STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not adhere to the resident's rights when they failed to follow their own theft and loss policy and procedures for one out of 17 sampled residents (Resident 27), when Resident 27's cell phone was lost and was not followed up and resolved timely. This failure resulted in Resident 27 experiencing emotional distress and not being able to use her personal property.Findings:A review of Resident 27's clinical record indicated Resident 27 was admitted April of 2025 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), diabetes (elevated sugar in the blood), muscle weakness, and need for assistance with personal care.A review of Resident 27's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/7/26, indicated Resident 27 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 7 had an intact cognition (mental process of acquiring knowledge and understanding). During an interview on 3/9/26 at 11:08 a.m. with Resident 27, Resident 27 stated her cell phone, which she brought in the facility when she was admitted , went missing. Resident 27 also stated she reported it to the facility staff immediately but up until now, it has not been resolved. Resident 27 further stated she feels annoyed and upset because there has been no resolution about the issue.During an interview on 3/11/26 at 12:46 p.m. with the Social Services Director (SSD), the SSD stated she was aware of Resident 27's report of missing cell phone. The SSD also stated they searched for the item but could not find it, so she advised the resident to contact the carrier of her phone to locate it. The SSD further stated that their process for theft and loss was once it was reported to her, she would initiate searching for the item but would verify first in the resident's inventory sheet. If they could not locate the missing item, they would come up with a resolution and would offer reimbursement of the missing item. The SSD then stated the timeline usually was she would get back to the resident within 2-3 days and would tell them about the result and resolution of the investigation. A review of Resident 27's inventory sheet, signed by Resident 27 and a facility staff on 4/19/25, indicated, .1 cell phone .A review of Resident 27's THEFT AND LOSS RECORD, indicated, .DESCRIPTION OF ARTICLE: iPhone 14 Max .ESTIMATED VALUE .Unknown .DATE/TIME ARTICLE DISCOVERED MISSING: 9/12/25 [at] 23:00 [11 p.m.] .Resident [Resident 27] reported to staff [charge nurse] regarding resident's missing cell phone .A review of an entry on Resident 27's THEFT AND LOSS RECORD, signed by the SSD on 9/17/25, indicated, Searched and asked staff, with resident consent, checked her bedside drawer, closet and under her bed but unfortunately cannot locate her device. Assisted resident checking with her purse .Advised resident to call the [phone] carrier since they have the ability to locate on their end.A review of an entry on Resident 27's THEFT AND LOSS RECORD, signed by the SSD on 10/2/25, indicated, Asked resident family if they called her phone carrier, resident stated to call son, [NAME]. but never called.During a concurrent interview and record review on 3/11/26 at 1:46 p.m. with the SSD, Resident 27's inventory sheet and theft and loss record were reviewed. The SSD confirmed that (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 27 had 1 cell phone when she was admitted to the facility. The SSD also confirmed that there has been no resolution regarding Resident 27's report of her missing cell phone. The SSD stated she does not know what happened and just stopped following up since the last entry. The SSD further stated the policy should have been followed, and resident 27's report of missing cell phone should have been resolved and should have been reimbursed at this time.During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated that when a resident complains about theft and loss, staff should follow their policy. The DON also stated staff should follow back to the resident and discuss conclusion of the complaint within 72 hours, including the reimbursement process. The DON further stated the SSD missed to follow back with resident 27's complaint and the complaint was just dropped.A review of the facility's policy and procedures (P&P) titled, Theft and Loss Prevention Policy, undated, indicated, .If you suspect something has been stolen, please notify nursing staff immediately. We will take a full report and investigate the theft of an item worth more than $25. We will report the theft of any item worth more than $100 to local police .Failure to safeguard patient property; reimbursement; citation .A long-term care facility .which fails to make reasonable efforts to safeguard patient property shall reimburse a patient for or replace stolen or lost patient property at its then current value .A review of the facility's P&P titled, GRIEVANCES, dated 12/2017, indicated, 6. The department manager will: .6.2 Investigate the grievance; 6.3 Take corrective actions, as needed; .6.5 Notify the person filing the grievance of resolution within 72 hours by providing a copy of the Grievance Form to the resident/resident representative .

