STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fillmore, LLC	118 B Street Fillmore, CA 93015

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility staff failed to maintain privacy and right for one of 19 residents sampled (Resident 1) on Enhanced Barrier Precautions (EBP an infection control strategy in nursing homes) inicated by foley catheter (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine) and G-tube (gastrostomy tube - a flexible tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications) when care was provided in the activity room in presence of other resdients. This facility failure has the potential to lead to resident's decline in mental health and a decline in overall physical well-being During an observation on 3/18/26 at 4:00 p.m., in the dementia care unit activity room. Licensed Vocational Nurse (LN 1) and Certified Nurse Assistant (CNA 3) were observed providing tube feeding to Resident 1 and there were no privacy practices provided to the resident observed during the procedure. A review of the medical record for Resident 1, dated 2/18/26, revealed physician orders for Enhanced Barrier Precautions (EBP) indicated by foley catheter and G-tube every shift. During an interview with Director of Nursing (DON) on 03/18/2026 at 5:35 p.m., DON indicated, that infection control practices (EBP) and dignity must be practiced for all residents, including protecting bodily privacy during treatment procedures. During a review of Policies and Procedures (P&P) titled Dignity dated 01/2026, the P&P inidicated in part, 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure information regarding a Physician Orders for Life-Sustaining Treatment (POLST-physician orders indicating the patient's wishes during a medical crisis, such as cardiopulmonary resuscitation [CPR], and/or artificial nutrition/hydration [receiving food and water through a tube], was provided to one of nineteen sampled residents (Resident 3) or the legally recognized decisionmaker. This failure results in the unsigned POLST to be invalid and had the potential to cause uncertainty among healthcare staff regarding the resident's personal preferences with end of life care.During review of Resident 3's Physician Orders for Life-Sustaining Treatment (POLST) form dated 2/11/23, the POLST indicated orders to Attempt Resuscitation/CPR, full treatment, and use of long-term artificial nutrition including feeding tubes. The POLST was marked to indicate the information was discussed with the resident and that there was no advance directive. The POLST was signed and dated 2/11/23 by the physician, listed the name of Resident 3's sister as the legally recognized decisionmaker however it was not signed by the resident or sister. During review of Resident 3's comprehensive Minimum Data Set (MDS - a federally mandated, standardized clinical assessment tool used to evaluate the functional capabilities, health needs, and care requirements of residents) dated 1/5/26, the MDS indicates Resident 3 has a BIMS score (Brief Interview for Mental Status - a 0-15 point tool used to assess cognitive function, covering memory, orientation, and recall. Scores are categorized into three levels: 13-15 = Intact Cognition, 8-12 = Moderate Impairment, and 0-7 = Severe Impairment) of 15. During a concurrent interview and review on 3/18/26 at 2:00 p.m. with Registered Nurse Supervisor (RNS), Resident 3's POLST was reviewed. RN Supervisor acknowledged the POLST was not signed by the resident or the resident's representative. During a review of the facility's policy and procedure (P&P) titled, Physician Orders for Life Sustaining Treatment (POLST) or Request Regarding Resuscitative Measures Form, dated -1/2025, the P&P indicated in part, . A health care provider shall explain the form and medical intervention and procedures offered on the form. This shall be completed by the healthcare provider based on patient preferences and medical indications. This form must be signed by a physician and the patient or his/her legally recognized health care decision maker.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information to one of nineteen sampled residents (Resident 37) about a bed-hold (a reservation that allows one to stay in, or return to, a care facility) when Resident 37 was transferred to a hospital. This failure had the potential of Resident 37 not being fully informed of their right to request a bed hold and to return to the facility after hospitalization, potentially leading to an inappropriate discharge. (I am not sure, if we can write this because the both hospital SNF know about the 7 day hold and there was no outcome. If resident was interviewed and they complaint about an issue with the document not being given)Review of an online article published by the California Advocates for Nursing Home Reform (CANHR) titled, Nursing Home Residents Have The Right To A 7-Day Bed Hold When hospitalized , dated May 2018, indicates in part, .In addition to including information about bed-hold policies in the admissions agreement, the facility must give a written bed-hold notice to the resident and/or the resident's family upon being transferred to the hospital, as is required by both federal law and state regulations .