

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1260 Travis Blvd Fairfield, CA 94533	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and record review the facility failed to ensure safe and effective pharmaceutical services for a census of 55 residents when Resident 41 and Resident 47's controlled drug (drug with potential for abuse) uses and removal signed out from the Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident) were not documented in their Medication Administration Record (MAR-a legal document that list administered drugs).This failed practice may contribute to unsafe controlled medication handling and/or risk of controlled drug diversion (unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace).Findings:1a. A review of Resident 41's clinical record indicated Resident 41 was admitted May of 2020 and had diagnoses that included gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints), neuralgia (pain caused by irritation or damage to a nerve), and neuritis (inflammation of a nerve causing pain).A review of Resident 41's active physician's order, dated 4/25/23, indicated, Resident is not capable of giving informed consent and/or able to participate in treatment plan.A review of Resident 41's active physician's order, dated 4/21/25, indicated, Norco Tablet [a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] 5-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hoursas needed for moderate-severe pain 4-10 pain scale [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-6 is moderate pain, 7-10 is severe pain] .A random audit of Resident 41's MAR and the CDR for Norco, for August and September 2025, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR on the following times: 1 tablet on 8/18/25 at 1:02 p.m.1 tablet on 8/19/25 at 1:06 a.m. 1 tablet on 9/8/25 at 12:25 p.m.1b. A review of Resident 47's clinical record indicated Resident 47 was admitted May of 2025 and had diagnoses that included dementia (memory loss that interferes with daily functions, muscle weakness, and need for assistance with personal care.A review of Resident 47's active physician's order, dated 5/16/25, indicated, HYDROcodone-Acetaminophen [Norco] Oral Tablet 5-325 MG . Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain 4-10 .A random audit of Resident 47's MAR and the CDR for Norco, for August and September 2025, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR on the following times:1 tablet on 8/25/25 at 9 a.m.1 tablet on 9/4/25 at 7:45 a.m.During a concurrent interview and record review on 9/10/25 at 1:58 p.m. with Licensed Nurse (LN) 2, Resident 41 and Resident 47's's CDR and MAR were reviewed. LN 2 confirmed the finding of Norco being signed out of Resident 41 and Resident 47's CDR but was not accurately documented on the MAR. LN 2 stated that Norco administration should be both signed out in the CDR and signed in the MAR.During an interview on 9/11/25 at 9:52 a.m. with the Consultant Pharmacist (CP), the CP stated he would expect nurses to always sign off the CDR and MAR when administering controlled medications. The CP further stated there would be a risk for controlled drug diversion or issues like unsafe handling of controlled drugs if the CDR and MAR are not both signed.During an interview on 9/11/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated he would expect the nurse to sign both the CDR and MAR when administering controlled medications. The DON further stated once the nurse pops the controlled medication in the pill cup, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they should sign the CDR, then after administering the medication, the nurse should sign the MAR.A review of the facility's policy and procedure (P&P) titled, Documentation of Medication Administration, revised 1/2025, indicated, 1. A nurse or certified medication aide (where applicable) documents all medications administered to eachresident on the resident's medication administration record (MAR). 2. Administration of medication is documented immediately after it is given.A review of the facility's P&P titled, Medication Administration, dated 5/2016, indicated, 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications .5. When PRN [as needed] medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral) .d. Signature or initials of person recording administration and signature or initials of person recording effects .A review of the facility's P&P titled, Controlled Substances, dated 1/2025, indicated, Dispensing and Reconciling Controlled Substances .1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure safe medication administration practices were followed when the facility's medication error rate was more than 5% (percentage- number or ratio that expressed as a fraction of 100) for a resident census of 55. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of three errors out of 36 opportunities which resulted in a facility wide medication error rate of 8.33% in one out of 9 residents (Resident 32) observed for medication administration. These failures had the potential for unsafe and ineffective medication use for Resident 32 and had the potential to negatively affect the residents' medical conditions. Findings: During a medication administration observation which started on 9/8/25 at 10:54 a.m. with Licensed Nurse (LN) 1, LN 1 administered a total of six pills to Resident 32 which included 1 capsule of aspirin-dipyridamole (a medication used to prevent stroke) ER (extended release) 25-200 mg (milligrams- unit of measurement), 1 capsule of docusate sodium (a medication utilized for managing and treating infrequent or difficult bowel movements) 100 mg, and 1 tablet of buspirone (a prescription medication used to treat anxiety and/or depression) 5 mg. A review of Resident 32's active physician's order, dated 6/30/25, indicated, Aspirin-Dipyridamole ER Oral Capsule Extended Release 12 Hour 25-200 MG .Give 1 capsule by mouth two times a day related to UNSPECIFIED SEQUELAE [a condition which is the consequence of a previous disease or injury] OF CEREBRAL INFARCTION [damage to a part in the brain due to a disrupted blood flow]. A review of Resident 32's active physician's order, dated 6/10/25, indicated, Docusate Sodium Oral Capsule 100 MG .Give 1 capsule by mouth two times a day for bowel management. A review of Resident 32's active physician's order, dated 7/15/25, indicated, busPIRone HCl Oral Tablet 5 MG .Give 1 tablet by mouth two times a day for manifested by [sic] self isolation related to MAJOR DEPRESSIVE DISORDER, RECURRENT [persistently depressed mood or loss of interest in activities, causing significant impairment in daily life] .A review of Resident 32's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of September 2025 indicated Resident 32's morning dose of aspirin-dipyridamole, docusate sodium, and buspirone were all scheduled at 9 a.m. During a concurrent interview and medication order review on 9/8/25 at 2:32 p.m. with LN 1, LN 1 acknowledged the observed medication administration of aspirin-dipyridamole, docusate sodium, and buspirone to Resident 32 which were two hours after the scheduled time. LN 1 stated she was aware that the medications were administered late. LN 1 also stated she was supposed to administer the medications an hour before or after the scheduled time of administration to maintain therapeutic level (concentration of a medication in the body that is high enough to produce the desired medical effect without causing significant side effects) of medication in the resident. During an interview on 9/11/25 at 9:52 a.m. with the Consultant Pharmacist (CP), the CP stated nurses really need to administer medication within that 1-hour before or after scheduled time frame. The CP further stated there would be a risk that residents could not get the full effect of the medication, possible side effect issues, and poor therapeutic level management. During an interview on 9/11/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that nurses should always follow the facility's policy in administering scheduled medication which was either 1 hour before or after the scheduled time. Requested the facility's medication administration policies and procedures (P&P) discussing the timing of administering medications but none was provided. A review of the facility's policies and procedures titled, Medication Administration, revised 5/2016, indicated, 14. Medications are administered within 60 minutes of scheduled time .Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center .A review of a facility document titled, MEDICATION ADMINISTRATION TIMES, undated, indicated, MEDICATION ADMINISTRATION TIMES :9:00 AM, 12:00 PM, 5:00 PM, 9:00 PM, 6:30 AM.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmaceutical products were properly handled and stored in accordance with the facility's policies and procedures (P&P), and accepted professional principles for a census of 55 when:1. Multiple expired wound dressings (a material applied to a wound to protect it, promote healing, and prevent infection) were stored in the treatment cart;2. An expired medicated shampoo prescribed for a resident was stored in the treatment cart; and,3. An out of the package syringe needle (injection needle) was found in the treatment cart. These failures had the potential for residents to receive pharmaceutical products that were expired or with unsafe or reduced potency, and risk for residents and/or staff injury and/or infection. Findings:1. During a concurrent observation and interview which started on [DATE] at 11:38 a.m. with Treatment Nurse (TN) 2, of the facility's treatment cart, five silicone wound dressing (a type of wound dressing used to manage wounds with discharges while also helping to reduce scarring and provide pain-free dressing changes) with an expiration date of [DATE], and six occlusive petrolatum gauze wound dressing (a type of wound dressings used to treating wounds such as burns, by creating a moist, breathable, non-sticking environment that protects the wound, reduces pain during changes, and promotes healing) with an expiration date of [DATE] were found stored in the treatment cart. TN 2 confirmed the observation. TN 2 stated expired wound dressings should be discarded and not be used because the wound dressings would have less effectiveness in treating wounds.2. During a concurrent observation and interview which started on [DATE] at 11:38 a.m. with TN 2, of the facility's treatment cart, a medicated shampoo prescribed for a resident with an expiration date of [DATE] was found stored in the treatment cart. TN 2 confirmed the observation. TN 2 stated the expired shampoo should have been discarded because the resident would be at risk for side effects and the treatment would not be as effective as desired.3. During a concurrent observation and interview which started on [DATE] at 11:38 a.m. with TN 2, of the facility's treatment cart, an out of the package syringe needle (injection needle) with a needle cap on, was found in the treatment cart. TN 2 confirmed the observation. TN 2 stated they don't use syringe needles in their treatments and was wondering why there was a syringe needle in the treatment cart. TN 2 further stated the out of the package syringe needle should not be in the cart because of safety issues. During an interview on [DATE] at 3:16 p.m. with the Director of Staff Development (DSD), the DSD stated expired wound dressings, and medicated shampoo should not be stored in the treatment cart because the wound dressing and shampoo would not be effective anymore. The DSD further stated the out of the package syringe needle should not be in the treatment cart and they should have been discarded in a sharp container to prevent staff or resident injury. During an interview on [DATE] at 10:49 a.m. with the Director of Nursing (DON), the DON stated all expired wound dressings, and medicated shampoo should be discarded because they would not be effective when used. The DON further stated an opened syringe needle should not be stored in the treatment cart because of the risk for needle prick. A review of the facility's policy and procedures (P&P) titled, Medication Storage, dated 9/2010, indicated, .biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective .administration A review of the facility's P&P titled, Disposal Of Sharps Needles and Syringes, revised 1/2015, indicated, Used sharps, needles and syringes will be disposed of safely and in accordance with applicable laws. Procedures: . 2. Needles are not to be recapped after use to avoid needle-sticks. 3. Syringes and Needles shall be placed into puncture- resistant sharp disposal containers immediately after use. Needles are not to be deliberately bent or broken .		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to enrich the caloric content of meals for five of seven residents (Resident 3, Resident 4, Resident10, Resident 37 and Resident 42) with fortified (increased calorie and/or protein content) dietary orders when the cook omitted the scoop of melted butter intended for fortification. This failure had the potential to put these residents at risk for poor nutritional status. Findings:A review of Resident 3's admission record indicated Resident 3 was admitted on [DATE] with the diagnosis of Multiple Sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord). A review of Resident 3's physician (MD) orders indicated an order, dated 12/4/23, for a fortified diet. A review of Resident 4's admission record indicated Resident 4 was admitted on [DATE] with a diagnosis of a Stage 3 pressure injury (Full thickness loss of skin, dead and black tissue may be visible).A review of Resident 4's physician (MD) orders indicated an order, dated 4/19/21, for a fortified.A review of Resident 10's admission record indicated Resident 10 was admitted on [DATE] with a primary diagnosis of UTI (an infection in the bladder and urinary tract) and severe protein calorie malnutrition.A review of Resident 10's physician orders indicated an order, dated 1/27/25, for a fortified diet.A review of Resident 37's admission record indicated Resident 37 was admitted on [DATE] with a diagnosis of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movements) and Dysphagia (difficulty swallowing). A review of Resident 37's physician (MD) orders indicated an order, dated 12/25/24, for a fortified diet.A review of Resident 42's admission record indicated Resident 42 was admitted on [DATE] with a diagnosis of Multiple Sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord). A review of Resident 42's physician (MD) records indicated an order, dated 3/21/23, for a fortified diet.During an observation on 9/9/25 beginning at 11:34 a.m. in the kitchen of the lunch tray line, [NAME] 2 was plating resident meals. Several residents were noted to have an indication for a fortified meal on their tray tickets and no additional calories were observed to have been added to meals. At 11:58 a.m. [NAME] 2 looked up at the surveyor and acknowledged the current omission and added a scoop of melted butter to the plate. [NAME] 2 did not check to see if they had missed other fortified diet meals prior to their realization. During an interview on 9/9/25 with the Dietary Supervisor (DS) at 4:00 p.m., the DS confirmed several residents had not received their fortified meals today and explained melted butter was usually added to the meal for extra calories. The DS stated, without the diet fortification the residents were at risk of not getting the extra nutrition they needed. A review of the facility's policy and procedure (P&P) titled, Fortification of Food: Increasing Calories and/or Protein in the Diet, the P&P indicated the enrichment of foods will be done on an individual basis for residents who cannot consume adequate amounts of calories and/or protein to sustain their weight or nutrition status.