STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056151	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fullerton, LLC	330 W. Bastanchury Road Fullerton, CA 92835

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was implemented for one of 21 final sampled residents (Resident 91). * The facility failed to implement the compressive care plan for Resident 91's right upper arm AV shunt (arteriovenous shunt is a direct connection between an artery and a vein that bypasses the normal network of small capillaries). The facility failed to ensure the facility staff did not obtain Resident 91's blood pressure on his right arm, the arm with his dialysis access site/ AV shunt). This failure had the potential to damage the AV shunt and/or increase the risk of blood clots for Resident 91.Findings: Review of the facility's P&P titled Care Plan revised 4/2024 showed 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. Medical record review for Resident 91 was initiated on 9/8/25. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's care plan focus titled End Stage Renal Disease (ESRD) initiated 8/27/25, showed an intervention to not obtain Resident 91's blood pressure on his right arm, the site of his AV shunt. Review of Resident 91's Order Summary Report showed the following physician's orders:- dated 8/26/25, for the nursing staff not to obtain Resident 91's blood pressure on his right arm (location of AV shunt); and- dated 8/29/25, for Resident 91 to receive hemodialysis (a medical treatment for kidney failure that uses an artificial kidney (dialyzer) to filter waste, salts, and excess fluid from a patient's blood when the kidneys are unable to do so) twice a week on Monday and Friday at 0430 hours. Review of Resident 91's Weights and Vitals Summary showed documentation the nursing staff obtained Resident 91's blood pressure on his right arm (location of AV shunt) on the following dates and times:- on 8/28/25 at 0822 hours (blood pressure measured at 155/63 mmHg);- 8/30/25 at 0934 hours (blood pressure measured at 118/80 mmHg);- 9/4/25 at 0827 hours (blood pressure measured at 112/50 mmHg);- 9/5/25 at 0918 hours (blood pressure measured at 130/80 mmHg);- 9/6/25 at 0816 hours (blood pressure measured at 138/70 mmHg); and- 9/6/25 at 0916 hours (blood pressure measured at 134/82 mmHg). On 9/10/25 at 0922 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the findings and stated the nursing staff should not have obtained Resident 91's blood pressure utilizing his right arm, the location of Resident 91's AV shunt, in accordance with Resident 91's ESRD care plan. Cross reference F698, example # 2.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services related to pressure injuries (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore to promote wound healing) were provided to one of two final sampled residents (Resident 2) reviewed for pressure injuries. * The facility failed to ensure LVN 3 administered the wound treatment as per the physician's orders to Resident 2's right heel pressure injury. This had the potential for Resident 2 not receiving the appropriate care and services to promote healing of the pressure injury.Findings: Review of the facility's P&P titled Wound Care revised 1/2025 showed it is the policy for the facility to provide guidelines for the care of wounds to promote healing. To review the resident's care plan to assess for any special needs of the resident. To use no -touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. Place gauze to cover all broken skin.Remove dry gauze and apply treatments as indicated. Medical record review for Resident 2 was initiated on 9/8/25. Resident 2 was admitted to the facility on [DATE], and had a diagnosis of Stage 3 (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle are not exposed) pressure injury of the right heel. Review of Resident 2's H&P examination dated 11/25/24, showed Resident 2 had no capacity to understand and make medical decisions. Review of Resident 2's plan of care showed a care plan problem dated 6/11/25, addressing Resident 2's right heel Stage 3 pressure injury. The interventions showed Resident 2 was seen by the Wound Care Physician Assistant and the right heel was reassessed and measured, with the new order to cleanse with normal saline, pat dry, apply collagen (powder, wound filler dressing topically applied and promotes wound healing), and Thera honey (sterile, medical-grade honey dressing used to treat a variety of wounds), and alginate (absorb wound fluid resulting in gels that maintain a physiologically moist environment and minimize bacterial infections at the wound site), then apply the dry sterile dressing/kerlix for 21 days. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was at risk for developing pressure injuries and had an unhealed Stage 3 pressure injury. Review of Resident 2's Order Summary Report showed a physician's order dated 9/5/25, for the right heel Stage 3 pressure injury, to cleanse with normal saline (NS), pat dry, apply collagen, Thera honey, alginate, and dry sterile dressing/kerlix every day shift for 21 days. On 9/10/2025 at 831 hours, a wound treatment observation for Resident 2 was conducted with LVN 3 and the IP. LVN 3 was observed preparing the following:- a 250 ml bottle of sterile 0.9% normal saline;- an unopened packet of calcium alginate dressing, with silver;- an unopened 1 gram packet of collagen powder; and- a 0.5-ounce tube of Thera honey gel. During the wound treatment observation, after cleaning the right heel, LVN 3 was observed using a tongue depressor to apply the Thera honey gel to the right heel wound bed. LVN 3 was then observed removing the collagen powder with a tongue depressor and applying the powder on top of the Thera honey gel. However, a significant amount of the white- collagen powder was observed on Resident 2's bed, directly under the right heel, and not on the wound bed. After performing hand hygiene and donning new gloves, LVN 3 proceeded to apply the calcium alginate (with silver) dressing. LVN 3 was stopped and verified the collagen powder on the resident's bed and the minimal amount of collagen powder observed on the right heel wound bed. LVN 3 was observed reapplying the collagen powder to the wound bed, on top of the Thera honey gel, and applied the calcium alginate (with silver) dressing, dry dressing and kerlix. On 9/10/25 at 0909 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 3. LVN 3 was asked about the resident's physician's order for the treatment medications for Resident 2's right heel pressure injury. LVN 3 stated the Thera honey gel should be applied first, followed by the collagen powder on top of the Thera honey. LVN 3 verified during the wound treatment observation for Resident 2, she applied the Thera honey gel to the wound bed, followed by