(https://canhr.org/nursing-home-residents-have-the-right-to-a7-day-bed-hold-when-hospitalized /) During a review of Resident 37's Progress Notes (PN), dated 10/11/25, the P&P indicated, Resident 37 was drowsy, had signs of unusual weakness, a low oxygen saturation level, and an elevated heart rate and temperature. The resident was transferred to the hospital. Further evaluation at the hospital indicated the resident had a kidney infection. Resident 37 was discharged to the facility on [DATE]. Review of Resident 37's Bed Hold Notification, dated 2/3/23, indicates the resident signed the document on admission but the section titled To be Completed upon Transfer was blank. During an interview on 3/19/26 at 4:04 p.m. with Registered Nurse Supervisor (RNS), RNS was asked about Resident 37's hospital transfer form. RNS stated that nurses send residents to the hospital with a copy of the face sheet and a list of their medications. When asked about the information provided to Resident 37 regarding the bed hold policy, RNS stated that residents are informed of the bed hold policy during the admission process and that those records were kept with medical records. During a review of the facility's policy and procedure (P&P) titled, Bed Hold Notice, dated 7/2025, the P&P indicated, It is the policy that this facility shall inform the resident, or the resident's representative, in writing of the right to exercise the bed hold provision under the State Plan (7 days for California), at the time of admission, and at the time of transfer for hospitalization or therapeutic leave.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to resubmit a Preadmission Screening and Resident Review (PASRR - a tool to determine if the person had or was suspected of having a mental illness or intellectual disability) for two out of nineteen sampled residents (Resident 5 and Resident 45) when the residents were diagnosed with a new mental illness. This failure had the potential to result in Resident 5 and Resident 45 to not receive the appropriate medical services for their mental illness diagnoses.During review of Resident 5's medical records, the admission Record (AR), dated 5/13/25, indicated Resident 5 was admitted with a diagnosis of paranoid schizophrenia (intense, irrational delusions and auditory hallucinations, often involving themes of persecution or conspiracy, feeling watched, followed, or plotted against, that leads to severe anxiety [feeling of fear, dread, or uneasiness], social withdrawal, and potential agitation). Resident 5's medical record showed a level I PASRR on 5/2/25 and was determined that a level II PASRR was not required.After Resident 5 was admitted , the resident was diagnosed with anxiety on 7/26/25 (after admission), post-traumatic stress disease (PTSD - re-experiencing flashbacks, nightmares, and frightening thoughts of a terrifying event) on 9/10/25, and unspecified psychosis (hallucinations, delusions, disorganized thinking, or behavior that is not attributable to a substance or known medical condition) on 10/1/25. Resident 5's Order Summary (OS), indicated Zyprexa (an antipsychotic medication used to manage hallucinations, delusions, and mood) was started on 10/17/25. A repeat PASRR was not re-submitted. During review of Resident 45's AR dated 7/6/24, the AR indicated the resident was originally admitted on [DATE] with diagnoses that included anxiety and unspecified psychosis. A PASRR level I was completed 2/16/24 and a level II PASRR was not required. Resident 45's care plan was updated on 10/20/25 for psychosocial wellbeing problems/needs related to anxiety. Review of Resident 45's order summary indicated the resident was started on 0.5 mg (milligrams - metric unit of mass) of Trazadone (an antidepressant medication widely used off-label to treat insomnia due to its sedating effects, and sometimes for depression, anxiety, or PTSD-related nightmares). A new PASRR was not initiated after the resident's care plan was updated or after starting Trazadone. During a concurrent interview and review on 3/19/26 at 11:54 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 