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, serve food in accordance with professional standards for food service safety when:1. Four steamtable pans were found wet, stacked in the ready to use shelves. 2. One cook failed to follow food safety/sanitation procedures while preparing cooked ready to eat foods.3. One diet aide was observed putting a clean and sanitized dish rack on the kitchen floor. These failures had the potential to lead to food borne illness for the 51 residents eating facility prepared meals. Findings:1) During an observation of the initial kitchen tour on 9/8/25 at 8:57 a.m., four steamtable pans were observed to be stacked wet (wet nesting) on the bottom shelves in the food preparation area, which indicated they were ready to use. During an interview, on 9/8/25 at 9:22 a.m., with the Dietary Supervisor (DS), the DS stated that wet nesting is not desirable. The DS confirmed the observation of the wet trays and instructed the dishwasher to re-wash them. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, The Food and Nutrition Services Director is responsible for instructing employees in the fundamentals of sanitation in food service and for training employees to use appropriate techniques. The Food and Drug Administration (FDA) Food Code 2022, 4-9 Protection of Clean Items. Drying 4-901.11 -Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 2. During the initial kitchen tour on 9/8/25 at 9 a.m., a cooked ready to eat beef roast in a bag had been placed in the sink next to the cook. During a concurrent observation and interview, on 9/8/25 at 9:02 a.m. with the cook, the cook stated that the roast was already cooked, and it is in a sealed bag. During an interview with the DS on 9/8/25 at 4 p.m., the DS stated that the cook should have placed the cooked roast package in a bowl on the counter and that the cooked roast had the potential for food borne illness to the residents. During an interview with the Registered Dietician (RD) on 9/9/25 at 10:05 a.m., the RD stated that the DS had stopped by to talk to him about the cooked roast in the sink. The RD confirmed the potential for contamination of wrapped food in the sink risking cross contamination and that cooked/ready to eat food cannot be placed in the sink. During a review of the facility's policy and procedure (P&P) titled, Food Borne Illness Outbreak, dated 2023, the P&P indicated, Important factors which lead to many foodborne illness outbreaks, cross contamination. The Food and Drug Administration (FDA) Food Code 2022, 3-302. Preventing food and ingredient contamination 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (1) Except as specified in (1)(d) below or when combined as ingredients, separating raw animal foods during storage, preparation, holding, and display from: (a) Raw ready to eat food . (b) Cooked ready-to-eat food . FDA Food Code 2022 Chapter 3. Food Chapter 3 - 11 (2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: (a) Using separate equipment for each type, or in separate areas; .sanitizing as specified under S 4-703.11; (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings; (5) Cleaning hermetically sealed containers of food of visible soil before opening; 3. During a subsequent kitchen tour on 9/8/25 at 10 a.m., the dietary aide was observed placing a dish rack on the floor after emptying clean glasses. The dishwasher picked it up and loaded dirty dishes on it. During an interview with the DS on 9/8/25 at 4 p.m. the DS acknowledged the dietary aide should not put anything on the floor and that it could contaminate the dish rack. During an interview with the RD on 9/9/25 at 10:05 a.m. he stated that putting the rack on the floor (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contaminates the rack and should never be placed on the floor.During a review of the facility's policy and procedure (P&P) titled, Food Borne Illness Outbreak, dated 2023, the P&P indicated, Unsanitary dishware, examples: Improperly cleaned and sanitized tableware, utensils and cutting equipment; failure to protect sanitized ware from contamination.According to the 2022 Federal Food and Drug Administration (FDA) Food Code 4-9 Protection of Clean Items. Drying 4-901.11 -Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 55 when:1. A shared manual blood pressure machine (a device which measures blood pressure), a shared stethoscope (a device used to listen to the body's internal sounds), and a shared pulse oximeter (a medical device that measures the pulse rate and oxygen level in the blood) was not sanitized properly in between use of residents.2. One facility staff did not remove or properly cover a bracelet under personal protective equipment (PPE) while performing wound care for Resident 25.3. Enhanced Barrier Precaution (EBP, an infection control intervention that utilizes the use of gowns and gloves during direct care activities to reduce transmission of multi-drug-resistant organisms) guidelines were not followed for Res 5 and Res 53. These failures had the potential to spread germs and cause infection for a census of 55. Findings: 1. During an observation on 9/8/25 at 10:33 a.m., with Licensed Nurse (LN) 1, LN 1 was observed checking a resident's blood pressure using a manual blood pressure machine and stethoscope, and the resident's pulse rate using a pulse oximeter which were all shared between residents. LN 1 wrapped the manual blood pressure machine on the resident's upper arm and used the stethoscope to check for the resident's blood pressure. LN 1 then placed the pulse oximeter on one of the resident's fingertips and waited for about a minute to read the results. After reading the results, LN 1 went out the room, wiped the shared manual blood pressure machine, stethoscope, and pulse oximeter using a wipe of [Brand name] GERMICIDAL DISPOSABLE WIPE quickly (approximately 5-10 seconds each) to clean the blood pressure machine, stethoscope, and pulse oximeter's outer surfaces, then placed the three items on top of the medication cart to let it dry. During another observation on 9/8/25 at 10:44 a.m., with LN 1, LN 1 was observed checking a resident's blood pressure using a manual blood pressure machine and stethoscope, and the resident's pulse rate using a pulse oximeter which were all shared between residents. LN 1 wrapped the manual blood pressure machine on the resident's upper arm and used the stethoscope to check for the