| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055189 | A. Building<br>B. Wing | 11/08/2021 |

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

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40849<br><br>Based on interview and record review, the facility failed to implement its policies and procedures to address resident care needs to one of the six residents (Resident 1) who had wandering behaviors. This failure resulted in Resident 1 not having a plan of care for wandering/elopement, upon admission.<br><br>Findings:<br><br>During a concurrent interview and record review on 11/3/21, at 10:21 a.m., with Unlicensed Staff G, Resident 1's medical records were reviewed. The medical records indicated Resident 1 was admitted to the facility on [DATE], and there was no documentation of an elopement assessment. Unlicensed Staff G stated it was the practice of the facility for all residents to have an elopement assessment upon admission. Progress notes, dated 10/22/21, indicated Resident 1 went missing around 6:15 p.m., and was found in another facility across the street.<br><br>During an interview on 11/3/21, at 10:34 a.m., Management Staff D stated an elopement assessment was part of the admission assessment. Management Staff D stated she did not know why Resident 1 did not have an elopement assessment upon admission.<br><br>A review of the facility's, Admission Assessment, policy and procedure, dated 11/2012, it indicated, 1. Upon admission, resident will be assessed for basic needs and services necessary for the resident to attain or achieve his/her highest practicable well-being.<br><br>A review of the facility's, Wandering Resident Alarm Band Management, policy and procedure, dated 7/2014, it indicated, 1. All residents will be assessed for risk of elopement upon admission .<br><br>A review of the facility's, Elopement Risk Precautions and Procedures, policy and procedure, dated 1/2013, it indicated, 1. Obtain information during pre-admission or admission conferences with the resident and or family regarding any history of exit seeking/ or the potential for elopement. |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>40849<br><br>Based on interview and record review, the facility failed to provide needed care to one of the six residents (Resident 1) with a Wanderguard bracelet (monitoring device for residents who are at risk of wandering, ensuring the alarm is activated), who was able to leave the facility undetected. This failure had the potential to result in Resident 1's unmet needs and failure to prevent a potential recurrence of his elopement.<br><br>Findings:<br><br>During an interview on 11/3/21, at 4:23 p.m., Licensed Staff H was asked if staff monitored the use and functionality of Wanderguard bracelets for each resident using them. Licensed Staff H stated monitoring was documented in the MAR (Medication Administration Record) by clicking, yes or no, but, truthfully, it did not happen. Licensed Staff H stated they did not check the Wanderguard bracelet if it was on the residents' ankle or not, or if it was working. Furthermore, Licensed Staff H was asked if she knew how Resident 1 got out of the facility, and she stated, Resident 1 might have used A-wing door near the kitchen.<br><br>A review of the facility's, Wandering Resident Alarm Band Management, policy and procedure, dated 7/2014, it indicated, 3. Facility uses multi-faceted approaches to assure resident safety: a. Environmental such as but not limited to: i. Alarmed doors, ii. Alarmed bracelets .<br><br>During an interview on 11/3/21, at 11:11 a.m., Management Staff D and Management Staff E were asked how Resident 1, while wearing a Wanderguard bracelet, left the facility undetected, and if they find out which door was used. Management Staff D stated Resident 1 may have used A-wing door. When Management Staff D and Management Staff E were asked if they investigated the root cause of Resident 1's elopement, they did not reply.<br><br>A review of the facility's, Elopement Risk Precautions and Procedures, policy and procedure, dated 1/2013, it indicated, 11. The medical record will also reflect an analysis of the events leading up to the elopement and interventions to prevent occurrence.<br><br>During an interview on 11/3/21, at 1:42 p.m., Management Staff E was asked if they reported Resident 1's elopement to the police. Management Staff H stated she, missed notifying the police for the elopement incident.<br><br>A review of the facility's, Policy and Procedure on Unusual Occurrence, dated 7/2012, it indicated, Procedure .3. The verbal report will be accompanied by written report to the same agency or any agency as mandated where unusual occurrences should be reported, such as ombudsman, police department and the like. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>40849<br><br>Based on observation, interview and record review, the facility failed to implement infection prevention and control practices, when six staff did not screen for Covid-19, prior to start of shift. This failure could result in undetected spread of Covid-19 (disease caused by a virus called SARS-Cov-2 which spreads when an infected person breathes out droplets containing the virus) infection among residents and staff in the facility.<br><br>Findings:<br><br>During an interview on 11/3/21, at 8:25 a.m., Unlicensed Staff I stated her work started at 6 a.m., and she was assigned to screen all staff and visitors entering the facility.<br><br>During an interview on 11/3/21, at 12:11 p.m. and 12:23 p.m., Housekeeping Staff F stated she used A-wing door to enter the facility in the morning at 5 a.m., for work. Housekeeping Staff F stated some CNAs (Certified Nursing Assistants) also entered thru the A-wing door in the morning, around 5:30 a.m. Housekeeping Staff F was asked about Covid-19 screening prior to start of shift, and she stated she was not familiar with Covid-19 screening. Housekeeping Staff F further stated, [Unlicensed Staff I] took her temperature around 6 a.m., and asked her questions about Covid-19.