to address any psychosocial needs. RN 1 stated not documenting every shift possibly delayed necessary care. During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the DON, Resident 2 ' s Nursing Notes, dated from 10/8/2024 to 10/11/2024, were reviewed. The DON stated there were no documentation regarding Resident 2 ' s COC for the night shift on 10/9/2024, the night shift on 10/10/2024, or the morning shift on 10/11/2024. The DON stated the licensed nurse assigned to Resident 2 should document every shift for 72 hours on the nursing note. The DON stated staff monitored Resident 2 ' s emotions to see if Resident 2 was feeling depressed or happy every shift for three days. The DON stated it was important to document so nurses could know if Resident 2 had any negative outcomes from the incident. The DON stated the potential risk of not documenting every shift was another altercation. During a review of the facility ' s Policy and Procedure (P&P) titled "Change of Condition," revised on 7/2012, the P&P indicated the licensed nurse responsible for the resident would continue assessment and documentation every shift for 72 hours or until condition is stable.	F 658		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from	F 760	CORRECTIVE ACTION On 10/22/24, Resident 2's physician was notified of the medication error. No new orders were received. No adverse symptoms were observed. On 10/22/24, the DON gave an in-service education for licensed staff regarding administering medications in accordance with parameters, if indicated.	

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F 760	Continued From page 5 significant medication error by administering amiodarone (a medication that prevents and treats irregular heartbeat) and metoprolol tartrate (medicine to treat high blood pressure) outside the parameters (specific instructions that you could measure) as ordered by the physician for one of three sample residents (Resident 2). These deficient practices had the potential to cause complications of hypotension (low blood pressure, dizziness and fainting leading to falls) and low pulse (leading to loss of consciousness). Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on 9/19/2024. Resident 2 ' s diagnoses included hypertension (high blood pressure), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which caused the heart to not pump the blood efficiently), and cardiomyopathy (a diseases of the heart muscle that made it harder for the heart to pump blood). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 2 used a cane/ crutch for mobility. During a review of Resident 2 ' s History and Physical (H&P), dated 9/2/2024, the H&P indicated Resident 2 had the capacity to	F 760	IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION Any resident with medication parameters are potentially affected. On 11/07/24, the MRD conducted an audit of in-house residents with medication parameters. One resident was identified as being affected by the deficient practice on 11/03/24 at 14:00. The attending physician was notified with no new orders. The offending nurse had a directed one on one in-service training by the DON on 11/07/24 to ensure that the deficient practice does not recur. MEASURES TO PREVENT RECURRENCE On 10/22/24, the DON conducted an in-service education for licensed nurses regarding medications with drug parameters and the significance of following the parameters. On 11/07/24, the DON conducted a directed one on one in-service education for a licensed nurse who was found to be deficient in this regulation. As of 11/07/24, the MRD/designee shall conduct an admission audit for medications with parameters within 24 hours of admission, with any new medication order with parameters and, for this particular deficiency, weekly for 4 weeks, monthly for 3 months and then quarterly for 3 quarters. Any deficient practices shall be reported to the DON/designee for immediate corrective action.	11/07/24

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F 760	Continued From page 6 understand and make decisions. During a review of Resident 2 ' s Order Summary Report as of 10/22/2024, the report indicated on 9/19/2024 the physician ordered to hold amiodarone and metoprolol tartrate if Resident 2 ' s pulse was less than 60 beats per minute (BPM). During a concurrent interview and record review on 10/22/2024 at 11:55 AM with the Director of Nursing (DON), Resident 2 ' s Medication Administration Record (MAR) for October 2024 was reviewed. The MAR indicated amiodarone was administered on 10/8/2024 at 9:00 AM with a pulse of 56 BPM, on 10/8/2024 at 5:00 PM with a pulse of 54 BPM, and on 10/9/2024 at 5:00 PM with a pulse of 54 BPM. The MAR also indicated metoprolol tartrate was administered on 10/8/2024 at 9:00 AM with a pulse of 56 BPM, on 10/8/2024 at 5:00 PM with a pulse of 54 BPM, on 10/9/2024 at 5:00 PM with a pulse of 54 BPM, on 10/15/2024 at 5:00 PM with a pulse of 56 BPM, and on 10/21/2024 at 9:00 AM with a pulse of 53 BPM. The DON stated the check mark on the MAR indicated the medication was administered. The DON stated the nurse should hold amiodarone and metoprolol tartrate with a pulse less than 60 BPM. The DON stated resident ' s pulse would go down and might lose consciousness if amiodarone and metoprolol tartrate were administered with a pulse less than 60 BPM. The DON stated the right thing to do was to call the doctor. During a review of the facility ' s policy and procedure (P&P) titled, "Medication Administration," revised on 7/2013, the P&P indicated drugs must be administered in accordance with the written orders of the	F 760	The pharmacist consultant shall review monthly for medications with parameters for 3 months, then quarterly for 3 quarters to ensure monitoring and effectiveness of the corrective measure. MONITORING AND INCORPORATION INTO THE QA SYSTEM The MRD/designee shall conduct an admission audit for medications with parameters within 24 hours of admission, with any new medication order with parameters and, for this particular deficiency, weekly for 4 weeks, monthly for 3 months and then quarterly for 3 quarters. The results of these audits shall be reported to the DON/designee for immediate corrective action. The DON/designee shall present at the quarterly QAPI meeting for three quarters, a summary of the MRD/designee monitoring and the corresponding corrective action(s), if needed. These findings shall be reviewed by the QAPI committee to identify potential trends and/or patterns. Based on this review, the committee shall give guidance on additional monitoring and/or corrective actions to ensure ongoing compliance, if needed. Once compliance has been achieved for 3 quarters, monitoring of this deficient practice will no longer be necessary and the systemic changes will be deemed effective.	

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F 760	Continued From page 7 attending physician. The P&P further indicated that medication for hypertension that required parameters before administration should be complied with.	F 760		