resident's blood pressure. LN 1 then placed the pulse oximeter on one of the resident's pointing fingertips and waited for about a minute to read the results. After reading the results, LN 1 went out the room, wiped the shared manual blood pressure machine, stethoscope, and pulse oximeter using a wipe each of [Brand name] GERMICIDAL DISPOSABLE WIPE quickly (approximately 5-10 seconds each) to clean the blood pressure machine, stethoscope, and pulse oximeter's outer surfaces, then placed the three equipment on top of the medication cart to let it dry. During an interview on 9/8/25 at 2:32 p.m. with LN 1, LN 1 confirmed the two subsequent observations of her cleaning the shared blood pressure machine, stethoscope, and pulse oximeter's outer surfaces quickly (approximately 5-10 seconds each) in between use of residents. LN 1 stated the shared blood pressure machine, stethoscope, and pulse oximeter should have been wiped for two (2) minutes each to disinfect the three pieces of equipment properly and prevent cross contamination between residents. During an interview on 9/11/25 at 9:25 a.m. with the Infection Preventionist (IP), the IP stated that the facility's shared blood pressure machine, stethoscope, and pulse oximeter should be disinfect properly every after each resident's use to prevent the risk of infection. The IP further stated that nurses should follow the manufacturer's guidelines of the purple top wipe (germicidal disposable wipe) when sanitizing a shared equipment which was to wipe it, and it should remain visibly wet for two (2) minutes. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that staff should always properly disinfect shared equipment after use of each resident to prevent the risk of cross-contamination. A review of the facility's policy and procedures (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 5/2024, indicated, 6. Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. A review of the [Brand name] GERMICIDAL DISPOSABLE WIPE label indicated, TO DISINFECT AND DEODORIZE HARD, NONPOROUS SURFACES: .Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry . 2. A review of Resident 25's clinical record indicated Resident 25 was admitted [DATE] with diagnoses that included surgical aftercare following surgery on the skin and subcutaneous tissue (a layer of loose connective tissue [supports, protects, joins, and provides structure to other tissues and organs, storing fat, and facilitating nutrient transport], located beneath the skin. Hidradenitis Suppurativa (a chronic, inflammatory condition that causes painful, recurring lumps and abscesses), Sick Sinus Syndrome (a condition where the heart's natural pacemaker, known as the sinus node, does not function properly). Cardiac Pacemaker (a small, implantable device that helps regulate the heart's rhythm by sending electrical pulses). Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage). A review of Resident 25's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/22/24, indicated Resident 25 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 25 had intact cognition. A review of Resident 25's active order, dated 8/6/25, indicated, Lt buttocks surgical site: Cleanse with Dakin's (a dilute sodium hypochlorite solution used to clean and disinfect wounds such as cuts, burns, and diabetic foot ulcers to prevent or treat infection and promote healing), pat dry, apply Santyl (the brand name for collagenase, a prescription ointment that removes dead tissue from chronic skin ulcers and severely burned areas. It is a debriding (a medical procedure that involves removing dead or infected tissue from a wound) agent that helps clean the wound and facilitate healing) + gauze and cover with abd (Army Battle Dressing) pad and tape. Every day shift for wound healing. During an observation on 9/9/25 at 1:58 p.m. in Resident 25's room, Treatment Nurse (TN) 1 performed Resident 25's daily surgical wound dressing change. TN 1 sanitized hands, applied a gown and non-sterile gloves, set up the bedside table with dressing supplies and trash bag and informed Resident 25 of the dressing change to be performed. TN 1 addressed Resident 25's pain level after medicating Resident 25 before planned wound change. TN 1 washed hands in bathroom sink and re-gloved and placed a chux (a disposable bed pad used for absorbing liquids) under dressing area, removed tape, changed gloves, removed gauze, changed gloves. TN 1 saturated clean gauze with Dakin's solution and wiped the wound, patted dry with clean dry gauze and applied Santyl. TN 1 dressed the wound with dry gauze covered with abd gauze and taped. During the wound cleansing, TN 1's bracelet slipped down arm and was visible on the outside of the glove and gown of right wrist. TN 1's bracelet touched the wound when TN 1 was wiping the wound with the gauze. TN 1 continued to dress the wound. TN 1 changed gloves and cleaned the workspace. TN 1 de-gloved and de-gowned in the room and sanitized hands with hand sanitizer. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 9/9/25 at 2:10 p.m. with TN 1, TN 1 indicated the expectation for jewelry during a dressing change is to remove the jewelry or tuck the jewelry under the gown to avoid contact with the wound. TN 1 stated the reason is to avoid infection. TN 1 acknowledged the bracelet had dropped down the arm to the wrist during the dressing change. TN 1 indicated no awareness that the bracelet touched the wound. During an interview on 9/9/25 at 2:19 p.m. with IP, the IP confirmed the expectation for jewelry during dressing changes is to remove the jewelry to avoid contact with wound. IP confirmed the reason is to avoid infection. During an interview on 9/11/25 at 9:42 AM with the DON, the DON stated the expectation for jewelry, such as a bracelet, during a dressing change is for the jewelry to be removed to avoid contact with the wound and potential infection. The DON stated if the TN noticed the bracelet became exposed, the TN should have removed gloves and gown, remove the bracelet, re-gowned and gloved and restarted the dressing process. A review of the facility's P&P titled, Infection Control Policies/Practices/Programs, revised June 2012, indicated, It is the policy of this facility that the primary principle of this facility's infection control policies, practices and programs are to establish guidelines to abide by to provide a safe, sanitary and comfortable environment and to assist in preventing the development and transmission of diseases and infections. 2. The objective of our infection control policies, practices and programs are to: a. Investigate, control, and prevent infections in the facility including but not limited to infectious microorganisms for both contacts and droplet types and forms. 