5's and Resident 45's PASRR's were reviewed. MDSC stated that PASRR's are resubmitted when a resident has been hospitalized for a prolong period of time or when there is a significant change in mental status or a cognitive decline. MDSC stated a repeat PASRR is not repeated when a resident is prescribed psychotropic drugs (chemical substances that change brain function, resulting in alterations in perception, mood, consciousness, or behavior) or if diagnosed with a new mental disease diagnosis. After reviewing Resident 5's and Resident 45's admission records, order summaries and care plans, MDSC acknowledged the residents did not have repeat PASRR's after changes with their mental conditions. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Annual Resident Review (PASARR), dated 4/2024, the P&P indicates in part, . The purpose of this policy is to define and set expectations regarding the appropriate pre admission assessment of all individuals with a mental disorder and individuals with intellectual disability. It is the policy of the facility to coordinate the assessment process with the Pre admission Screening and Annual Resident Review program (PASARR) under Medicaid and Subpart C to the extent practicable to avoid duplicative testing and effort. This includes incorporating the recommendations from the PASARR level II determination and evaluation in the residents assessment, care plan, and transition of care; and referring all level II residents and all residents with new or evident conditions related to Level II review upon significant change in status assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, facility staff failed to ensure a care plan (CP - written document that outlines the specific nursing interventions and goals for a patient's care, based on their assessed needs and diagnoses) pertaining to noncompliance with dialysis was reviewed, evaluated for effectiveness, and revised accordingly for one out of the nineteen sampled residents (Resident 3). This deficient practice has the potential to place Resident 3 at significant risk for hospitalization, severe cardiovascular events, and even death due to unmet medical needs.During a review of Resident 3's Order Summary (OS), 3/20/26, the OS indicates, Resident #3 goes to dialysis every Tuesday, Thursday and Saturday. Review of Resident 3's Progress Notes (PN), dated 12/24/25, 1/3/26, 1/8/26, 1/17/26, 1/20/26, 1/27/26, 2/5/26, 2/28/26, and 3/19/26 indicate the resident refused to go to dialysis. During a review of Resident 3's Care Plan (CP), dated 5/15/24, the CP indicates the resident is at risk for complications related to refusing to go to dialysis. During a concurrent interview and review on 3/20/26 at 9:25 a.m. with Minimum Data Set nurse (MDS), Resident 3's care plan for dialysis non-compliance was reviewed. MDS stated the resident had a pattern of not wanting to go to dialysis. When MDS was asked what changes or revisions had been done to Resident 3's noncompliance with dialysis, MDS was unable to verbalize or provide documentation indicating Resident 3's CP interventions were evaluated and revised based on the resident's pattern of refusing to attend dialysis treatments. MDS acknowledged Resident 3's care plan interventions for dialysis noncompliance were not revised although the resident continued to be non-compliant. During a concurrent interview and review on 3/20/226 at 9:45 a.m. with Registered Nurse Supervisor (RNS), Resident 3's CP for dialysis noncompliance was reviewed. RNS stated that resident CP's are reviewed by the MDS nurse and are updated depending on the resident's current status at the time of MDS assessment and lookback period. RNS further stated that interventions should be reevaluated by the target date. RNS acknowledged that Resident 3's CP interventions should have been discussed with the interdisciplinary team (IDT - a group of professionals from different disciplines who work collaboratively to provide patient-centered care) and revised if the interventions are determined to be ineffective or not working. During review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 4/2024, indicates A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.The interdisciplinary team reviews and updates the care plan:.when the desired outcome is not met.