the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	collagen powder. When asked about the treatment order for the alginate dressing, LVN 3 reviewed the physician's order and verified the physician's order showed to apply the alginate dressing, however, LVN 3 stated the order did not show to use calcium alginate with silver. LVN 3 verified during the wound treatment observation she used the calcium alginate with silver. LVN 3 stated the wound treatments should be administered as per the physician's order. On 9/10/25 at 0958 hours, a telephone interview was conducted with Physician Assistant 1. When asked about the physician's order for the treatment medications for Resident 2's right heel pressure injury, Physician Assistant 1 stated the treatment nurse was expected to first apply the collagen powder to the wound bed, followed by the Thera honey gel, and then the alginate dressing. When asked about the alginate dressing, Physician Assistant 1 stated the facility could use the calcium alginate, however, calcium alginate with silver was not needed for Resident 2's wound. On 9/11/25 at 1234 hours, an interview was conducted with the DON. The DON stated the treatment nurse was expected to administer the wound treatments as per the physician's order. The DON stated if the wound treatment order had multiple medications, the treatment nurse was expected to administer the wound treatment as listed per the physician's order. The DON further stated if the treatment nurse had any questions, the treatment nurse should obtain an order clarification. On 9/11/25 at 1248 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the environment remained free from accident hazards for one of one final sampled resident (Resident 43) reviewed for falls. * The facility failed to ensure Resident 43's post fall risk assessment was completed accurately to identify the resident's risk for fall and to prevent further falls and/or injuries. This failure posed the risk of not providing the necessary care to the resident to prevent further falls and/or injuries.Findings: Review of the facility's P&P titled Fall Management revised on 12/2024 showed the following:- the licensed nurses/designee will gather data from the resident, family of interested party about the resident's history of falling; and- the licensed nurse will evaluate, and document falls that occur while the resident is in the facility; for example, when and where the fall occurs, observations of the events, injuries, treatments, etc. Review of the facility's P&P titled Documentations revised on 1/2025 showed the following:- documentation should reflect all findings after assessment was done and reflect concern or problems of resident; and - However, it is discouraged to have a late entry, if possible, licensed nurses should be precise and accurate which will be reflected in the resident medical record. Medical record review for Resident 43 was initiated on 9/10/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 12/31/24, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's MDS assessment dated [DATE], showed Resident 43's BIMS score was nine, indicating moderate cognitive impairment. Review of Resident 43's Fall Risk Assessment (post fall) dated 8/7/25, showed under the section for history of falls, no falls in the past six months was marked. In addition, the assessment showed a total score of nine, which placed Resident 43 at a low risk of fall. On 9/10/25 at 1445 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 43's Fall Risk Assessment (post fall) dated 8/7/25, and verified the above findings. RN 1 stated the resident's Fall Risk assessment dated [DATE], was inaccurate because Resident 43 had a fall episode on 8/7/25. RN 1 stated if the post Fall Risk Assessment was completed accurately, Resident 43's fall risk score would have been 10, which placed Resident 43 at a high risk of fall. Furthermore, RN 1 stated the negative outcome of the inaccurate assessment would affect Resident 43's fall prevention and plan of care. On 9/11/25 at 0944 hours, an interview was conducted with the Administrator and DON. The DON stated she reviewed Resident 43's documentation and assessments and conducted an IDT meeting after the resident's fall on 8/7/25. The DON stated she reviewed Resident 43's post Fall Risk assessment dated [DATE], however, she did not notice the inaccuracy of the assessment. In addition, the DON stated if Resident 43's Fall Risk Assessment was completed accurately, Resident 43's fall risk score would have been 10, which placed Resident 43 at a high risk of fall. The Administrator and DON were informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary dialysis care and services for two of two final sampled residents (Residents 10 and 91) reviewed for dialysis care. * The facility failed to follow up on Resident 10's laboratory results for the laboratory tests obtained at the dialysis center. * The facility failed to ensure the facility staff did not obtain Resident 91's blood pressure on six occasions on the arm with his AV shunt. These failures had the potential for the residents to experience medical complications and negatively affect Residents 10 and 91's physical well-being. Findings: Review of the facility's P&P titled Dialysis Services 1/2025 showed it is the policy of this facility to provide adequate and appropriate care to dialysis clients in coordination with the dialysis center. Coordination of care may include the following: information transmitted to the dialysis unit by the facility prior to dialysis through the phone and/or communication binder which resident carries when going to the dialysis center, where information regarding resident is reflected for the dialysis center awareness. The same binder is brought back by the resident to the facility where the dialysis center relayed any information regarding post dialysis findings or other concerns and/or special treatment to be followed by the facility if applicable. The facility may be required to provide the following interventions for dialysis residents” assessment of laboratory values such as: BUN, serum creatinine, sodium, potassium, calcium, magnesium, phosphate levels, hemoglobin and hematocrit. The dialysis access site is to include avoidance of blood pressure readings, venipunctures and trauma to the dialysis access extremity. 