3. During a review of the clinical record for Resident 53, the clinical record indicated Resident 53 was admitted to the facility on [DATE], with the diagnoses that included Cellulitis (common bacterial skin infection), and Gastrostomy (GT, feeding tube directly into the stomach). During a concurrent observation and interview with Certified Nurse Assistant (CNA) 4 inside Resident 53's room on 9/9/25 at 9:40 a.m., CNA 4 did not wear a gown when they performed direct nursing care to Resident 53. CNA 4 stated that with the help of CNA 5, they used the Hoyer lift (mechanical device used to assist individuals with mobility) to transfer Resident 53 from bed to recliner. CNA 4 acknowledged she did not wear a gown when they performed the task, and she stated that she should have worn a gown to promote infection control. CNA 4 confirmed there was an EBP signage posted by Resident 53's door, and it indicated when and how to properly wear the gown and gloves for residents with EBP. During an interview with CNA 5 on 9/9/25 at 9:50 a.m., CNA 5 stated they turned Resident 53 to her sides, tucked the Hoyer sling and mechanically lifted Resident 53 and transferred her to the recliner. CNA 4 helped CNA 5 during the transfer. CNA 5 acknowledged that she wore a gown and gloves to promote infection control as Resident 53 is on EBP. CNA 5 confirmed that CNA 4 did not wear a gown when they performed direct care to Resident 53. During an interview with the DON on 9/9/25 at 10:25 a.m., the DON stated the staff should have worn gown and gloves when performing direct nursing care such as transferring residents who are on EBP from the bed to recliner to promote infection prevention. During an interview with IP on 9/10/25 at 12:05 p.m., the IP stated Resident 53 had a GT and was on EBP. The IP continued, the staff should have worn gowns and gloves during direct nursing care to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent the spread of infection. In a review of the facility's policy and procedure, titled Enhanced Barrier Precaution Policy, revised 1/2025, the P&P indicated, It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO). 4. A review of Resident 5's admission record indicated that Resident 5 was initially admitted on [DATE] and returned on 8/12/25 after hospitalization for Sepsis (a life-threatening blood infection). Resident 5 was on Dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) and had a Stage 4 pressure injury (Full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone). A review of Resident 5's active orders indicated that he was placed on EBP on 8/13/25 for Dialysis Access Site and wound treatment. During an observation on 9/8/25 at 11:35 am, CNA 3 was seen changing Resident 5's pillowcases without wearing a gown. A sign was present outside of Resident 5's room indicating that Resident 5 and his roommate were both on EBP. During an interview on 9/8/25 with CNA 3 at 11:42 am outside of Resident 5's room, CNA 3 confirmed that both Resident 5 and his roommate were on EBP. CNA 3 confirmed she only put on gloves and not a gown because changing pillowcases was not considered direct contact. During an interview on 9/11/25 with the DON, the DON stated, If a resident is on EBP it means staff must wear PPE (personal protective equipment used to prevent the spread of infection) for direct care, gloves, gown and mask if indicated. Changing linens is considered direct care, it's on the sign and the resident has contact with the sheets. Precautions are there to protect both residents and staff. A review of the facility's policy titled, Enhanced Barrier Precautions Policy, last reviewed in 2024, indicated that changing linens is considered a high contact resident care activity, and that a gown and gloves must be worn when changing linens.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide appropriate treatment and services to maintain or improve mobility, and prevent decline in range of motion (ROM) for two out of 19 sampled residents (Resident 30 and Resident 23) when:1. Resident 30's restorative nursing program (RNA program- interventions that actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning) frequency was not followed; and,2. An RNA program referral from Physical Therapy (PT) was not implemented for Resident 23.This failure had the potential for Resident 30 and Resident 23 to experience a decline in range of motion and/or function and not achieve their highest practicable physical wellbeing.Findings: 1. A review of Resident 30's clinical record indicated Resident 30 was admitted June of 2023 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) following cerebral infarction (damage to a part in the brain due to a disrupted blood flow) and contractures (permanent shortening of muscles, skin, and nearby soft tissue that results in limited range of motion and stiffness) of left hand and right knee. A review of Resident 30's Minimum Data Set (MDS—a federally mandated resident assessment tool) Cognitive Patterns, dated 8/7/25, indicated Resident 30 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 5 out of 15 which indicated Resident 30 had a severely intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 30's MDS Functional Abilities indicated Resident 30 was dependent with eating, oral hygiene, toileting hygiene, shower/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. A further review of Resident 30's MDS Functional Abilities indicated Resident 30 was also dependent with rolling left and right, chair/bed-to-chair transfer, and tub/shower transfer. During a phone interview on 9/8/25 at 3:15 p.m. with Resident 30's daughter, Resident 30's daughter stated Resident 30 was not getting his exercises as often as he needed. A review of Resident 30's active physician's order, dated 10/13/23, indicated, RNA to provide PROM [passive range of motion- the movement of a joint by an external force] for BLE's [bilateral lower extremities- both legs] .3x/wk [three times a week] with 1 person assist. every day shift. A review of Resident 30's active physician's order, dated 10/13/23, indicated, RNA to provide PROM for LUE [left upper extremity- left arm] .3x/wk with 1 person assist, as tolerated. every day shift. A review of Resident 30's care plan intervention, revised 1/23/24, indicated, RNA to provide PROM for BLE's .3x/wk with 1 person assist. every day shift .RNA to provide PROM on LUE .3x/wk with 1 person assist, as tolerated. PROVIDE RNA AS ORDERED . During a concurrent interview and record review on 9/10/25 at 2:49 p.m. with Restorative Nurse Assistant (RNA) 1, Resident 30's RNA flowsheet for the August and September 2025 were reviewed. RNA 1 confirmed that Resident 30 only received PROM of BLE and LUE on 8/1, 8/4, 8/7, 8/11, 8/13, 8/15, 8/18, 8/20, 8/22, 8/26, 8/28, 9/1, and 9/4. The RNA 1 confirmed that Resident 30 did not get his exercises in accordance with the ordered RNA program frequencies which were three times a week. RNA 1 stated the RNA frequency order should have been followed. RNA 1 further stated there (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be a risk for contracture and decline in function if Resident 30's RNA program frequency was not followed. During an interview on 9/10/25 at 3:16 p.m. with the Director of Staff Development (DSD), the DSD stated RNA program frequency should have been followed and there should have been documentation about why the exercises were not done. The DSD further stated Resident 30 would be a risk for contracture and weakness if the RNA program frequency was not followed. During an interview on 9/11/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that he would expect that RNA program frequency would be followed. The DON further stated that the resident would be at risk for decline in function if the RNA program frequency was not followed. A review of the facility's policy and procedures titled, Restorative Program, revised 4/2019, indicated, The Restorative Program focuses on achieving and maintaining optimal physical, mental and psychological functioning of the resident to attain/maintain each resident's highest practicable functioning. The facility provides Restorative Programs to promote the resident's ability to adapt and adjust to living as independently and safely as possible. 