<br><br>During an interview on 11/3/21, at 12:17 p.m., and 12:26 p.m., Unlicensed Staff I stated she was told by the previous Administrator that she needed to sign the Covid-19 daily screening tool even though she was not in the building yet. Unlicensed Staff I further stated, she had no idea who screened the staff who came in to work before 6 a.m.<br><br>A review of the facility's, Employee Daily Screening Tool, for Covid-19, dated 11/3/21, it indicated five staff (Housekeeping Staff F, Unlicensed Staff K, L, M and N) came in for work between 4:32 a.m. and 5 a.m., and the screening tool was signed by Unlicensed Staff I who came in at 6 a.m.<br><br>During an observation on 11/3/21, at 1:46 p.m., Unlicensed Staff J was in the nursing station looking for something and few minutes later, she went to the receptionist desk and did her Covid-19 screening.<br><br>During an interview on 11/3/21, at 1:46 p.m., Unlicensed Staff J was asked what time she started her shift and why she did not get screening prior to start of shift. Unlicensed Staff J stated her shift started at 1:30 p.m. , and she did not screen for Covid-19 because she was in a, hurry to get, something.<br><br>During an interview on 11/3/21, at 1:58 p.m., Management Staff D and E, and Licensed Staff B were asked about staff screening for Covid-19 prior to start of shift. Licensed Staff B stated all staff knew they needed to be screened prior to start of shift. Management Staff D stated NOC (nocturnal-night) shift licensed nurses should screen staff who came in before 6 a.m.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of the facility's, Screening for Covid-19 Symptoms prior to Entrance in the Facility, policy and procedure, undated, it indicated, Screening of employees: All employees entering the facility will be screened by an employee assigned or trained as a screener before they can go to their work assignments .The screener will review the questionnaires answered by the employee. If no signs and symptoms of Covid-19, employee will proceed to their work assigned unit. |

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| F 0921<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40849<br><br>Based on observation, interview and record review, the facility failed to provide a safe environment to 28 residents, who were identified by facility staff as ambulatory and/or used wheelchairs, enabling them to independently maneuver throughout the facility, when:<br><br>1. B-wing exit door was observed left open, with no alarm for unauthorized exit or entry, and with a Wanderguard Alarm which was not functioning;<br><br>2. A-wing door alarm was off, and the door was left unlocked and able to be opened from inside and outside; and,<br><br>3. Only one of six facility exit doors had a working Wanderguard Alarm system in place (Entrance/Lobby Door).<br><br>These failures could have resulted in injury, harm or even death, to all 28 residents, including one resident (Resident 1) who had a Wanderguard (monitoring device for residents who are at risk of eloping, ensuring the alarm is activated) bracelet and was able to leave the facility, undetected, and was later found in another Skilled Nursing Facility across the street.<br><br>Findings:<br><br>1. A review of Resident 1's medical record indicated a diagnosis of early onset Alzheimer's Disease (progressive disease that destroys memory and other important mental functions). The medical record also indicated a placement of a Wanderguard to prevent elopement.<br><br>During an observation on 11/3/21, at 8:52 a.m., B-wing exit door was cracked open and had no alarm. The B-wing door led to a laundry room, the backyard and smoking area, and also led to the back parking with two wooden gates that were also left open, with no locks and ultimately allowing access to the front of the building and the busy six-lane main road of [NAME] Boulevard.<br><br>During a concurrent observation and interview on 11/3/21, at 9 a.m., Maintenance Staff A was holding the B-wing door open. Maintenance Staff A was asked why the door was left open and did not alarm. Maintenance Staff A showed the Wanderguard alarm box, and stated the alarm worked with residents who wore Wanderguard devices (such as bracelets or anklets), and if a resident without a Wanderguard exited this door, it would not be detected (the alarm would not sound). Maintenance Staff A further stated the door should be locked all the time and did not know why it was left open.<br><br>During an interview on 11/3/21, at 9:30 a.m., Management Staff C was asked how often facility doors were checked to ensure safety and security. Management Staff C stated he checked all doors every day in the morning, lunch time and afternoon, to make sure they were locked, and alarms were working, but he did not document it. Management Staff C further stated, staff sometimes turned off the alarms when they exited the doors and forgot to turn them back on and left the doors unlocked and opened like what happened with A- & B-wing doors. Management Staff C stated he did not have control of staff if they wanted to go in and out of those doors.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a concurrent observation and interview, with Management Staff C, on 11/3/21, at 3:49 p.m., the B-wing door had a Wanderguard alarm but did not have an unauthorized exit and entry alarm. Management Staff C was asked to check the Wanderguard alarm, using his remote, and the alarm did not go off. When Management Staff C was asked why there was no regular alarm on this door and why the Wanderguard alarm was not working when he checked it that morning, he did not reply.