1. Medical record review for Resident 10 was initiated on 9/8/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of renal dialysis dependence. Review of Resident 10's H&P examination dated 9/1/25, showed Resident 10 had the capacity to understand and make decisions. The H&P also showed Resident 10 had ESRD and received hemodialysis treatments. Review of Resident 10's Order Summary Report for September 2025 showed a physician's order dated 8/27/25, for hemodialysis treatment on Mondays, Wednesdays, and Fridays at 0900 hours, pick-up at 0830 hours. Review of Resident 10 ‘s Nurse's Dialysis Communication Record for 9/3/25, showed the dialysis center documented the monthly laboratory tests for Resident 10 were obtained. However, further review of Resident 10's medical record failed to show if the laboratory test results were obtained from the dialysis center and/or placed in the resident's medical record. On 9/9/25 at 1413 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON reviewed Resident 10's Nurse's Dialysis Communication Record for 9/3/25, and verified the dialysis center documented the monthly labs for Resident 10 was obtained. The ADON reviewed Resident 10's medical record and verified Resident 10's monthly laboratory test results were not in Resident 10's medical records. On 9/9/25 at 1442 hours, an interview and concurrent medical record review for Resident 10 was conducted with the DON. The DON stated for any laboratory tests obtained at the dialysis center, the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN supervisor was responsible for following up to ensure the laboratory results were in the resident's medical records. The DON stated the RN supervisor should follow up as soon as possible, within 24 hours. On 9/11/25 at 1234 hours, a follow up interview was conducted with the DON. The DON stated if any laboratory tests were drawn at the dialysis center and documented in the communication record, the receiving licensed nurse at the facility should follow up and obtain the laboratory results. On 9/11/25 at 1248 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 91 was initiated on 9/8/25. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's Order Summary Report showed the following physician's orders: - dated 8/26/25, to monitor Resident 91's AV shunt on his right upper arm every shift; - dated 8/26/25, for the nursing staff not to obtain Resident 91's blood pressure on his right arm (location of AV shunt); and - dated 8/29/25, for Resident 91 to receive hemodialysis twice a week on Monday and Friday at 0430 hours. Review of Resident 91's Weights and Vitals Summary showed documentation the nursing staff obtained Resident 91's blood pressure on his right arm (location of AV shunt) on the following dates and times: - on 8/28/25 at 0822 hours (blood pressure measured at 155/63 mm Hg); - 8/30/25 at 0934 hours (blood pressure measured at 118/80 mm Hg); - 9/4/25 at 0827 hours (blood pressure measured at 112/50 mm Hg); - 9/5/25 at 0918 hours (blood pressure measured at 130/80 mm Hg); - 9/6/25 at 0816 hours (blood pressure measured at 138/70 mm Hg); and - 9/6/25 at 0916 hours (blood pressure measured at 134/82 mm Hg). On 9/10/25 at 0922 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated she was assigned to provide care for Resident 91. LVN 1 was asked what arm she utilized to obtain Resident 91's blood pressure. LVN 1 stated she would obtain Resident 91's blood pressure utilizing his left arm (the arm without the AV shunt). LVN 1 stated she would not and should not obtain Resident 91's blood pressure utilizing his right arm, due to the location of his AV shunt, which was located on his right arm. LVN 1 stated obtaining the blood pressure on Resident 91's right arm (location of AV shunt) had the potential to damage Resident 91's dialysis access site (right arm AV shunt). LVN 1 then reviewed Resident 91's medical record and verified the nursing staff documented having obtained Resident 91's blood pressure on his right arm, on the following dates and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times: 8/28/25 at 0822 hours, 8/30/25 at 0934 hours, 9/4/25 at 0827 hours, 9/5/25 at 0918 hours, 9/6/25 at 0816 hours, and 9/6/25 at 0916 hours. LVN 1 stated the nursing staff should not have obtained Resident 91's blood pressure utilizing his right arm, where Resident 91's AV shunt was located. On 9/11/25 at 1330 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings and stated the nursing staff should not obtain Resident 91's blood pressure having utilized his right arm, the location of Resident 91's AV shunt. The DON stated obtaining the blood pressure on the arm in which Resident 91's AV shunt was located had the potential to damage Resident 91's AV shunt.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the appropriate treatment and services designed to help attain and maintain a resident's highest practical physical, mental, and psychosocial well-being for one of one final sampled resident (Resident 24) reviewed for dementia (group of conditions that cause a progressive decline in cognitive abilities, including memory, thinking and reasoning) care. * The facility failed to obtain the neurologist's progress notes and develop a dementia care plan for Resident 24. This failure had the potential for Resident 24 to not receive the appropriate treatment and services needed for her dementia.Findings: Review of the facility's P&P titled Dementia - Clinical Management revised 1/2025 showed the staff and physician will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes. The staff and physician will review the current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments. As needed, the physician may obtain a psychiatrist or neurologist consultation to assist with diagnosis, treatment selection, monitoring of responses to treatment, and adjustment of medications. For the individual with confirmed dementia, the staff and physician will identify a resident-centered care plan to maximize remaining function and quality of life. Medical record review for Resident 24 was initiated on 9/8/25. Resident was admitted to the facility on [DATE]. Further review of Resident 24's medical record showed on 7/30/25 (after her admission to the facility), Resident 24 had the diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident 24 's H&P examination dated 11/18/24, showed Resident 24 had no capacity to understand and make medical decisions. Review of Resident 24's progress note for a licensed nurse's entry dated 7/30/25 at 1630 hours, showed Resident 24's returned to the facility from her neurology appointment with the physician's note and orders. Review of Resident 24's Physician's Progress Note dated 7/30/25, showed a full progress note would be sent to the facility in a day or two. The preliminary clinical conclusion showed the following:- Should start anti-dementia medications.