2. Residents who receive restorative services have a care plan with individualized, measurable goals and interventions. Findings: 2. A review of Resident 23's clinical record indicated Resident 23 was admitted [DATE] with diagnoses that included multiple fractures (a medical condition where a bone breaks or cracks) of ribs, traumatic pneumothorax (occurs when air enters the pleural space, the area between the lung and chest wall, due to an injury), muscle weakness, history of falling, abnormalities of gait (gait refers to the pattern of walking, including the sequence, rhythm, and speed of steps) and mobility (the ability to move or be moved freely and easily). A review of Resident 23's MDS Cognitive Patterns, dated 6/23/25, indicated Resident 23 had a BIMS score of 15 out of 15 which indicated Resident 25 had intact cognition. A review of Resident 23's MDS section GG Functional Abilities, dated 6/29/25, indicated Resident 23 was unable to walk ten feet and used a walker (a mobility aid that provides support and stability for people who have difficulty walking due to leg weakness, balance problems, or recovery from injury or surgery) or a wheelchair (a chair fitted with wheels for use as a means of transport by a person who is unable to walk). A review of Resident 23's RNA program referral, dated 7/22/25, written by Physical Therapist (PT) 1, PT 1 recommended, RNA for ambulation using FWW (front wheeled walker) approximately 150 ft or as tolerated, QD (everyday), 3x/wk (3 times a week) with one person assist, to maintain functional levels. A review of Resident 23's orders revealed no order was placed for the RNA program referral dated 7/22/25. A review of Resident 23's care plan revealed no care plan was initiated for the RNA program. During an interview on 9/8/25 at 11 a.m. with Resident 23, Resident 23 stated she did not understand why PT was not happening. Resident 23 stated she was told by PT 1 that insurance coverage for (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued PT was denied. Resident 23 stated it was not possible because she had insurance. During an interview on 9/9/25 at 8:58 am with PT 1, PT 1 stated Resident 23 was discharged from the PT program due to insurance coverage on 7/2/2025. PT 1 stated that Resident 23 reached PT goals and was denied by insurance for further PT. PT 1 stated Resident 23 was notified. Resident 23 was referred to the RNA program on 7/22/25. PT 1 stated the referral was placed on the RNA's desk. PT 1 stated the normal process for RNA program referral is to place the referral on the RNA's desk if the RNA is working or put it in the communication binder if the RNA is not working. During an interview on 9/9/25 at 9:51 a.m. Social Service director (SSD), SSD confirmed Resident 23's last day of insurance coverage was 7/3/25. During an Interview on 9/9/25 at 11:55 am with RNA 1, RNA 1 stated they were not aware of the referral and were notified by PT today, 9/9/25. RNA stated the usual process for RNA program referrals begins with PT initiating the referral. PT places the referral on the RNA desk if she is working that day or places it in the communication binder with the referral sticking up to indicate there is a new referral. RNA 1 stated the referral is given to the nurse who is assigned to the resident. The nurse signs off on the referral and returns it to the RNA signed and dated. The RNA implements the plan of care. RNA 1 confirmed the referral was not seen and therefore was not implemented for Resident 23. During an Interview on 9/9/25 at 12:19 PM with PT 1, PT 1 confirmed Resident 23 should have begun the RNA treatment plan on the referral, dated 7/22/25. During an interview on 9/9/25 at 12:48 p.m. with Treatment Nurse (TN) 1, TN 1 stated when an RNA program referral is received, a Licensee Nurse (LN) enters it as an RNA order and then places it in a binder at the nurse's station for the doctor or nurse practitioner (NP) to sign. TN 1 stated the order is immediately available for the RNA to implement. During an interview on 9/9/25 at 1:35 p.m. with the Administrator (Admin), the admin stated when appropriate, residents are referred to the RNA program by PT and the RNA gives a copy of the referral to the Admin and the DON. The administrator indicated they work closely with Resident 23 and was aware of her being discharged from physical therapy and referred to RNA Program. Admin confirmed PT refers residents to the RNA Program. The RNA gives the referral to a nurse to enter the order. Admin confirmed the expectation was for the RNA to implement the plan once the order is entered. Interview on 9/11/25 at 9 a.m. with the DON, the DON stated the process for RNA program referral starts with the Physical Therapist giving the LN who is assigned to the resident the referral. The LN calls the doctor to get the order, and the nurse inputs the order and initiates a care plan. The DON states the RNA has no reason to be involved in the initial referral process and states the RNA is being used as the middle person between the Physical Therapist and the LN. The DON states the RNA should implement the order on the day the order is entered unless it is late in the day, the RNA will implement the following day. The DON states he would attempt to locate the written procedure for this process. A review of the initial Interdisciplinary Team (IDT) Care Conference, dated 6/20/25, revealed no discussion regarding rehabilitation. A review of the IDT notes dated 9/9/25, two months after the referral date of 7/22/25, indicated, IDT (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	met today on a discussion regarding the RNA referral done by PT on 7/22/25. Informed resident by RNA that there is a referral for RNA Program. A review of the facility's policy titled, RNA Referral revised July 2012, indicated it is the policy of the facility to provide rehabilitative services and a restorative program for resident to prevent deterioration and achieve and maintain optimal levels of functioning and independence. 1. Based on assessment result a recommendation will be forwarded to the attending physician. 3. Attending physician will give an order either for skilled rehabilitation therapist or R.N.A. program. 6. Skilled therapist will assess resident if qualified to undergo skilled rehabilitation services or just to be on R.N.A. program. 7. The skilled therapist can also initiate and recommend restorative program active treatment. 8. Restorative Assistant carries out program in according to the written plan of care.