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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. Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the accepted professional principles and current standard of practice for a census of 51 when:1. Multiple DuoNeb (a combination medication containing albuterol sulfate and ipratropium bromide used to treat tightening of the muscles lining the airways) vials (small container) were found stored out of its foil package;2. A total of five loose pills were found in medication cart D wing; and,3. Two expired bottles of Vitamin B12 were found stored in the medication room.These failures had the potential for diversion of the loose medications, and for residents to receive medication that was expired or with unsafe or reduced potency.Findings:1. During a concurrent observation and interview which started on 3/9/26 at 10:35 a.m. with Licensed Nurse (LN) 2 of medication cart C wing, two boxes with multiple DuoNeb vials were found stored out of the foil package. One box was labelled with an opened date of 1/27/26 and the other box was not labelled with its opened date. LN 2 confirmed the observation. LN 2 stated DuoNeb vials should be always stored inside the foil pack because it would expire in 1 week if it was taken out of the foil package. LN 2 further stated there should be an open date label on the medication to know when it was first used.During a phone interview on 3/12/26 at 8:48 a.m. with the Consultant Pharmacist (CP), the CP stated DuoNeb medication is sensitive to light and heat and should be stored inside the foil package. The CP further stated DuoNeb medication could easily expire or the potency could get affected if it was stored outside the foil package causing the medication to not work or it could be defective. During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated he expects nurses to follow proper storage of medications. The DON further stated DuoNeb vials should be kept inside the foil package because it could get easily be affected by light.A review of a facility's P&P titled, LABELING AND STORING MEDICATIONS, revised 1/2026, indicated, 2. Liquid Medication - Vials .Must be dated and initialed by the Licensed Nurse who first opened the container .A review of a facility document titled, Abridged List of Medications with Shortened Expiration Dates, undated, indicated, Generic Name .Albuterol/Ipratropium .Brand Name .DuoNeb .Beyond Use Date (BUD) Notes .DuoNeb: Store in foil and away from heat and light. Unit-dose vials should remain stored in protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week .2. During a concurrent observation and interview which started on 3/11/26 at 1:48 p.m. with LN 3, of medication cart D wing, a total of five loose pills were found inside the first and second-right drawer of the medication cart. LN 3 confirmed the observation. LN 3 stated there should not be loose pills inside a medication cart because it could contaminate the medications inside the cart and if the loose pills fall out of the medication cart, a resident might take it.During a phone interview on 3/12/26 at 8:48 a.m. with the CP, the CP stated medications should be secured and labelled. The CP further stated loose pills in a medication cart causes potential medication error and a risk for the loose pills to fall out of the medication cart and a resident might take it.During an interview on 3/12/26 at 9:22 a.m. with the DON, the DON stated that loose pills inside the medication carts are potential cause of medication errors and staff would not know what medication those are anymore.A review of the facility's P&P titled, LABELING AND STORING MEDICATIONS, revised 1/2026, indicated, It is the policy of this facility that resident's medication will be properly labeled and stored in the locked medication room/carts .3. The medications of each resident are kept and stored in their originally received containers.3. During a concurrent observation and interview which started on 3/11/26 at 2:09 p.m. with LN 3, of the medication room, two bottles of Vitamin B12, containing 30 tablets each, and with an expiration date of 12/2025 were found stored in the medication room and ready to be used. LN 3 confirmed the observation. LN 3 stated the expired medications should have been discarded. LN 3 further stated that expired medications can be ineffective or might cause harm (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the residents if accidentally administered. During a phone interview on 3/12/26 at 8:48 a.m. with the CP, the CP stated expired medications should not be stored in medication rooms because if it was administered, the medication would not be effective anymore.During an interview on 3/12/26 at 9:22 a.m. with the DON, the DON stated it was not okay to store expired medications in the medication room because it could get administered to residents which could cause undesired effects.A review of the facility's P&P titled, LABELING AND STORING MEDICATIONS, revised 1/2026, indicated, 5. Medications no longer in use or medications which have expired will be disposed of in accordance with Federal and State Laws.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the Dietary Supervisor (DS) met the required job qualifications of Dietary Supervisor per facility policy and procedures.This failure had the potential for unsafe food handling, and food borne illness in a highly susceptible population of 51 residents. During an interview on 3/9/26, at 9:45 a.m., with the DS, the DS confirmed she had been employed at the facility for one year in the position of Dietary Supervisor. DS stated she did not have a Certified Dietary Manager certification, nor was she currently enrolled in a Dietary Manager training program. The DS further stated she was responsible for all the training, hiring, and scheduling of dietary staff and ordered the food and kitchen supplies. During an interview on 3/10/26, at 3:50 p.m., with the Administrator (ADM), the ADM confirmed the current job description for Dietary Supervisor stated Certified Dietary Manager required. The ADMN acknowledged the current Dietary Supervisor did not possess the Certified Dietary Manager certificate as required by the facility job description. During a review of facility document titled, Job Description and Performance Standards, Position Title Dietary/Food Service Supervisor, revised February 2018, indicated, Qualifications Either a Certified Dietary Manager or Certified Food Protection Professional.