- For arrhythmia, two options are to be presented to the current cardiologist for his decisions. Review of Resident 24's Order Summary Report for September 2025 showed the following physician's orders:- dated 7/30/25, to administer galantamine hydrobromide (dementia medication) 4 mg one tablet by mouth two times a day for unspecified dementia, and- dated 7/30/25, to administer memantine (dementia medication) 5 mg, one tablet by mouth two times a day related to unspecified dementia. Review of Resident 24's MAR for 9/2025 showed Resident 24 was administered the galantamine hydrobromide and memantine medications from 9/1 to 9/9/25 at 0900 and 1700 hours, except on 9/6 and 9/7/25. Review of Resident 24's medical record failed to show the facility had developed or implemented a plan of care to address Resident 24's dementia. Further review of Resident 24's medical record failed to show Resident 24's complete neurology progress notes from 7/30/25. In addition, the resident's medical record failed to show the documentation the facility had attempted to obtain the progress notes from the neurologist. On 9/10/25 at 1403 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 2. RN 2 stated Resident 24 was alert and oriented to person and place but was forgetful and confused at times. RN 2 verified Resident 24 was diagnosed with dementia; however, the facility did not develop a care plan addressing the resident's dementia. RN 2 stated for the residents diagnosed with dementia, there should be a care plan developed specific to the resident's dementia. RN 2 reviewed Resident 24's medical record and verified the above findings. On 9/10/25 at 1601 hours, an interview and concurrent medical record review for Resident 24 was conducted with the DON. The DON stated when the resident was seen by a consultant, the facility (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible for obtaining the consultation progress notes and the progress notes should be placed inside the resident's medical record within 24 hours. The DON stated for the residents with a new diagnosis of dementia, while at the facility, there should be monitoring of the residents' behaviors. The DON stated the interventions for the residents were dependent on the behaviors the residents were exhibiting. The DON further stated the facility should review the resident's neurology progress notes to determine certain behaviors to monitor for. The DON reviewed Resident 24's medical record and verified the neurology progress notes was not in Resident 24's medical record. The DON stated the IDT meeting should have been conducted specific to the resident's diagnosis of dementia to determine what needs Resident 24 may have at the facility and a care plan should have been developed specific to Resident 24's dementia. On 9/11/25 at 1248 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs for two of two final sampled residents (Residents 10 and 91) reviewed for dialysis care. * The facility failed to ensure accurate monitoring for the administration of Resident 10's blood pressure medications on the days Resident 10 had dialysis treatments. Resident 10's BP medications were sent with the resident to be administered by the dialysis nurse, however the facility's licensed nurses documented the administrations in Resident 10's MAR (Medication Administration Record). * The facility failed to ensure Resident 91's carvedilol (used to treat high blood pressure) and calcium acetate (supplement) medications were administered on time, in accordance with the facility's P&P. These failures had the potential to negatively affect Residents 10 and 91's health condition.Findings: Review of the facility's P&P titled Medication Administration revised 1/2025 showed medications shall be administered in accordance with the facility's established policies and procedures. Medications must be administered by the same person preparing the dosage for administration. Medications must not be prepared in advance and must be administered within one hour before or after the administration time per the physician's order. The medications should be immediately charted following the administration by the licensed nurse who administered the medication. In the event that the resident is not in the facility during the scheduled medication administration time (i.e. out on pass, on dialysis services, appointment services and other emergencies), the physician will be notified for any orders and will be documented. 1. Medical record review for Resident 10 was initiated on 9/8/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 9/1/25, showed Resident 10 had the capacity to understand and make decisions. The H&P further showed the resident had ESRD and received hemodialysis treatment. On 9/9/25 at 1413 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. When asked about the facility's process for the administration of the BP medications to Resident 10 on the days the resident was scheduled for dialysis treatment, the ADON stated the dialysis center had called and informed her of Resident 10's BP dropping during the dialysis treatment. The ADON stated she had instructed the licensed nurses assigned to Resident 10, to send the scheduled 0900 hours blood pressure medications with Resident 10, to be administered at the dialysis center. The ADON stated she did not document the call from the dialysis center in Resident 10's medical record or informed Resident 10's physician. Additionally, the ADON reviewed Resident 10's medical record and stated there were no physician's orders to send the BP medications with Resident 10 to the dialysis center. The ADON stated for the BP medications that were sent with Resident 10, the dialysis center should document the administration of the BP medications in the resident's Nurse's Dialysis Communication Record. However, review of Resident 10's Nurse Dialysis Communication Record dated 8/29, 9/1, 9/3, and 9/5/25 failed to show documented evidence Resident 10's BP medications scheduled at 0900 hours were administered in the dialysis center during the resident's scheduled dialysis days. The ADON reviewed Resident 10's listed Nurse Dialysis Communication Record and verified the dialysis center did not document the administration of any BP medication during the dialysis treatment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fullerton, LLC	330 W. Bastanchury Road Fullerton, CA 92835