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure one out of 19 sampled residents (Resident 2) was provided with appropriate care and services with enteral feeding (also referred to as tube feeding/ feeding tube- the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when Resident 2's gastrostomy tube (G-tube- a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) was not flushed with water before medication administration and enteral feeding. This failure had the potential for Resident 2 to experience complications of the G-tube such as clogging and for the resident not to attain his highest practicable well-being. Findings: A review of Resident 2's clinical record indicated Resident 2 was admitted November of 2023 and had diagnoses that included encounter of gastrostomy status, dysphagia (swallowing difficulties), and hemiplegia (complete loss of the ability to move one side of the body). A review of Resident 2's active physician's order, dated 11/9/23, indicated, Resident is capable of giving informed consent and/or able to participate in treatment plan. A review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool) Swallowing/Nutritional Status, dated 8/12/25, indicated Resident 2 has used a feeding tube while a resident in the facility. A review of Resident 2's care plan, initiated 2/24/24, indicated, The resident [Resident 8] requires tube feeding (gtube) r/t [related to] CVA [cerebrovascular accident/stroke- a condition that occurs when a blood vessel in the brain becomes blocked or ruptures, cutting off blood flow to the brain] with Hemiplegia, Dysphagia . A review of Resident 2's care plan intervention, dated 4/25/25, indicated, ENTERAL FEEDING: Flush G-tube with 30cc [cubic centimeter- unit of measurement] of water BEFORE and AFTER feedings .ENTERAL FEEDING: Flush G-tube with 30cc of water BEFORE and AFTER medication administration AND flush with 5cc of water in between EACH medication given for prevention of tube clogging. A review of Resident 2's active physician's order, dated 4/24/25, indicated, ENTERAL FEEDING: Flush G-tube with 30cc of water BEFORE and AFTER medication administration AND flush with 5cc of water in between EACH medication given for prevention of tube clogging every shift. A review of Resident 2's active physician's order, dated 8/11/25, indicated, ENTERAL FEEDING: Flush G-tube with 60ml [milliliter- unit of measurement] of water BEFORE and AFTER feedings every 6 hours. During an observation on 9/9/25 at 12:16 p.m. with Licensed Nurse (LN) 1, in Resident 2's room, LN 1 was observed doing Resident 8's tube feeding. LN 1 positioned Resident 8 properly, checked Resident 8 feeding residual [left feeding formula] amount, and checked the gastrostomy tube placement, but did not flush tube with water before starting medication administration and enteral feeding. The flow of the medication and feeding formula was observed to be sluggish during the procedure. During a subsequent interview on 9/9/25 at 1:03 p.m. with LN 1, LN 1 confirmed that she did not flush Resident 2's G-tube with water before starting medication administration and enteral feeding. LN 1 stated she should have flushed the tube with water before starting medication administration and enteral feeding. LN 1 further stated that it could cause the G-tube to clog if the tube was not flushed with water before medication administration and enteral feeding. During an interview on 9/10/25 at 3:16 p.m. with the Director of Staff Development (DSD), the DSD stated that the G-tube needed to be flushed with water before starting medication administration and enteral feeding to make sure the tube was patent and to prevent clogging. During an interview on 9/11/25 at 10:14 a.m. with the Director of Nursing (DON), the DON stated the nurse was supposed to flush the G-tube with water before starting medication administration and enteral feeding. The DON further stated there would be a risk of clogging if the G-tube was not flushed with the ordered water amount before medication administration and enteral feeding. A review of the facility's policy and procedures titled, Enteral Nutrition: General Guidelines, revised 1/2025, indicated, MEDICATION ADMINISTRATION .15. Tube will be flushed with water before and after medication administration .		

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NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1260 Travis Blvd Fairfield, CA 94533	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure one out of 19 sampled residents (Resident 8) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 8's pain medication order was not consistently followed. This failure had the potential for Resident 8 to develop medication dependence (the inability of the individual to function normally in the absence of the drug), experience unrelieved pain, and not attain her highest practicable well-being. Findings: A review of Resident 8's clinical record indicated Resident 8 was admitted January of 2025 and had diagnoses that included arthritis (a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), muscle spasm, and need for assistance with personal care. A review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/22/25, indicated Resident 8 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 8 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 8's MDS Health Conditions, dated 7/22/25, indicated Resident 8 received scheduled and as needed pain medications and non-medication intervention for pain. During an interview on 9/8/25 at 10 a.m. with Resident 8, in Resident 8's room, Resident 8 stated she frequently experiences pain, and she has high pain tolerance. Resident 8 further stated the medications she was being given helps a little but was not enough. A review of Resident 8's Care Plan Report, revised 1/15/25, indicated, At risk for pain or discomfort related to muscle spasm, arthritis. A review of Resident 8's care plan intervention, initiated 1/15/25, indicated, Administer pain meds [medications] as MD [medical doctor] ordered and evaluate effectiveness. A review of Resident 8's physician's order, dated 4/25/25, indicated, HYDROcodone-Acetaminophen [Norco- a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] Oral Tablet 5-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hours as needed for 4-7 pain scale [numeric pain scale from 1 to 10; 1 being the lowest and 10 being the highest form of pain]. A review of Resident 8's physician's order, dated 4/25/25, indicated, oxyCODONE HCl [a pain medication used to relieve severe pain] Oral Tablet 5 MG .Give 1 tablet by mouth every 4 hours as needed for 8-10 pain .A review of Resident 8's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of July and August a 2025 indicated Resident 8 received 1 tablet of hydrocodone-acetaminophen which was indicated for 4-7 levels of pain on the following occasions: 7/3/25 at 3:15 p.m.- pain level was 87/5/25 at 12:46 a.m.- pain level was 07/27/25 at 9:24 a.m.- pain level was 88/6/25 at 11:15 a.m.- pain level was 88/20/25 at 10:19 a.m.- pain level was 88/22/25 at 9:17 a.m.- pain level was 10 During a concurrent interview and record review on 9/10/25 at 1:58 p.m. with Licensed Nurse (LN) 2, Resident 8's clinical records were reviewed. LN 2 confirmed that Resident 8's pain medication orders were not consistently followed. LN 2 stated that nurses should follow the physician's order when administering pain medication. LN 2 further stated it would be a risk for controlled drug dependence and/or uncontrolled pain if the physician's order was not followed. During an interview on 9/10/25 at 3:16 p.m. with the Director of Staff Development (DSD), the DSD stated that nurses should always follow the physician's parameters when administering pain medications to residents. The DSD also stated that it would be a risk for respiratory issues and controlled medication dependence and/or unrelieved pain if the physician's order would not be followed. During an interview on 9/11/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that she would expect that pain medications should be given as ordered by the physician. The DON further stated that residents would be at risk for either oversedation [excessive level of analgesia] and pain medication dependence if the resident was given too strong pain medication and/or uncontrolled pain if the resident was not given the right medication for pain. A review of the (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's P&P titled, Medication Administrations, dated 5/2016, indicated, Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber .A review of the facility's P&P titled, Pain Management, revised 1/2025, indicated, The licensed nurse and multidisciplinary team will evaluate pain using a consistent approach and a standardized pain assessment instrument appropriate tothe resident's cognitive level .Pain medications should be selected based on pertinent treatment guidelines; administering the lowest dose possible to effectively manage the resident's pain .		