

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Greenfield Care Center of Fullerton, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 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</p>		