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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. 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 51 when:1. Facility did not have an enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs-bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use) signage for Resident 1 and Resident 8 who were both on EBP;2. Residents' non-pharmaceutical (not medicinal drug related) personal belongings were found stored in one out of two sampled medication carts with pharmaceutical products; and,3. Kitchen staff was observed not wearing facial hair restraints as required. These failures had the potential to spread germs and cause infection among a vulnerable resident population and staff. Findings: 1a. A review of Resident 1's clinical record indicated Resident 1 was admitted February of 2026 and had diagnoses that included stage 5 chronic kidney disease (severe kidney failure where the kidneys can no longer adequately filter waste or fluid, leading to fatigue, severe swelling, nausea, and little-to-no urine output), and dependence on renal dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). A review of Resident 1's active physician's order, dated 2/9/26, indicated, On Enhanced Barrier Precautions r/t [related to] Foley Catheter [a flexible, indwelling tube inserted through the urethra into the bladder to continuously drain urine], Hemodialysis [treatment for kidney failure that uses a machine and a filter, the dialyzer, to clean waste and remove excess fluid from the blood] access site, and Wound treatment. [NAME] [wear] PPE on Resident's High Contact Resident Care Activities and Doff [remove] PPE before exiting room. Hand Wash before and after. A review of Resident 1's care plan, dated 2/9/26, indicated, On Enhanced Barrier Precautions r/t Foley Catheter, Hemodialysis access site, and Wound treatment . During a concurrent observation and interview on 3/9/26 at 9:25 a.m. in Resident 1's room, Resident 1 was observed to have a dialysis access site on left chest. Resident 1 stated he has wound on his left foot. There was no observed signage in Resident 1's room that he was on EBP. 1b. A review of Resident 8's clinical record indicated Resident 8 was admitted in December of 2025 and had diagnoses that included obstructive and reflux uropathy (occurs when the urine cannot drain through the urinary tract), muscle weakness, and need for assistance with personal care. A review of Resident 8's active physician's order, dated 12/15/25, indicated, On Enhanced Barrier Precautions r/t Foley Catheter. [NAME] gown and gloves for high contact Resident care activities. Doff PPE before exiting room. A review of Resident 8's care plan, dated 12/15/25, indicated, [resident 8] is on Enhanced Barrier Precautions r/t: Foley Catheter use. During an observation on 3/9/26 at 9:31 a.m. in Resident 8's room, Resident 8 was observed connected to a urinary catheter draining in a urinary bag. There was no observed signage in Resident 8's room that he was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/9/26 at 11:20 a.m. with Certified Nurse Assistant (CNA) 3, in front of Resident 1 and Resident 8's room, there was no observed signage in front of Resident 1 and Resident 8's room indicating that they were on EBP. CNA 3 confirmed the observation. CNA 3 stated Resident 1 usually goes to dialysis three times a week, but she was not sure if Resident 1 was on any kind of infection control precaution. A review of a facility document titled, ENHANCED BARRIER PRECAUTION PROGRAM, dated 3/9/26, indicated Resident 1 was still on EBP due to his dialysis site and Resident 8 was also still EBP due to his foley catheter. During an interview on 3/11/26 at 4:32 p.m. with the Infection Preventionist (IP), the IP stated it was the facility's standard to place EBP signage in front of resident's room if they were on EBP. The IP further stated EBP signage should have been placed in front of Resident 1 and Resident 8's room to indicate and remind staff that they should wear gloves and gown when doing high contact care for the residents. During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated there should be EBP signage in front of residents' rooms who were on EBP. The DON also stated there would be a risk that staff might not wear gloves and gown when doing high contact care if there was no EBP signage in front of the resident's room. The DON further stated there would be a risk for the residents to get infection if the staff would not wear gloves and gown when caring for them. A review of the facility's policy and procedures titled, Enhanced Barrier Precautions Policy, revised 1/2025, indicated, 3. Enhanced Barrier Precautions are to be implemented .when other Transmission-based precautions do not apply, when facility identifies any resident with: .b. Wounds or skin openings that require dressings .c. Any indwelling medical device, for example: i. Central lines [a tube inserted into a large vein to provide long-term access to the blood supply used for extended treatments like chemotherapy, frequent blood draws, and dialysis] .ii. Urinary catheters .4. Post clear signage on the door/wall outside resident room .a. Type of precautions .iv. Enhanced Barrier Precautions . 