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, intervview and facility policcy and procedure, the facility failed to ensure timely wound assessment assessment was done for one of nineteen sampled residents (Resident 7) when there were no documentation to show track changes in size, tissue type, moisture levels, and infection signs, on certain weeks.This failure had the potential to affect treatment plans and delay healing.During a review of Resident 7's admission Record (AR) dated 3/20/26, the AR indicated that Resident 7 is a [AGE] year-old male who was initially admitted to the facility on [DATE], current diagnoses includes, Acute Respiratory Failure with Hypoxia (condition where the respiratory system fails to oxygenate the blood properly resulting in low oxygen saturation), Pressure Ulcer of Sacral Region stage 4 (full^thickness loss of skin with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone), Abnormal Finding of Blood Chemistry (laboratory values documented as outside the normal reference range), Diarrhea (passage of three or more loose, watery stools per day), Fever (elevated body temperature associated with illness or infection), Pain, Hyperlipidemia (condition characterized by high levels of cholesterol in the blood).During a review of Resident 7's Weekly Wound Assessment (WWA: regular evaluation of a wound's healing progress, typically conducted every 7 days, to track changes in size, tissue type, moisture levels, and infection signs), of right hip skin shear, WWA were documented on 2/18/26, 3/3/26 and 3/10/26. The review indicated that the facility failed to create WWA for the week of 2/25/26.During a review of Resident 7's WWA of left buttock stage 4 pressure injury, WWA were documented on 2/10/26, 2/17/26, 2/24/26 and 3/10/26. The review indicated that the facility failed to create WWA for the week 3/3/26During a concurrent interview and record review of Resident 7's WWA on 3/20/26 at 11:45 a.m. with Infection Preventionist (IP) indicated, that the WWA for right hip skin shear was not initiated on week of 2/25/26 and WWA for left buttock stage 4 pressure injury was not also initiated on week 3/3/26. IP acknowledged that the facility failed to create WWA for right hip skin shear on week of 2/25/26 and WWA for left buttock stage 4 pressure injury on week 3/3/26.During a concurrent interview and record review of Resident 7's WWA on 3/20/26 at 12:07 p.m. with Wound Nurse (WN), indicated, that the WWA for right hip skin shear was not initiated on week of 2/25/26 and WWA for left buttock stage 4 pressure injury was not initiated on week 3/3/26. WN acknowledged that the facility failed to create WWA for right hip skin shear on week of 2/25/26 and WWA for left buttock stage 4 pressure injury on week 3/3/26.A review of facility's policy and procedure (P&P) titled Wound Care, Rev. 01/24 indicated in part. Policy Statement . It is the policy for the facility to provide guidelines for the care of wounds to promote healing. The policy indicated, Documentation.6) All assessment data (i.e., wound bed color, size, drainage, odor, pain, etc.) obtained when inspecting the wound, weekly by the wound nurse/designee.Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 365 in the section titled, Informatics and Documentation, indicated, Documentation is a key communication strategy that produces a written account of pertinent data, clinical decisions and interventions, and patient responses in a health record. Documentation in a patient's health record is a vital aspect of nursing practice.

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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, and record review, the facility failed to ensure:Expired items in the medication storage room were disposed of according to policy and procedures and manufacturer's instructions. Treatment medications and medical supplies in the treatment cart were properly labeled and expired medication and supplies were discarded.The temperature for station 3 medication refrigerator was within acceptable range. These failures had the potential for residents to receive expired medications and and ineffective treatment supplies.1.During a concurrent observation and interview on 3/18/26 at 2:25 p.m. with Registered Nurse Supervisor (RNS), the medications inside the refrigerator located in the respiratory storage room were inspected. A box of Acetaminophen suppositories (a rectal medication used to treat mild pain or fever) had expired on 9/1/25 and a bottle of Acidophilus Probiotic (beneficial bacteria supplements that promote digestive health, enhance immunity, and help maintain healthy gut flora) was opened on 2/10/26 had expired on 3/9/26. RNS confirmed and acknowledged both medications were expired.During a concurrent observation and interview on 3/18/26 at 2:30 p.m. with RNS in the respiratory storage room, the respiratory supplies were found:Mask, Non-Rebreathing Elongated, Adult with Safety Vent and 7 ft. Start Lumen Tubing (expiration date 3/03/26)Sterile Water for Irrigation 