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Order Summary Report for September 2025 showed the following physician's orders: - dated 8/27/25, for hemodialysis treatment on Mondays, Wednesdays, and Fridays at 0900 hours, pick-up at 0830 hours; - dated 8/27/25, to administer amlodipine (blood pressure medication) 10 mg one tablet by mouth daily; and - dated 8/27/25, to administer hydralazine (blood pressure medication) 100 mg one tablet by mouth three times a day. Review of Resident 10's MAR for 8/2025 and 9/2025 showed the following: * For the amlodipine 10 mg one tablet by mouth one time a day, the amlodipine medication was administered to Resident 10 from 8/28 to 9/9/25 at 0900 hours. * For the hydralazine 100 mg one tablet by mouth three times a day, the hydralazine medication was administered to Resident 10 from 8/1 to 8/22/25 and from 9/1 to 9/8/25 at 0900, 1300, and 1700 hours. * For the clonidine 0.1 mg one tablet three times a day dated 6/21/25, and discontinued 8/26/25, the clonidine medication was administered to Resident 10 from 8/1 to 8/22/25 at 0900, 1300, and 1700 hours. Review of Resident 10's Medication Admin Audit Report for 9/3/25, showed the following documentation: * For the amlodipine 10 mg one tablet by mouth one time a day, RN 4 documented the amlodipine medication was administered at 0800 hours. * For the hydralazine 100 mg one tablet by mouth three times a day, RN 4 documented the hydralazine medication was administered at 0800 hours. On 9/9/25 at 1505 hours, an interview was conducted with Resident 10. Resident 10 stated she had dialysis treatments on Mondays, Wednesdays, and Fridays. Resident 10 stated on the days she had dialysis treatment, the facility sent the BP medications: clonidine, hydralazine, and sometimes amlodipine with her, to be administered by the dialysis nurse. On 9/10/25 at 1045 hours, a telephone interview was conducted with RN 4. RN 4 stated Resident 10 received dialysis treatment on Mondays, Wednesdays, and Fridays, left the facility at around 0800 hours and returned around lunch time. When asked about Resident 10's BP medications scheduled on 9/3/25 at 0900 hours, RN 4 stated he did not administer Resident 10's BP medications scheduled at 0900 hours but instead, placed Resident 10's BP medications in the medication pouch and sent the medications with the resident, to bring to the dialysis center. When RN 4 was asked how he knew the BP medications were administered to Resident 10, RN 4 stated he asked Resident 10, and she told him she took the medications at the dialysis center. On 9/10/25 at 1552 hours, an interview and concurrent medical record review for Resident 10 was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the DON. The DON stated she spoke with RN 4 and RN 4 had informed the DON on 9/3/25, he sent Resident 10's BP medication with her to the dialysis center. The DON reviewed Resident 10's Nurse's Dialysis Communication Record for 9/3/25, and verified the dialysis nurse did not document the administration of the BP medications. The DON also reviewed Resident 10's MAR for 9/2025 and verified RN 4 documented he administered Resident 10's amlodipine 10 mg and hydralazine 100 mg on 9/3/25 at 0900 hours. On 9/11/25 at 1234 hours, a follow up interview was conducted with the DON. The DON stated the licensed nurse who prepared the resident's medication and removed the medication from the medication pack should be the person to administer the medication. The DON stated once the medication was administered to the resident, the licensed nurse should sign/document the administration of the medication in the resident's MAR. On 9/11/25 at 1248 hours, a follow up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 91 was initiated on 9/8/25. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's Order Summary Report showed the following physician's orders: - dated 8/26/25, to administer calcium acetate (medication to lower phosphate in the blood) 667 mg orally three times a day (scheduled at 0730 hours, 1230 hours, and 1730 hours). - dated 9/2/25, to administer carvedilol (anti-hypertension medication) 6.25 mg orally two times a day (scheduled at 0730 hours and 1730 hours). Review of Resident 91's Nurse's Dialysis Communication Record dated 9/8/25, showed Resident 91 left the facility for his dialysis appointment on 9/8/25 at 0400 hours, and had returned to the facility at 0840 hours. Review of Resident 91's Medication Administration Audit Report dated 9/8/25, showed the following documentations: - the licensed nurse administered Resident 91's carvedilol 6.25 mg medication orally on 9/8/25 at 0841 hours. Resident 91's carvedilol 6.25 mg medication was scheduled to be administered at 0730 hours. - the licensed nurse administered Resident 91's calcium acetate 667 mg medication orally on 9/8/25 at 0840 hours. Resident 91's calcium acetate 667 mg medication was scheduled to be administered at 0730 hours. In accordance with the facility's P&P, the carvedilol and calcium acetate medications should have been administered within one hour of the scheduled administration time. On 9/9/25 at 1554 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified Resident 91's Nurse's Dialysis Communication Record dated 9/8/25, showed Resident 91 left the facility for his dialysis appointment on 9/8/25 at 0400 hours, and then returned to the facility at 0840 hours. RN 3 stated the facility did not send any medications with Resident 91 to be (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken at the dialysis center. RN 3 stated Resident 91's carvedilol 6.25 mg and calcium acetate 667 mg medications (scheduled for 0730 hours) should have been administered within one hour of the scheduled administration time, in accordance with the facility's Medication Administration P&P, however, the facility failed to do so.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. Two of the three licensed nurses (LVN 1 and RN 1) observed were found to have made errors during the medication administration observation for two final sampled residents (Residents 33 and 54). * LVN 1 did not administer Resident 54's Creon (medication used to help digest food) medication with meals or food as ordered by the physician. * RN 1 did not administer Resident's 33's artificial tears ophthalmic solution (used for dry eye) as ordered by the physician. These failures had the potential to negatively impact the residents' health outcomes and posed the risk of possible complications.Findings: Review of the facility's P&P titled Policy and Procedure in Medication Administration revised 1/2025 showed the medications shall be administered in accordance with our established policies and procedures. The drugs must be administered in according with the written orders of the attending physicians (Five Rights). 