STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. Building B. Wing	07/15/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40849 Based on observation, interview and record review, the facility failed to protect three of the three residents (Residents 1, 2 and 3) from physical abuse, when it did not provide supervision to one resident (Resident 1), who was ambulatory and with a history of physical aggression. This failure resulted in Resident 2's facial cut and bruising, and feeling of not being safe in the facility, and Resident 1's cut in the forehead. Findings: During a review of Resident 1's, Minimum Data Set (MDS-assessment tool of health status for all residents in long term care facilities), dated 7/24/20, it indicated Resident 1 had highly impaired hearing, absence of spoken words and was independent of Activities of Daily Living, which included walking in room, corridor and unit. During a concurrent observation and interview on 12/7/20 at 9:10 a.m., with Resident 2 in the dining room, Resident 2 did not have a visible wound or bruising on his face. Resident 2 stated he was sitting on his wheelchair outside the dining hall when Resident 1 hit him in the face. Resident 2 stated he did not say or do anything to Resident 1 before he was hit. Resident 2 stated, he felt, stupid because he did not, fight back. Resident 2 stated he did not, feel safe staying in the facility. During a review of Resident 2's, Progress Notes, dated 11/20/20 at 12:35 p.m., it indicated Resident 2 had a linear cut to his lower left jaw measuring 3.5 cm (centimeters), bruising to the right orbital and bruising and swelling to the left orbital. During an interview on 12/7/20 at 9:43 a.m., Resident 3 stated Resident 1 took a picture of him on his phone while he was outside in the smoking area. Resident 3 stated, days before the incident, Resident 1 was taking pictures of residents and showing them to, anybody and making gestures like the, gun and motioning his hand across his neck. Resident 3 stated he went inside the dining hall and pointed to Resident 1's phone, and Resident 1 raised his arm to hit him, so he [Resident 3] grabbed Resident 1 and started fighting, and they both fell on the floor. During an interview on 12/7/20, at 12:35 p.m., Licensed Staff F stated, Resident 1 had a tiny cut on the forehead from the fight. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/7/20, at 10:29 a.m., Licensed Staff C stated Resident 1 did not like certain staff members and, motioning spraying, thinking that staff were, poisoning him. Licensed Staff C stated, Resident 1 was monitored for, aggressive behavior and, inappropriate behavior. During an interview on 12/7/20 at 11:27 a.m., Management Staff E stated Resident 1 had a history of being violent when Resident 1 hit one staff member previously. Management Staff E further stated, if Resident 1 did not like the person, he would gesture his hand in front and across his neck and motion with his hand, gun. Review of Resident 1's, Care Plan for pushing another resident, dated 7/17/20, indicated Resident 1, apparently pushed another resident when victim attempted to open bedroom door. Resident 1 was, in another resident's room watching television. A care plan for unpleasant behavior, dated 3/31/20, indicated Resident 1, showing unpleasant behavior (getting in staff members' face, barely sleeping, using other residents' bathroom). A care plan for taking pictures, dated 4/9/20, indicated, .took a picture of one of the staff and pointed to the picture and gestured to cut the throat of the staff in the picture. Doing gesture to cut the throat of the Administrator and DSD (Director of Staff Development) and staff at risk for safety issues. A care plan for possible altercation, dated 7/18/20, indicated, possible altercation, Resident 1 tried to enter room [ROOM NUMBER]. Review of Resident 1's, Progress Notes, dated 11/22/20 at 9:21 a.m., indicated Resident 1 pushed Licensed Staff F, took away a bottle of medicine from Licensed Staff F and threw it on the floor. During an interview on 1/5/21, at 11:39 a.m., Management Staff G stated, a one-on-one sitter for Resident 1 was discussed as an intervention, but the staff members were, not comfortable doing it. Management Staff G stated staff members, were afraid of Resident 1's, outburst. Management Staff G stated the facility decided on every 30 minutes' monitoring of Resident 1's whereabouts instead of every 15 minutes' monitoring. Management Staff G stated it was, quite excessive for every 15 minutes' monitoring on top of what the staff members were also assigned to do. Review of facility's, Abuse and Neglect Prevention Management, policy and procedure, with revised date, 12/2014 indicated, Prevention-C. The facility staff promotes an altercation free culture through, c. Supervision.

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F 0656 Level of Harm - 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. 40849 Based on interview and record review, the facility failed to provide psychosocial care needs for two of three residents (Residents 1 and 2) when: 1. The facility did not develop a plan of care for Resident 2 after an altercation, and; 2. The facility did not implement a resident-to-resident altercation care plan for Resident 1. This failure resulted in: 1. Resident 2 being unable to discuss how he felt after the physical altercation. 2. Resident 1's second physical altercation with another resident (Resident 3). Findings: 1. During a review of Resident 2's, Progress Notes, dated 11/20/20, it indicated Resident 2 was, sitting on a wheelchair when another resident came up to him and hit him in the face three times. During a concurrent observation and interview on 12/7/20 at 9:10 a.m., with Resident 2 in the dining room, Resident 2 did not have a visible wound or bruising on his face. Resident 2 stated he was sitting on his wheelchair outside the dining hall when Resident 1 hit him in the face. Resident 2 stated he did not say or do anything to Resident 1 before he was hit. Resident 2 stated he felt, stupid because he did not, fight back. Resident 2 stated he did not, feel safe staying in the facility. Resident 2 stated, nobody talked to him about how he felt after being hit in the face. During an interview on 12/7/20, at 1:06 p.m., Management Staff G stated Management Staff H met with Resident 2 for, psychosocial visits. During an interview on 12/7/20, at 1:57 p.m., Management Staff H stated she did not have documentation of whether she spoke to Resident 2 about the incident, and she did not do a one-on-one visit or follow-up with Resident 2 after he was hit in the face. During an interview on 12/7/20, at 1 p.m., Licensed Staff A stated there was no care plan for the physical altercation incident for Resident 2. Licensed Staff A stated she forgot to make a care plan. 2. During a review of Resident 1's care plan dated, 11/20/20, it indicated, Goal-Resident will not exhibit another resident-to-resident altercation in 30 days if possible, for 90 days. Interventions-SSD (Social Service Designee) will make frequent room visits x2 every shift and provide relief from any psychosocial distress. During a review of Resident 1's, Progress Notes, dated 11/20/20 thru 12/3/20, they did not show documentation the SSD provided psychosocial visits to Resident 1. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes, dated 11/22/20 at 4:07 p.m., they indicated, resident was in an altercation with another resident. Review of facility's, Abuse and Neglect Prevention Management, policy and procedure, with revised date, 12/2014, indicated, Incident Management- The facility system to follow up on altercations will place an emphasis on preventing future altercations. This system includes, but is not limited to: -Resident's communications and functional mobility, with consideration of proactive strategies. -A multidisciplinary approach to the development of individualized behavior care plans, including social services, recreational activities, and external consultations. -Interventions for all parties that could be involved in altercations.