500 mL (opened with an expiration date of 7/2025)Piston Enteral Feeding Syringe (expiration date of 12/1/25)Female catheter to female ENFit Adapter (expiration date 2/1/26)Full suction kit (manufacturing date of 7/30/2019 [shelf life of 5 years] expired 7/29/24)Disposable Exhalation Port (dates of manufacture 5/28/20 & 6/2/20, [shelf life of 5 years] expired on 5/27/25 and 6/1/25)Curaplex Nasal Oxygen Cannula, Adult with 7 ft Tubing and Non-Flared Tip (expiration date 9/7/25)Flex Trach Adaptors with expiration dates of 9/30/24 and 11/2/23Emma Airway Adapter Adult/Pediatric (expiration date 8/28/24)[NAME] RCI 25 ft. Star Lumen Tubing (expiration date 2/26/25)Medline Tracheostomy Clean and Care Tray (expiration date 10/31/25)RNS confirmed and acknowledged the following supplies made available for use were expired and should be discarded.During a concurrent observation and interview on 3/18/26 at 3:33 p.m. with RNS in station 3 medication storage room, two bottles of Acidophilus Probiotic (beneficial bacteria supplements that promote digestive health, enhance immunity, and help maintain healthy gut flora) opened on 2/1/26 with a 30 day open expiration date of 3/1/26, and a box of Unifine Safe Control (pen needles) with an expiration date 6/25/25 were found. RNS confirmed and acknowledged the following supplies available for use were expired and should be discarded.2. During a concurrent observation and interview on 3/19/26 at 9:27 a.m. with Wound Nurse (WN), Treatment Cart 1 was inspected. WN acknowledged the following supplies were opened and available for use but should be discarded:Thera Calazinc Body Shield (skin barrier protection ointment) was opened; package indicates single use only.100 mL bottle of normal Saline, dated 3/18/26 was half empty and that the package label indicates do not reuse.SkinTegrity ECO hydrogel (a clear, non-oily wound dressing containing glycerin and aloe designed to maintain a moist environment for healing dry to minimally exudating wounds) with open date of 2/3/26.During a concurrent observation and interview on 3/19/26 at 9:37 a.m. with RNS, treatment cart 1 supplies were inspected. RNS stated the TheraCalazinc is a one-time use only and should not be in the treatment cart for use once it's been opened; the normal saline was used, no longer sterile and should have been discarded after it was used; and the SkinTegrity ECO hydrogel was opened and was expired since it is only good for 30 days after opening.During a concurrent observation and interview on 03/19/2026 at 9:54 a.m. with Registered Nurse (RN 5), the sub-acute unit treatment cart was inspected. Two ointments of Collagenase Santyl (a prescription medicine that removes dead tissue from wounds so they can start to heal), an Ammonium Lactate cream (a topical medication used to treat dry, scaly skin), and silver (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sulfadiazine (a topical antibiotic used to prevent and treat wound infections) were opened and available for use without an open date recorded. Additionally, a one-time use normal saline irrigation solution bottle of 100 milliters (mL) was partially empty and available for use with an open date of 3/18/26. RN 5 acknowledged the ointments were expired and should be discarded. RN 5 stated the 100 mL normal saline bottle was good for 24 hours.During an interview on 3/19/26 at 10:02 a.m. with Registered Nurse (RN 3), RN 3 was asked what the expiration of 100 mL normal saline bottles is once they are opened. RN 3 stated the bottles expire 24 hours after opening and are used for multiple residents during the 24 hour period.During an interview on 3/19/26 at 4:00 p.m. with Minimum Data Set Nurse (MDSC) who is also responsible for ordering nursing supplies, MDSC acknowledged the 100 mL normal saline irrigation solution bottles must be discarded once the bottle is opened and used on a resident.During a concurrent observation and interview on 3/19/26 at 10:13 a.m. with RNS, station 3 treatment cart was inspected and found to have expired medications and supplies. RNS acknowledged the following should not be in the cart and available for use:Zinc Oxide ointment (a topical medication used to treat and prevent skin irritations, such as diaper rash, minor burns, cuts, and chafing skin) opened on 1/23/26 with a 30 day expiration date ofViaLok Vial access device (a needle-free, sterile, single-use device designed to safely access medication vials) with an expiration date of 10/13/25Two ammonium lactate lotions (a prescription or over-the-counter topical medication used to treat severe dry, scaly skin) with an expiration date of 7/5/25 prescribed for residents that were no longer listed the facility's censusOne-time use normal saline irrigation solution bottle of 100 mLTwo DeCloggers (flexible tubing used to clear obstructed feeding tubes) were opened and had signs of previous use and/or contamination based on the yellowish brown stains on the packaging.During review of the DeClogger instructions for use (IFU), copyright dated 2022, the IFU indicates in part, The DeClogger should be disposed of after a single use.Cross-contamination risk. Do not reuse DeCloggers as this may spread contamination from one patient to another patient. 