1. Review of the facility's P&P titled Policy and Procedure on Administration of Eye Drops revised 1/2025 showed to ensure that eyecare/medication are appropriately provided based on the physician's order in consideration with OBRA regulation.The following procedures will be undertaken in eye drop administration:- Check the label and follow the physician's instructions. On 9/9/25 at 0911 hours, a medication administration observation for Resident 33 was conducted with RN 1. RN 1 prepared the following medications for Resident 33:- one capsule of aspirin-dipyridamole (anti-platelet medication) 25 - 200 mg;- one tablet of amlodipine (medication to treat high blood pressure) 5 mg, hold if the systolic blood pressure was below 110 mmHg;- one tablet of Lasix (diuretic medication) 20 mg;- one tablet of losartan potassium (medication to treat high blood pressure) 50 mg, hold if the systolic blood pressure was below 110 mmHg;- one tablet of multi-vitamins with minerals (supplement);- one tablet of potassium chloride (supplement) extended release 20 mEq;- one patch of lidocaine (local anesthetic medication) 5%, to apply topically to both knees and right shoulder;- one nasal spray of fluticasone propionate nasal spray (nasal spray primarily used to relieve symptoms associated with allergies and other conditions affecting the nasal passages) to each nostril;- two tablets of acetaminophen (an analgesic medication used to relieve mild pain) 325 mg;- two tablets of bisacodyl (laxative) 5 mg;- two tablets of docusate sodium (stool softener) 100 mg; and- artificial tears ophthalmic solution (eye drop, use for dry eye) to both eyes. RN 1 was observed administering two drops of the artificial tears ophthalmic solution to Resident 33's right eye and then administered two drops of the artificial tears ophthalmic solution to the resident's left eye. Medical record review for Resident 33 was initiated on 9/8/25. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's Order Summary Report dated 9/9/25, showed a physician's order dated 12/27/22, to administer one drop of the artificial tears ophthalmic solution in both eyes two times a day for dry eyes. On 9/9/25 at 1053 hours, an interview was conducted with Resident 33. Resident 33 verified she always got two drops of the artificial tears ophthalmic solution to her left and right eye from the licensed nurses during the medication administration. On 9/9/25 at 1425 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was informed and verified the findings. RN 1 stated she did not follow the physician's order when she administered the artificial tears ophthalmic solution to Resident 33 during the medication observation. 2. Review of the facility's P&P titled Medication Administration Schedule revised 1/2025 showed the medications are administered according to established schedules. Scheduled medications that must be given around mealtimes may fluctuate based on delivery and consumption of meals. Time critical medications are designated by the pharmacy and include medications that need to be administered before, with, or after meals. On 9/9/25 at 1201 hours, a medication administration observation for Resident 54 was conducted with LVN 1. During the medication administration observation, Resident 54 was not observed with a lunch tray or food at the bedside. LVN 1 prepared the following (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications for Resident 54:- artificial tears lubricant (eye drop, use for dry eye);- one tablet of carbidopa-levodopa (medication to treat Parkinson's disease) 25-100 mg; and- one capsule of Creon delay-release 24,000 units, to give with meals. LVN 1 was observed administering the Creon medication to Resident 54 without food. Medical record review for Resident 54 was initiated on 9/8/25. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 54's Order Summary Report dated 9/9/25, showed the following physician's order dated 8/20/22, to administer Creon capsule delayed release particles 24,000 units by mouth with meals for peptic ulcer, do not crush, chew or break open a capsule. Swallow the capsule whole with a full glass of water. On 9/9/25 at 1401 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the Creon medication was not administered to Resident 54 with meals nor food. On 9/11/25 at 0919 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage and disposal of medications. * The facility failed to ensure Resident 78's medication was stored properly and safely. * The facility failed to ensure the opened package of the [NAME] collagen powder (sterile, medical grade wound dressing, manage wounds by providing a moist healing environment) medication was stored properly in Medication Cart A. * The facility failed to dispose of the expired supply from the Medication Storage Room A. These failures had the potential to alter the efficacy of the stored medications, infection risk to the residents, and result in inappropriate administration of the prescription medications.Findings: Review of the facility's P&P titled Labeling and Storing Medications revised 1/2025 showed it is the policy of this facility that resident's medication will be properly labeled and stored in the locked medication room/carts. In addition, the medications no longer in use or medications which have expired will be disposed of in accordance with the Federal and State Laws. 1. Medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's Quarterly MDS assessment dated [DATE], showed Resident 78 has a BIMS score of six, indicating severe cognitive impairment. On [DATE] at 0917 hours, during the initial tour of the facility, Resident 78 was observed sitting on his wheelchair. There was a medication box container labeled with each day of the week, on the resident's overbed table. Resident 78 stated he was not aware of the medication box container on his overbed table. On [DATE] at 0941 hours, an observation, interview, and concurrent medical record review for Resident 78 was conducted with LVN 2. LVN 2 verified the medication box container labeled with each day of the week contained the following:- Monday compartment: two white capsules and one gray capsule;- Tuesday compartment: two white capsules and two gray capsules;- Wednesday compartment: two white capsules and two gray capsules;- Thursday compartment: empty;- Friday compartment: empty;- Saturday compartment: two white capsules and two gray capsules; and- Sunday compartment: two white capsules and two gray capsules. LVN 2 verified the above findings and stated she was not familiar with the medications inside the medication box container. LVN 2 further stated there was no need to have the medications at Resident 78's bedside. On [DATE] at 1526 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated there was no need to have the medications at the resident's bedside. 2. a. On [DATE] at 1526 hours, an inspection for Medication Cart A was conducted with RN 5. During the inspection of Medication Cart A, the following was observed: - one opened individual pack of the [NAME] collagen powder. The package's description showed the medication was a single use only. On [DATE] at 1534 hours, an interview was conducted with RN 5. RN 5 verified the above findings. RN 5 was asked regarding the facility's process when opening an individual package of medication. RN 5 stated the individual package was single use only and needed to be discarded after the single use. b. On [DATE] at 1018 hours, an inspection of Medication Storage Room A was conducted with RN 6. During the inspection of Medication Storage Room A, the following was observed:- nine sealed individual packages of BBL culture swab (used to collect and transport clinical samples, such as from the wounds, throat or skin to a laboratory for culture and testing) with an expiration date of [DATE]. On [DATE] at 1041 hours, an interview was conducted with RN 6. RN 6 verified the above findings. On [DATE] at 0919 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed in the kitchen. * The facility failed to ensure the blender used for meal was air dried prior to storing. * The facility failed to ensure the food preparation utensil was not clean and in good working condition. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Order List dated 9/8/25, showed 85 of 88 residents consumed the food prepared in the kitchen. 1. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. Review of the facility's P&P titled General Food Preparation and Handling revised 1/2025 showed all the equipment should be cleaned, sanitized, air-dried and reassembled after each use. On 9/8/25 at 0753 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. The following was observed:- one clean blender was observed stored wet with visible water inside and the lid on. The DSS verified the inside of the blender and the lid was not air-dried. The DSS stated the dietary aide used it earlier and washed it. 2. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled General Food Preparation and Handling revised 1/2025 showed the plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of. On 9/9/25 at 0950 hours, during the kitchen observation, an observation and concurrent interview was conducted with the DSS. The following was observed:- one serving scoop with food residue and melted white handle. The DSS verified the above findings. On 9/11/25 at 0944 hours, an interview was conducted with the Administrator and DSS. The Administrator and DSS were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical record was accurately maintained for one of 21 final sampled residents (Resident 91). * The facility documented (on three separate days) having obtained Resident 91's blood sugar, however, Resident 91 was out of the facility for his dialysis appointment, during the times the facility documented having obtained Resident 91's blood sugar. This failure resulted in Resident 91's medical record containing inaccurate information.Findings: Medical record review for Resident 91 was initiated on 9/8/25. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's Order Summary Report showed the following physician's orders:- dated 8/29/25, for Resident 91 to receive hemodialysis twice a week on Monday and Friday at 0430 hours.- dated 8/26/25, to obtain Resident 91's blood sugar once daily and to contact the physician if Resident 91's blood sugar was less than 60 mg/dL or greater than 250 mg/dL. a. Review of Resident 91's Nurse's Dialysis Communication Record dated 9/1/25, showed Resident 91 left the facility for his dialysis appointment on 9/1/25 at 0345 hours, and returned to the facility at 0750 hours. Review of Resident 91's Vitals Summary dated 9/1/25, showed documentation Resident 91's blood sugar was obtained on 9/1/25 at 0530 hours (measured at 115 mg/dL). However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0345 hours, and returned to the facility at 0750 hours). Review of Resident 91's MAR dated 9/2025 showed documentation Resident 91's blood sugar was obtained on 9/1/25 at 0630 hours (measured at 115 mg/dL). However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0345 hours, and returned to the facility at 0750 hours). b. Review of Resident 91's Nurse's Dialysis Communication Record dated 9/5/25, showed Resident 91 left the facility for his dialysis appointment on 9/5/25 at 0400 hours, and returned to the facility at 0830 hours. Review of Resident 91's Vitals Summary dated 9/5/25, showed documentation Resident 91's blood sugar was obtained on 9/5/25 at 0533 hours (measured at 117 mg/dL). However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0400 hours, and returned to the facility at 0830 hours). Review of Resident 91's MAR dated 9/2025 showed documentation Resident 91's blood sugar was obtained on 9/5/25 at 0630 hours (measured at 117 mg/dL) . However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0400 hours, and returned to the facility at 0830 hours). 3. Review of Resident 91's Nurse's Dialysis Communication Record dated 9/8/25, showed Resident 91 left the facility for his dialysis appointment on 9/8/25 at 0400 hours, and returned to the facility at 0840 hours. Review of Resident 91's Vitals Summary dated 9/8/225, showed documentation Resident 91's blood sugar was obtained on 9/8/25 at 0533 hours (measured at 107 mg/dL). However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0400 hours, and returned to the facility at 0840 hours). Review of Resident 91's MAR dated 9/2025 showed documentation Resident 91's blood sugar was obtained on 9/8/25 at 0630 hours (measured at 107 mg/dL). However, Resident 91 was at the dialysis center at this time (Resident 91 left the facility at 0400 hours, and returned to the facility at 0840 hours). On 9/9/25 at 1534 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the above findings. RN 3 verified Resident 91 was at the dialysis center on 9/1, 9/5, and 9/8/25, during the times the facility documented (on the Vitals Summary and MAR) having obtained Resident 91's blood sugar.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment, and help prevent the development and transmission of diseases and infections. * The facility failed to ensure Kitchen Aide 1 performed proper hand hygiene after picking up trash off the floor. * The facility failed to ensure LVN 3 followed the infection control practices during the wound observation for Resident 2. LVN 3 placed Resident 2's right heel on the pillow after cleaning the wound. * The facility failed to ensure the facility staff performed hand hygiene after handling soiled linen. These failures posed the risk of the transmission of communicable diseases to the residents and employees throughout the facility.Findings: 1. Review of the facility's P&P titled Sanitation and Infection Control – Handwashing dated 2018 showed the Food Service workers will keep their hands and exposed portion of their arms clean. Hands must be properly and frequently washed to prevent cross contamination of food supplies or equipment. On 9/10/25 at 0934 hours, during the kitchen observation with the DSS, an observation and concurrent interview was conducted with the DDS and Kitchen Aide 1. Kitchen Aide 1 was observed picking up a small piece of white paper off the floor with her bare hand, touching the lid of the gray trash receptacle, and throwing the piece of paper in the trash receptacle. Kitchen Aide 1 then touched the empty metal cart. Kitchen Aide 1 was not observed washing her hands after touching the floor and the trash receptacle. Kitchen Aide 1 and the DSS verified