2. During a concurrent observation and interview which started on 3/11/26 at 1:48 p.m. with LN 3, of medication cart D wing, two nail clippers were found stored in the top right drawer next to prescribed medications and a black and silver flash drive was found stored next to the controlled medications (medications with high potential for abuse or addiction). LN 3 confirmed the observation. LN 3 stated he does not know who owns those personal items. LN 3 further stated personal items should not be stored inside medication carts because it could contaminate the medications. During a phone interview on 3/12/26 at 8:48 a.m. with the Consultant Pharmacist (CP), the CP stated medications carts should only contain pharmacological products and equipment's necessary for medication administration, and it should not contain personal items. The CP further stated that storing personal items in the medication cart causes risk for contamination of the medications. During an interview on 3/12/26 at 9:22 a.m. with the DON, the DON stated personal items should not be kept inside medication carts because of infection control concerns with medications. A review of the facility's P&P titled, LABELING AND STORING MEDICATIONS, revised 1/2026, indicated, It is the policy of this facility that resident's medication will be properly labeled and stored in the locked medication room/carts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Administering Medications, revised 1/2026, indicated, 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 3.During an observation on 3/10/26, at 8:48 a.m., Dietary Aide (DA) 1 was observed in the kitchen washing dishes with facial hair above his lips exposed with no covering. During a concurrent observation and interview on 3/10/26 at 8:54 a.m., with the Dietary Supervisor (DS), the DS confirmed DA 1 was not wearing adequate facial hair coverings. DS stated the expectation was for all kitchen staff to wear proper facial hair coverings and if not worn properly, hair could potentially fall into residents' food which would be unsanitary. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, undated, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of communicable diseases and infections .based on accepted national infection prevention and control standards.is a facility-wide effort involving all disciplines and individuals.Policies and procedures reflect the current infection prevention and control standards of practice. During a review of the facility's P&P titled, Dress Code, dated 2023, the P&P indicated, Hair net for hair .beards and mustaches (any facial hair) must wear beard restraint. According to the FDA Food Code 2022, Section 2-402.11, Hair Restraints, A. FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for one out of 17 sampled residents (Resident 3) when Resident 3's care plan interventions for recording and monitoring fluid intake and output were not implemented. This failure had the potential to result in Resident 3 not attaining their highest practicable physical, mental, and psychosocial well-being.Findings:Resident 3 was originally admitted to the facility March 2016 with multiple diagnoses which included type 2 diabetes mellitus (a disease where blood sugar is too high) and gastrostomy (opening made through the abdominal wall into the stomach to insert a feeding tube). A review of Resident 3's Minimum Data Set (MDS, an assessment tool) dated 1/15/26, indicated, Resident 3 had severe problems with thinking and memory.During a review of Resident 3's care plan, date initiated 1/20/26, care plan indicated, MONITOR AND RECORD #CC [metric unit of volume often used for medication dosages or fluid intake and output] FLUID INTAKE & OUTPUT Q [every] SHIFT. Every shift for FOR FLUID DAILY OUTPUT.During an interview and record review on 3/11/26, at 1:13 p.m., with Licensed Nurse (LN) 5, LN 5 reviewed Resident 3's medical record and confirmed the care plan indicated fluid intake and output should be recorded and monitored. LN 4 stated there was no documentation or orders for monitoring fluid intake and output found and confirmed it was not happening. During an interview on 3/11/26, at 1:33 p.m., with the Director of Nursing (DON), the DON stated all nursing staff have access to resident's care plans. DON further stated the expectation was for all nursing staff to follow the care plans and if not followed, residents may potentially have a change of condition and not reach their highest practical well-being. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure-Care plan, dated 1/26, the P&P indicated, A care plan is the summation of the resident concerns, goals, approaches and interventions in order to meet the goals and help minimize if not totally eradicate residents' problems.The individual comprehensive care plan identifies the professional services and the responsible person that evaluates the concerns and carried out the interventions to prevent or reduce re-occurrences.It further prevents, if feasible, further declines and deterioration of the resident's function or status.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and proper delivery of respiratory care consistent with the facility's policy and procedures (P&P) for one out of 17 sampled residents (Resident 27) when Resident 27's physician's order for oxygen therapy was not followed.This failure had the potential to result in Resident 27's oxygen needs to be not met and for Resident 27 to not achieve her highest practicable well-being.Findings:A review of Resident 27's clinical record indicated Resident 27 was admitted April of 2025 and had diagnoses that included congestive heart failure (CHF- a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems), diabetes (elevated sugar in the blood), muscle weakness, and need for assistance with personal care.A review of Resident 27's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/7/26, indicated Resident 27 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 27 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 27's MDS Special Treatments, Procedures, and Programs, dated 3/7/26, indicated Resident 27 had received continuous oxygen therapy on admission and while she was a resident in the facility.A review of Resident 27's care plan, revised 4/22/25, indicated, Ineffective Airway clearance r/t [related to] COPD and CHF medical diagnosis. Use Oxygen routine at 3 l/min [liters per minute/lpm- unit of measurement for oxygen administration flow rate] via NC [Nasal cannula- a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils] .Administer oxygen at 3 l/min via NC. Observe oxygen precautions .A review of Resident 27's physician's order, dated 2/26/26, indicated, O2 [oxygen] at 3 liter/minute via nasal cannula for SOB [shortness of breath], Wheezing [high-pitched sound caused by narrowed or inflamed airways], Chest Pain .and Notify MD every shift.During a concurrent observation and interview on 3/9/26 at 11:08 a.m. with Resident 27, in Resident 27's room, Resident 27 was lying on bed, awake, and was on oxygen via nasal cannula with the oxygen concentrator (machine) set at 2.5 lpm. Resident 27 stated she uses oxygen all the time and the setting should be at 3 lpm.During a concurrent observation and interview on 3/10/26 at 10:30 a.m. with Resident 27, in Resident 27's room, Resident 27 was sitting on a wheelchair, awake, and was on oxygen via nasal cannula with the oxygen concentrator set at 2 lpm. Resident 27 stated the nurses usually adjust the setting of her oxygen.During a concurrent observation and interview on 3/10/26 at 10:45 a.m. with Certified Nurse Assistant (CNA) 4, in Resident 27's room, CNA 4 confirmed that Resident 27's oxygen was set at 2 lpm.During a concurrent interview and record review on 3/10/26 at 12:18 p.m. with Treatment Nurse (TN) 1, Resident 27's clinical records were reviewed. TN 1 confirmed that Resident 27's physician's order for oxygen therapy was at 3 lpm. TN 1 stated Resident 27's oxygen order should always be followed. TN 1 further stated Resident 27 would be at risk for difficulty breathing or possible hypoxemia (abnormally low concentration of oxygen in the blood) if she was receiving too low oxygen therapy.During an interview on 3/12/26 at 9:15 a.m. with the Director of Staff Development (DSD), the DSD stated oxygen orders should be followed as ordered. The DSD further stated the resident would be at risk for hypoxemia if she would receive oxygen lower than what was ordered.During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated he would expect nurses to follow doctors order for oxygen administration. The DON further stated the resident would be at risk for shortness of breath and possible hypoxia (a dangerous condition characterized by insufficient oxygen reaching body tissues) if she was given lower than what her oxygen need was.A review of the facility's P&P titled, Oxygen Therapy, revised 1/2025, indicated, It is the policy of this facility that oxygen therapy is administered, as ordered by the physician .PROCEDURES: .5. Adjust oxygen flow, as ordered by physician .