3. During a concurrent observation and interview on 3/18/26 at 10:31 a.m. with the Wound Nurse (WN) in station 3 storage room, the medication refrigerator temperature was at 56 F (degrees Fahrenheit). The thermometer was clipped on a wire rack inside the middle of the refrigerator door. WN acknowledged the temperature reading was outside of acceptable range. WN immediately contacted the Registered Nurse Supervisor (RNS). RNS acknowledged the temperature was out of range but requested if it can be rechecked a few minutes later since it was within acceptable range previously. During review of the facility's Refrigerator Temperature Log for Station 3, the log indicated for March 1-17, 2026, the temperatures ranged between 37 F - 40 F. During an observation on 3/18/26 at 11:49 a.m. with RNS, the station 3 medication refrigerator temperature was rechecked and found to be at 46 F. RNS acknowledged the temperature was outside acceptable range and stated the temperature was dropping. RNS stated the electrical cord was not plugged in all the way into the electrical socket when it was checked earlier and asked if the temperature could be rechecked again while the refrigerator continued to stabilize. During an observation on 3/18/26 at 2:05 p.m. with RNS, the temperature for station 3 medication refrigerator was rechecked. The thermometer was located inside the freezer with a temperature of 24 F. RNS acknowledged the temperature was out of range and that the thermometer should not be placed in the freezer. RNS denied knowing who had moved the thermometer that was previously hanging on the inside of the refrigerator door. During a concurrent observation, interview, and record review on 3/19/26 at 8:24 a.m. with Registered Nurse (RN 4) in station 3 medication storage room, RN 4 acknowledged the refrigerator temperature was observed to be at 40 F. Station 3 Refrigerator Temperature Log, dated March 2026, was reviewed. RN 4also acknowledged the refrigerator's temperature was not recorded on 3/18/26. During a concurrent observation and interview on 3/19/26 at 2:08 p.m. with RN 4, the station 3 medication storage refrigerator was observed to be at 42 F. RN 4 stated new medication for the resident's was ordered overnight from the pharmacy.During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure on Expiration Date of Central Supplies, dated 7/2025, indicates in part, Policy: To (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fillmore, LLC	118 B Street Fillmore, CA 93015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure potency of all medical supplies, expiration date is being monitored. Procedure: The following strategies will be done to achieve the goal. 1. The central supply personnel assigned check the items in the central supply room under the supervision of the licensed nurse every two weeks. 2. Licensed nurses will check for the expiration date of any supplies they get from the central supply before its usage. 3. The pharmacy consultant will check the medication cart for any expired medication for destruction of for immediate reordering. 4. The QA will check the supplies in the central supply room monthly during their consulting visit.During a review of the facility's policy and procedure (P&P) titled, Administering Topical Medications, dated 7/2025, the P&P indicates in part, The purpose of this procedure is to provide guidelines for the safe administration of topical medications.Check the expiration date on the medication. Return any expired medications to the pharmacy. During a review of the facility's policy and procedure (P&P) titled Policy and Procedure On Medication Refrigerator Temperature, dated 1/2025, indicates in part, Policy: Per regulations, the medication refrigerator temperature range should be between 36 Fahrenheit and 46 Fahrenheit. Procedure: 1. Check the temperature before using the medication in the refrigerator. 2. Report to your supervisor or the DON immediately if the temperature is out of range and for immediate repair as needed. 3. Please document the temperature once per day every night shift and indicate the time and initial.