<br><br>2. During an observation on 11/3/21, at 9:10 a.m., with Licensed Staff B, A-wing door was closed and had a red box alarm attached, with a key in it. When A-wing door was opened, it did not alarm. When A-wing door was closed, it was able to be opened from the outside; it did not lock when it was closed.<br><br>During an interview on 11/3/21, at 10:53 a.m., Management Staff C was asked about Wanderguard alarms on the exit doors. Management Staff C stated four doors (B, C, D and Entrance/Lobby Door) had Wanderguard alarms except A-wing door. Management Staff C stated he did not know why there was no Wanderguard alarm on A-wing door.<br><br>During a second observation on 11/3/21, at 10:59 a.m., with Management Staff C, A-wing door was ajar, and no alarm sounded. Management Staff C closed the door, turned on the alarm and stated somebody opened it and did not lock it and turned off the alarm. A-wing door needed a key to unlock it from the outside knob before entering, so it would lock when closed from the inside. Management Staff C stated he did not know who else had the key to A-wing door except himself and Maintenance Staff A.<br><br>During an interview on 11/3/21, at 11:52 a.m., Management Staff D stated they found who had the extra key to A-wing door, it was the Housekeeping Staff F, and they instructed her to keep the door locked.<br><br>During an interview on 11/3/21, at 11:56 a.m., Housekeeping Staff F stated the previous Maintenance Supervisor gave her the key to the A-wing door because she started working at 5 a.m., and she used A-wing door to enter the facility. Housekeeping Staff F stated she might have forgotten to lock the door this morning.<br><br>During a third observation on 11/3/21, at 3:42 p.m., with Management Staff C, A-wing door was closed, and when opened to check for the alarm, the alarm was off. Management Staff C turned on the alarm.<br><br>A review of the facility's, Wandering Resident Alarm Band Management, dated 7/2014, indicated, 7. Maintenance is required to check door alarm system minimum monthly. Alarm band company tester will be used to test individual arm bands daily or per manufacturer recommendation.<br><br>A review of the facility's, Policy and Procedure on Wanderguard, dated 7/2012, indicated, Once resident with Wanderguard leaves the facility, the Wanderguard alarm will be activated. The staff at this time will be alerted that the resident is trying to go out from the facility.<br><br>3. During a concurrent observation of the D-wing door, and interview with Management Staff C, on 11/3/21, at 3:46 p.m., Management Staff C stated, A-, C- and D-wing doors did not have Wanderguard alarms, as he previously stated; they only had the regular alarm. Management Staff C did not reply when asked why he had previously indicated all doors had Wanderguard alarms.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a concurrent observation and interview, with Management Staff C, on 11/3/21, at 4:15 p.m., the Dining/Activity Room door was the exit door to the smoking area in the backyard and had two Wanderguard alarms on each side. When Management Staff C was asked to check these Wanderguard alarms using the remote, the alarms did not go off. Management Staff C stated he knew the Wanderguard alarms for the Dining/Activity Room and B-wing doors were not working when he checked them in the morning. When Management Staff C was asked how long the Wanderguard alarms were not working, he did not reply.<br><br>On 11/3/21 at 3:15 p.m., the Department identified an Immediate Jeopardy situation with respect to Environmental Condition of the exit doors in the facility.<br><br>On 11/3/21 at 4:38 p.m., the Facility Administrator submitted a Plan of Action (IJ Removal Plan).<br><br>On 11/3/21, at 5:05 p.m., the facility's IJ Removal Plan was approved.<br><br>A review of the facility's IJ Removal Plan, dated 11/3/21, at 5:05 p.m., indicated the following actions to address the Environmental Condition non-compliance listed in the IJ Template:<br><br>1. Non-compliance<br><br>A, B, C and D Wing door-alarms will be left on and alarm key will be given to charge nurses and the doors will be locked at all times.<br><br>Front door locked at all times and has wander guard sensor.<br><br>Dining Room door will have a door alarm on.<br><br>B-wing door and dining room door-new alarm will be placed.<br><br>2. Potential for serious injury, serious harm or death<br><br>In-service for staff not to use the A, C and D wing doors unless for emergency purposes.<br><br>In process of having wander guard system upgrade.<br><br>3. Need for immediate action for safety<br><br>A-wing door-alarm will be left on and alarm key will be given to charge nurses and the door will be locked at all times.<br><br>B-wing door-new alarm will be placed.<br><br>Wooden gate at the back of facility-door lock will be installed on both gates and will place a self-closing hardware.<br><br>Log to monitor alarms daily-Maintenance<br><br>In the interim until all doors will be equipped with alarm there all resident identified as high risk for elopement will be on q30-min (every 30 minutes) monitoring.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 11/8/21, at 11:32 a.m., the Department exited with the Director of Nursing. The Department informed the facility of the deficiencies identified during the survey. The facility was informed the deficiency determinations were preliminary and subject to Supervisory review. The facility was informed the Immediate Jeopardy was not lifted as of 11/8/21.<br><br>During an onsite visit on 11/17/21, at 2:55 p.m., the Immediate Jeopardy (IJ) was removed. The RN (Registered Nurse) Consultant and IP Nurse (Infection Preventionist) were present at the time the IJ was removed. |