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	055189	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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. Based on interview, and record review the facility failed to ensure safe and effective pharmaceutical services for a census of 51 residents when Resident 36'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 the Medication Administration Record (MAR-a legal document that list administered drugs).This failed practice may contribute to a possible medication administration error for Resident 36, unsafe controlled medication handling, and risk of controlled drug diversion (unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace).Findings:A review of Resident 36's clinical record indicated Resident 36 was admitted May of 2020 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) affecting right dominant side, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints), and neuralgia (intense pain caused by damaged or irritated nerves) and neuritis (inflammation of a nerve causing pain).A review of Resident 36's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/16/26, indicated Resident 36 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 36 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 36's MDS Health Conditions, dated 1/16/26, indicated Resident 36 received scheduled and as needed pain medications and non-medication intervention for pain. A review of Resident 36's active physician's order, dated 2/6/26, indicated, HYDROcodone-Acetaminophen Oral [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 8 hours as needed for pain management moderate to severe 4-10 [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 36's MAR and the CDR for Norco, for February 2026, indicated nursing staff signed out removal of Norco in Resident 36's CDR but did not document Norco administration on the MAR as follows: 1 tablet on 2/20/26 at 12:30 a.m., and 1 tablet on 2/23/26 at 3:20 a.m.During a concurrent interview and record review on 3/11/26 at 4:17 p.m. with Licensed Nurse (LN) 4, Resident 36's CDR and MAR were reviewed. LN 4 confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on two occasions. LN 4 stated that both the CDR and MAR should be signed when administering Norco to Resident 36.During a phone interview on 3/12/26 at 8:48 a.m. with the Consultant Pharmacist (CP), the CP stated that nurses should always need to sign the CDR and MAR when administering controlled medications. The CP further stated there would be a risk of possible medication error and double dosing if the CDR and MAR are not filled out properly. During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated that when a nurse administers a controlled drug, the nurse should take out the medication from the pack, sign the CDR, administer the medication, then sign the MAR. The DON further stated that there would be a potential for medication error because other nurses would not see if the resident was given the controlled drug already and also a risk for drug diversion if the MAR is not properly signed.A review of the facility's policy and procedure (P&P) titled, POLICY AND PROCEDURE IN MEDICATION ADMINISTRATION, revised 1/2026, indicated, Medications shall be administered in accordance with our established policies and procedures .12. Medications must be immediately charted following the administration by the license nurse who administered the medication.A review of the facility's P&P titled, Controlled Substances, revised 1/2026, 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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; .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure one out of nine sampled residents for medication administration (Resident 60) was free from significant medication error when Resident 60 did not receive prescribed insulin (medication used to manage blood sugar level) in accordance with the physician's order.This failure has the potential to result in Resident 60 experiencing hypoglycemia (too low blood sugar level) and other unnecessary insulin side effects which could negatively affect Resident 60's health.Findings:A review of Resident 60's clinical record indicated Resident 60 was admitted February of 2026 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood), congestive heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), muscle weakness, and need for assistance with personal care.A review of Resident 60's physician's order, dated 2/24/26, indicated, Resident is capable of giving informed consent and/or able to participate in treatment plan.A review of Resident 60's physician's order, dated 2/26/25, indicated, Insulin Lispro [a fast-acting type of insulin used to manage high blood sugar] Injection Solution 100 UNIT/ML [unit/milliliters- unit of measurement] .Inject as per sliding scale [a method of managing blood sugar levels where insulin doses are adjusted based on current blood sugar reading]: .if 140 - 169 = 3 units [unit of insulin measurement] .; 170 - 199 = 4 units; 200 - 249 = 6 units; 250 - 299 = 8 units; 300+ = 10 units .subcutaneously [under the skin] with meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS.During a medication administration observation which started on 3/9/26 at 11:38 a.m. with Licensed Nurse (LN) 1, Resident 60 had a finger stick blood sugar (a quick, routine procedure for monitoring blood sugar levels by pricking a finger) reading of 185 milligrams/deciliter (mg/dl- unit of measurement) and LN 1 administered 4 units of insulin lispro to Resident 60.During an observation on 3/9/26 at 12:34 p.m. in Resident 60's room, a staff was observed delivering Resident 60 her lunch meal. Resident 60's lunch meal tray was left on Resident 60's bedside table.During a concurrent observation and interview on 3/9/26 at 12:58 p.m. with Certified Nurse Assistant (CNA) 2, in Resident 60's room, CNA 2 started to assist