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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 and record review, the facility failed to maintain essential kitchen equipment on the ice machine clean and in safe operating condition. This failure has the potential to expose residents to contaminated ice and increased risk for food related illnesses. During an observation and insepction of the ice machine on 03/18/26 at 2:36 pm at the kitchen, a white tissue test was performed on the lower bin made of stainless steel inside the ice machine. After wiping the base of the bin, the white tissue contains a minimal amount of greyish-black residue. Repeating the procedure further back into the bin also showed minimal greyish residue. The Dietary Manager (DM), Maintenance Representative (MR) and Dietician (DIET) validates the findings. During an interview with the MR, MR states that he had cleaned the parts of the ice machine and inspects water flow where mineral scale or limescale build up occurs. MR verbalized he must have missed cleaning the other parts of the ice machine. During a review of the manufactures' manual, titled Ice-O-Matic dated 01/14, the Ice-O-Matic Service and Installation Manual indicated in part ICE Machine Cleaning and Sanitizing Instructions: Cleaning Stainless Steel: 1. Clean the stainless steel thoroughly once a week. Clean frequently to avoid build up of hard stubborn stains. Also, hard water stains left to sit can weaken the steel's corrosion resistance and lead to rust. During a review of the FDAFCA, dated 2022, the FDAFCA indicated, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. The objective of cleaning focuses on the need to remove organic matter from foodcontact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. (FDA Food Code Annex; 4-601.11).During a review of Policies and Procedures (P&P) titled Ice Machine Cleaning Procedure, undated, the Ice machine Cleaning Procedure indicated in part,3. Clean the inside of the machine with a sanitizing agent per the manufacturer's instructions. 5. Be sure special attention is paid to cleaning the door molding and lid of the machine.

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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** Facility failed to practice infection control when: 1. appropriate Personal Protective Equipment (PPE: clothing and equipment used in order to provide protection against hazardous substances or environments) for enhanced barrier precautions (EBP: an infection control strategy for nursing homes requiring staff to wear gowns and gloves during high contact care of residents) was not worn for two residents, Resident 1 and Resident 2.2. respiratory tubes were not changed in a timely manner for Resident 25 and 3. the facility failed to discard open or used saline bottles found in medication carts and de-cloggers (a flexible, threaded rod used to restore the patency [openness] of obstructed enteral feeding tubes). This failure had the potential to expose residents for further infection and contamination. 1.During a concurrent observation and interview on 3/18/26 at 10:31 a.m. with Licensed Vocational Nurse (WN), WN was observed performing a blood sugar check without wearing a gown on Resident #2 who was on EBP. WN stated only gloves were required because performing a blood sugar check was not a high contact care process. During an interview on 3/18/26 at 11:35 a.m. with the Infection Control Nurse (IP), IP stated any direct contact with a resident on EBP requires mask, gloves and gown. 3. During a concurrent observation and interview on 03/19/2026 at 9:54 a.m. with Registered Nurse RN 5, the sub-acute treatment cart was inspected. A normal saline irrigation solution bottle of 100 mL was partially empty and available for use inside the cart with an open date of 3/18/26. RN 5 agreed the label on the bottle indicates Do Not Reuse and then stated the bottle was good for 24 hours according to the facility nurse consultant. During an interview on 3/19/26 at 10:02 a.m. with Registered Nurse (RN 3), RN 3 was asked what the expiration of 100 mL normal saline bottles is once they are opened. RN 3 stated the bottles expire 24 hours after opening