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adhere to resident's food preferences as listed on their meal ticket for three of 14 sampled residents, Resident 32, Resident 4, and Resident 42 when: 1. Resident 32 was served pot roast, but her meal ticket indicated that she disliked meat; and 2. Resident 4 was served brussels sprouts that was on her list of food dislikes. 3. Resident 42 was given polenta (side dish made from cornmeal) with a documented corn allergy. These deficient practices had the potential for Resident 32, Resident 4, and Resident 42 to refuse to eat, potentially leading to weight loss, worsened medical conditions like slow wound healing, and a weakened immune system and for Resident 42 to have an allergic reaction. Findings: 1. Resident 32 was admitted in the facility on 6/10/25 with diagnosis that included Hypertension (high blood pressure) and Hyperlipidemia (high levels of fats in the blood). A review of Resident 32's Minimum Data Set (MDS, an assessment tool used to guide care) Section C - Cognitive Patterns dated 6/21/25, Resident 32 had a score of 15, which indicated Resident 32's cognitive level was intact. During a concurrent observation and interview with Resident 32 in the Dining room on 9/8/25 at 11:52 a.m., Resident 32 complained that they served her pot roast for lunch. Resident 32 stated I'm hungry, and that she had told the staff in the past she didn't like to eat meat, but they still served meat to her. Licensed Nurse 3 (LN 3) confirmed there was pot roast on Resident 32's plate. LN 3 further stated that Resident 32 doesn't like meat as indicated on her meal ticket, and the facility should respect Resident 32's food preferences. LN 3 took Resident 32's plate back to the kitchen and while Resident 32 waited for LN 3 to bring her food, Resident 32 watched other residents eat their meals. 2. Resident 4 was admitted in the facility on 4/19/21 with diagnoses that included Pressure Ulcer of Sacral Region Stage 3, (located at the bottom of the spine, sores that are deep and may require surgery), Adult Failure to Thrive (inability to sustain weight due to poor nutrition), and Gastro-Esophageal Reflux (stomach contents leak backwards into the esophagus [food pipe]). A review of Resident 4's MDS Section C - Cognitive Patterns dated 8/1/25, Resident 4 had a score of 15, which indicated Resident 4's cognitive level was intact. During a concurrent observation and interview with Resident 4, and LN 3 inside Resident 4's room on 9/8/25 at 12:24 p.m., Resident 4 stated she didn't like brussels sprouts. LN 3 confirmed that Resident 4's plate contained brussels sprouts, and it was listed on Resident 4's meal ticket that she disliked brussels sprouts. LN 3 stated the facility should have followed resident's food preferences to avoid possible decline in their health and quality of life. During an interview with the Director of Nursing (DON) on 9/9/25 at 10:25 a.m., the DON stated that the meal trays are being checked by the nurses before they are given to the residents to make sure the residents' food matches what was indicated on the meal tickets. The DON further stated that they must respect resident's food preferences to nourish their bodies and promote faster healing. During an interview with [NAME] 3 on 9/10/25 at 12:40 p.m., [NAME] 3 stated that he followed what was written on the meal tickets to prepare the residents' food during tray line (system used for (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preparing and delivering resident's meals). [NAME] 3 further stated that food items listed as dislikes on a meal ticket should not be added to residents' plates. During an interview with [NAME] 2 on 9/10/25 at 12:45 p.m., [NAME] 2 stated the meal tickets contained residents' information, such as name, diet, room number, likes and dislikes. [NAME] 2 further stated that if the food was labelled dislike, the cooks should not add it to the residents' plates. During an interview with the Dietary Supervisor (DS) on 9/10/25 at 12:53 p.m., the DS stated they assess residents' food preferences, such as likes, dislikes, and food allergies, and during tray line, the cooks should follow what was written on the meal tickets. The DS verbalized that good nutrition may improve overall quality of life for residents and it's important to serve the food they like to eat. In a review of the facility's Good For Your Health Menus (GFYHM), dated 9/8 &ndash; 14, 2025, The GFYHM indicated Monday September 8. Pot Roast, Mashed Potatoes and Gravy, Brussels Sprouts, Sweet Corn Salad, Ice Cream. In a review of the facility's policy and procedure (P&P) titled Resident Food Preferences, undated, the P&P indicated, It is the policy of this facility that nutritional assessments will include an evaluation of individual food preferences. 4. The resident's clinical record (orders, care plan, or other appropriate locations) will document the resident's like and dislikes. 3. Resident 42 was admitted to the facility on [DATE]. Resident 42 had a diagnosis of multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves), muscle weakness, epilepsy (disorder in which nerve cell activity in the brain causes seizures). Resident 42 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated normal thinking and memory. During a review of resident 42's face sheet dated 8/12/24, the face sheet indicated, Resident 42 was allergic to corn. The allergy view in the chart dated 4/22/19 documented a reaction of loose stools to corn. During an observation of the tray line on 9/9/25 at 11:45 a.m., the resident was given a scoop of polenta on their plate. The food ticket for the resident identified corn as an allergy. During an interview on 9/9/25 at 4 p.m. with the Dietary Supervisor (DS), the DS stated that the corn polenta should not have been placed on the resident's tray, and that the staff should review the allergies documented on the ticket. The resident could have had a possible allergic reaction if they had consumed the polenta. During a review of the facility's policy and procedure (P&P) titled, Individual Food Preferences and Allergies, dated December 2014, the P&P indicated, 11. A profile card for each resident shall be kept current and organized in a cardex in the dietary department. Information recorded on the card should include the diet order, food preferences, food allergies. The profile card must reflect periodic review of the medical chart by dietary supervisor. 12. Specific food preferences and allergies must be properly documented on resident's progress notes in the chart, resident profile cards, and tray cards.		