the above findings. In addition, Kitchen Aide 1 stated the importance of proper hand washing was to prevent contamination. The DSS stated all the kitchen staff must wash their hands after picking up anything from the floor. The DSS stated the floor was not considered clean. Furthermore, the DSS stated the negative outcome of failing to perform proper hand washing would contaminate the food and kitchen areas. On 9/11/25 at 0944 hours, an interview was conducted with the Administrator and DSS. The Administrator and DSS were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Wound Care revised 1/2025 showed it is the policy for the facility to provide guidelines for the care of wounds to promote healing. To position the resident and place a disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Medical record review for Resident 2 was initiated on 9/8/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 11/25/24, showed Resident 2 had no capacity to understand and make medical decisions. On 9/10/25 at 831 hours, a wound treatment observation for Resident 2 was conducted with LVN 3 and the IP. During the wound treatment observation, LVN 3 was observed cleaning Resident 2's right heel Stage 3 pressure injury with normal saline and gauze. After cleansing the right heel pressure wound, LVN 3 was observed placing Resident 2's right heel on the pillow and performing hand-hygiene. The pillow was observed making direct contact with the wound bed of Resident 2's right heel pressure wound. The IP verified the above findings. LVN 3 was then observed using a dry (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056151	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fullerton, LLC	330 W. Bastanchury Road Fullerton, CA 92835

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gauze to pat dry the right heel pressure wound and applying the Thera Honey gel to the right heel wound bed. On 9/10/25 at 0909 hours, an interview was conducted with LVN 3. LVN 3 stated after cleaning the resident's wound bed, if the wound touched anything in the resident's environment, the wound should be cleansed again to ensure a clean environment for the wound bed prior to the administration of the medication. On 9/10/25 at 0942 hours, an interview was conducted with the IP. The IP stated for the residents with wounds, the goal was for the wounds to not have any infections. The IP stated when providing wound treatments, after the wound bed was cleaned, the wound should be kept clean prior to the application of the topical treatments. The IP further stated if the wound was observed touching the bed or linen, the treatment nurse was expected to cleanse the wound again to prevent any possible infection. On 9/11/25 at 1248 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 1/2025 showed the facility considers hand hygiene the primary means to prevent the spread of infection. On 9/9/25 at 1128 hours, during the observation in the hallway in front of Room A, the Activity Assistant was observed going into Room A. The Activity Assistant was observed taking the soiled linen with her bare hand from Resident 14, who was standing in the room. The Activity Assistant then took the soiled linen to Shower Room A and went back to the Activity Room without washing or sanitizing her hands. On 9/9/25 at 1130 hours, an interview was conducted with the Activity Assistant. The Activity Assistant verified she did not perform hand hygiene after taking the soiled linen to Shower Room A. On 9/10/25 at 1526 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the facility staff were supposed to perform hand hygiene after handling soiled linens. On 9/11/25 at 0919 hours an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 21 final sampled residents (Resident 43) was revised to reflect the resident's current care needs and interventions. * The facility failed to revise Resident 43's long-term care plan addressing the resident's high risk for fall when Resident 43 sustained a fall on 8/7/25. This posed the risk of not providing Resident 43 with an individualized and person-centered care.Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Plans revised on 4/2025 showed the assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of the facility's P&P titled Care Plan revised on 1/2025 showed the following:- Long term care plan: this is a problem or concern of the residents that has been ongoing for longer periods of time;- A short-term problem that has been noted twice should be included in the long-term care plan;- The resident care plan is developed within seven days upon resident's admission, reviewed quarterly, annually or as often as needed as there is a change of condition; and- The evidence of a care plan that has been reviewed should include but not be limited to the new interventions that have been added in addition to the current ones. These interventions should be in chronological order as implemented or carried out. Medical record review for Resident 43 was initiated on 9/10/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 12/31/24, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's MDS assessment dated [DATE], showed Resident 43's BIMS score was nine, indicating moderate cognitive impairment. Further review of Resident 43's medical record showed Resident 43 had a recent fall on 8/7/25. However, review of Resident 43's plan of care revised 7/15/25, failed to show the resident's long-term care plan addressing the resident's high risk for fall reflected the resident's recent fall on 8/7/25. On 9/10/25 at 1445 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 43's plan of care. RN 1 verified Resident 43's long term care plan addressing the resident's high risk for fall was not revised to reflect the resident's fall episode on 8/7/25. RN 1 stated for new fall episodes, the licensed nurses must revise the residents' long-term care plan. On 9/10/25 at 1520 hours, an interview and concurrent medical record review was conducted with the MDS Assistant. The MDS Assistant reviewed Resident 43's plan of care and verified Resident 43's long-term care plan addressing the resident's high risk for fall was not revised to reflect the resident's recent fall episode on 8/7/25. The MDS Assistant stated she did not revise Resident 43's long-term care plan when the resident had a fall episode on 8/7/25. The MDS Assistant stated the negative outcome for not revising the resident's care plan would result in not having the current recommendations from the resident's recent fall episode. Furthermore, the MDS Assistant stated when revising the long-term care plan addressing the residents' risk for fall, the licensed nurses must add the new interventions and recommendations from the physician to prevent future falls. On 9/11/25 at 0944 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.