and confirmed the bottles were used for multiple residents during the opened 24 hour period. During an interview on 3/19/26 at 4:00 p.m. with Minimum Data Set Nurse (MDSC) who is also responsible for ordering nursing supplies, MDSC acknowledged the 100 mL normal saline irrigation solution bottles must be discarded once the bottle is opened and used on a resident. During a concurrent observation and interview on 3/19/26 at 10:13 a.m. with RNS, station 3 treatment cart was inspected and found to have open one-time use supplies available for use. RNS acknowledged the following should not have been available for re-use: One bottle of normal saline irrigation solution 100 mL with an open date of 3/18/26 Two DeCloggers were opened and had signs of previous use and/or contamination based on the yellowish-brown stains on the packaging. During review of the DeClogger instructions for use (IFU), copyright dated 2022, the IFU indicates in part, The DeClogger should be disposed of after a single use.Cross-contamination risk. Do not reuse DeCloggers as this may spread contamination from one patient to another patient. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 3/17/26 at 2:49 p.m. inside the room of Resident 25, the oxygen tubing was observed labeled 3/4, indicating the last date it had been changed. During an interview on 3/19/26 at 4:20 p.m., RN 2 stated that oxygen tubing is changed every Sunday, once per week. During a concurrent observation and interview on 3/20/26 at 10:04 a.m. with RN 3 in Resident 25's room, the oxygen tubing was labeled 3/18, indicating a different change date. The picture taken on 3/17/26 showing tubing labeled 3/4 was shown to RN 3. RN 3 confirmed that tubing should be changed weekly per facility policy and acknowledged that failure to do so could increase the risk of infection. During a concurrent interview and record review on 3/20/26 at 10:10 a.m. with RT 1 in the hallway near room [ROOM NUMBER], the picture of the oxygen tubing labeled 3/4 was shown to RT 1. RT 1 acknowledged that the oxygen tubing had not been changed in a timely manner. A review of the facility's policy and procedure titled Oxygen Therapy, Rev. 09/2012, indicated in part: Policy Statement. It is the policy of this facility that oxygen therapy is administered as ordered by the physician or as an emergency measure until the order can be obtained. The policy indicated, Procedures. 10) Oxygen tubing is to be replaced every week. Oxygen masks or nasal prongs are to be replaced every week. Oxygen concentrator filter is to be cleaned every week and replaced as needed secondary to wear and tear or other form of defect. Findings: Resident 1 was undergoing G-Tube (equipment used to deliver food or nutrition safely) feeding at the activity center with staff not wearing appropriate PPE. During a review of medical record of Resident 1, Resident 1 has orders dated 02/18/26 for EBP inicated by foley catheter and G-tube every shift. During an observation on 03/18/2026 at 4:00 pm on Resident 1, at the activity room of the dementia care unit, LIcensed Vocational Nurse (LVN)1 and Certified Nurse Assistant (CNA) 3 were providing tube feeding on Resident 1 wearing gloves but not he appropriate protective equipment. During an interview on 03/19/2026 at 9:00 AM at the nurses' station of the dementia unit with CNA 4 and CNA 5, CNA 4 and CNA 5 state that when providing care of Resident 1, we would bring Resident 1 back to the room and wear appropriate PPE. During an interview on 03/18/26 at 5:35 pm with the Director of Nursing (DON) the DON validates that infection control practices and dignity must be practiced for all residents. During a review of Policies and Procedures (P&P) titled Enhance Barrier Precations dated 2024, the Enhance Barrier Precautions indicated in part, 3. EBP are to be implemented in addition Standard Precautions when other transmissio-based precautions do not apply when facility identies any resident with c. ii urinary catheters; iii feeding tubes. 4b. PPE is required for all staff providing high contact resident care activities to include i. gown and gloves with 7. Device caare or use:central line, urinary catheter, feeding tube, tracheostomy/ventilator.