Resident 60 with her lunch meal. CNA 2 confirmed the observation. CNA 2 stated Resident 60 needs total assistance with eating and needs encouragement and cueing when eating.During an interview on 3/9/26 at 2:55 p.m. with LN 1, LN 1 confirmed that Resident 60's insulin lispro was administered too early if Resident 60 ate at 12:58 p.m. LN 1 stated that Resident 60 should have eaten within 15 minutes after her insulin lispro was administered. LN 1 also stated the facility's lunch mealtime was 11:30 a.m. and she was not sure why Resident 60's lunch meal was late. LN 1 further stated insulin Lispro is a rapid acting insulin and Resident 60 was at risk for hypoglycemia.During a phone interview on 3/12/26 at 8:48 a.m. with the Consultant Pharmacist (CP), the CP stated that the resident should eat within 10-15 minutes after insulin lispro administration because of the risk of hypoglycemia. The CP further stated the physician's order should always be followed.During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated that nurses should make sure that insulin lispro should be given with food or within 15 minutes after administration. The DON further stated there would be a risk for the resident's blood sugar to rapidly go down if the resident would eat too late after insulin lispro administration.A review of the facility's policy and procedure (P&P) titled, POLICY AND PROCEDURE IN MEDICATION ADMINISTRATION, revised 1/2026, indicated, 1. Drugs must be administered in accordance with the written orders of the attending physician .8. Diabetic resident on insulin should follow MD order .A review of the facility's P&P titled, Insulin Administration, revised 1/2026, indicated, 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order .The three key characteristics of insulin are: a. Onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose .Type .Rapid-acting .Onset* .10-15 min [minutes] .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to provide food in accordance with the physician's prescribed diet for one out of 17 sampled residents (Resident 55) when Resident 55 who was on Renal diet (a diet aimed at keep levels of fluids, electrolytes, and minerals balanced in the body in individuals with kidney disease) received a salt packet during the 3/9/26 lunch meal.This failure had the potential to negatively affect Resident 55's medical condition and for Resident 55 to not achieve his highest practicable well-being.Findings:A review of Resident 55's clinical record indicated Resident 55 was admitted February of 2026 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), end stage renal disease (occurs when the gradual loss of kidney function reaches an advanced state where kidneys no longer work as they should to meet the body's needs), dependence on renal dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), hypertension (high blood pressure), and need for assistance with personal care.A review of Resident 55's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/16/26, indicated Resident 55 was rarely or never understood. A review of Resident 55's MDS Nutritional Status, dated 2/16/26, indicated Resident 55 had therapeutic diet (specific meal plan prescribed by a doctor and planned by a dietitian to treat or manage a medical condition) while she was a resident in the facility. A review of Resident 55's MDS Functional Abilities, dated 2/16/25, indicated Resident 55 needed setup or clean up assistance with eating.A review of Resident 55's care plan, initiated 2/10/26, indicated, [Resident 55] is at risk for nutritional problem related to diagnosis of .Hypertension, and other medical problems (ESRD .DIALYSIS DEPENDENT) .All staff to be informed of resident's special dietary and safety needs .Diet as per MD order .A review of Resident 55's active physician's order, dated 2/10/26, indicated, CCHO [controlled carbohydrates- a diet used to keep blood sugar stable] /RENAL diet SOFT AND BITE SIZE texture, THIN LIQUIDS consistency.During a concurrent observation and interview on 3/9/26 at 12:25 p.m. with Resident 55, in Resident 55's room, Resident 55 was observed eating his lunch meal and there was a packet of iodized salt observed in Resident 55's meal tray. Resident 55's meal ticket was checked and indicated, Diet: Renal, CCHO. Resident 55 stated she did not want the salt packet, and it was just served together with his meal.During a concurrent observation and interview on 3/9/26 at 12:28 p.m. with Certified Nurse Assistant (CNA) 1, in Resident 55's room, CNA 1 confirmed that Resident 55 was served with a salt packet in his lunch meal. CNA 1 stated Resident 55 was on Renal diet and usually gets the normal meal tray. CNA 1 further stated salt packets are provided to residents on renal diet.During an interview on 3/9/26 at 12:36 p.m. with Licensed Nurse (LN) 1, LN 1 stated residents on renal diet should not get a lot of fluids and salt because it could affect their medical condition. LN 1 further stated staff should not provide salt packets to residents on renal diet. During an interview on 3/11/26 at 4:22 p.m. with the Dietary Supervisor (DS), the DS stated staff should follow the diet order of the residents. The DS also stated salt packets should not be provided to residents with renal diet order because extra salt could affect the salt and fluid balance of the residents. The DS further stated CNAs should know not to provide salt packets to residents on renal diet.During an interview on 3/12/26 at 9:22 a.m. with the Director of Nursing (DON), the DON stated the therapeutic diet order should always be followed. The DON further stated providing extra salt to residents on renal diet could affect their medical condition.A review of the facility's policy and procedures (P&P) titled, Liberal Renal Diet, revised 12/2024, indicated, Liberal Renal Diet, No Salt Packet on Tray (NSPOT) .Procedure .Follow menu guide for regular diet .Avoid .Salt Packet .