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	09/20/2022

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 - Minimal harm or potential for 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. 46132 Based on observation, interviews and record reviews, the facility: 1) failed protect one out of two sampled residents (Resident 39), when his roommate (Resident 33) punched the right side of his face while he was sleeping. This failure resulted in Resident 39 going to Emergency Department to seek treatment for bruising, swelling and laceration below his right eye; and, 2) failed to observe a condition, which might be predictive of potential abuse, when the facility transferred the perpetrator (Resident 33) in a room with a non-verbal, dependent resident (Resident 42). This failure had the potential to put Resident 42 at risk for abuse. Findings: Review of facility's census on 8/30/22, indicated Resident 33 was transferred to another room after an altercation with Resident 39 occurred. Review of Resident 39's Minimum Data Set assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) indicated he had a diagnosis of Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), with a Brief Interview for Mental Status (BIMS, a screen used to assist with identifying a resident's current cognition) score of 4, indicating severe cognitive impairment. Review of Resident 33's MDS indicated he had a diagnosis of Epilepsy and scored 15 on his BIMS, indicating his cognition was intact. Resident 42's MDS indicated he was not interviewable and was dependent on staff for provision of care. During an interview on 8/30/22 at 9:15 a.m., Licensed Nurse G stated she was not present when Resident 39 and Resident 33 had an altercation and stated it was unexpected. She described Resident 39 as dependent on staff, quiet, preferred to be in bed and slept most of the time. She stated Resident 33 was friendly to staff and other residents. She stated both residents were dependent on staff for provision of care. She stated Resident 33 was able to wheel himself around the facility independently. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 9:30 a.m., Resident 33 was awake in bed. He stated he recalled the altercation with his roommate. When asked about the altercation, Resident 33 stated, Oh yeah, and I will punch him again. I punched his smug face, my hand hurts after. He should not be calling me names! When asked who his roommate was, Resident 33 stated he did not remember his name, but would probably recall him once he saw his face. Resident 33 stated his roommate called him, a faggot and stupid, which irritated and angered him. He stated there was another roommate present when he punched Resident 39's face, but he does not recall his name either. Resident 33 stated, Ask him and he will tell you the same story. Resident 33 stated he felt good, the only thing bothering him was his current roommate (Resident 42) because he had his privacy curtain drawn all the time and was blocking the sunlight. He stated he talked to the staff about this issue. During an observation on 8/30/22 at 9:45 a.m., LN G verified Resident 42 was non-verbal, not interviewable and dependent on staff. During an interview on 8/30/22 at 9:47 a.m., Licensed Nurse C (LN C) verified there were three residents occupying the same room on the day of the alleged incident. She stated Resident 47 was on A bed, Resident 39 was on B bed and Resident 33 was on D bed. LN C stated Resident 39 was typically quiet and would only talk if he wanted to. LN C stated Resident 39 would typically get upset if staff tried to change his pad or clean him when he did not want to at that time. LN C stated Resident 39 was a good person. LN C stated she had not heard Resident 39 call anyone a, faggot, and she had never heard Resident 39 calling Resident 33, faggot. LN C stated she was surprised to learn Resident 33 punched Resident 39. LN C stated it was usually Resident 33 and Resident 47 who would have arguments on no particular subject. LN C stated, although Resident 33 was talkative, he had not been known to physically hurt staff or other residents. During a concurrent observation and interview on 8/30/22 at 9:50 a.m., Resident 39 was asleep in bed and was noted with greenish/yellowish-tinged discoloration below and to the side of his right eye. LN C verified this area was where Resident 33 punched him. Resident 39 denied pain when LN C asked if he was in pain. During an interview on 8/30/22 at 10 a.m., Certified Nursing Assistant T (CNA T) stated she had worked with Resident 39 in the past and had not heard him call staff or residents, faggot or stupid. CNA T stated she was surprised to learn Resident 33 punched Resident 39. She stated Resident 33 had no history of harming anyone. During a concurrent observation and interview on 8/30/22 at 10:15 a.m., Resident 39 stated he was still sleepy. When asked what happened to his right eye he stated, I woke up when I was punched, it happened about a week ago. Resident 39 did not recall the name of the person who punched him, but stated it was his roommate. Resident 39 stated he did not know why he was punched. Resident 39 refused to answer further questions and stated, I want to sleep. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 10:30 a.m., Licensed Nurse E (LN E) verified she was the nurse on duty when the altercation between Resident 33 and 39 occurred. LN E stated Resident 39 was very quiet and slept most of the time. LN E stated Resident 33 was talkative and friendly to staff. LN E stated it was the other roommate, Resident 47, who was known to say weird things, was the instigator, and would get Resident 33 into arguments. She stated Resident 47 would say things with conviction, and Resident 33 would believe whatever he said. Licensed Nurse E stated, maybe Resident 47 told Resident 33 that Resident 39 was talking, shit about him, and Resident 33 believed him. LN E stated there were no yelling or screaming heard prior to the discovery of this altercation. LN E stated Resident 47 was present in the room when she came to assess Resident 39. LN E verified she did not ask Resident 47 about the altercation between his roommates. LN E stated she did not understand why Resident 33 punched resident 39. LN E stated, on 8/22/22, her attention was called by the Certified Nursing Assistant F (CNA F) who reported noticing blood streaming on Resident 39's right cheek. She stated Resident 39 was in bed at that time. LN E stated Resident 33 started saying, Yes I did that, I punched him in the face. I'll do it again. LN E stated Resident 33 said he punched Resident 39 because he called him a faggot, nigger and stupid. LN E stated Resident 39 was quiet when asked what happened to his right cheek. LN E stated the laceration on Resident 39's right cheek was slightly deep, and she called the physician to get him transferred to the hospital for further evaluation. LN E stated, on the same day, Resident 33 was transferred to a room in a different hallway. LN E stated Resident 33's current roommate, Resident 42, was nonverbal, unable to move independently and just, does not do or say anything, which could irritate Resident 33. LN E stated the facility should be protecting every resident. LN E stated it would be ideal if Resident 33 did not have a roommate at this time because of his history of punching Resident 39. LN E stated there was a risk Resident 33 might do the same thing to his current roommate (Resident 42) and worried that since Resident 42 was non-verbal, things could go undetected and unreported for a period of time. LN E stated, while Resident 33 was dependent on staff during transfers, once on his wheelchair, he was able to wheel himself independently. LN E stated there was a risk he might go to his roommate and could hurt him. LN E also recalled Resident 33 getting visibly upset and cussed at her when she told him, We don't hurt people. LN E stated the altercation was reported to the local law enforcement. During an interview on 8/30/22 at 11:15 a.m., Resident 47 was in a wheelchair in front of the nursing station. Resident 47 stated he recalled an incident where his roommate was punched by their other roommate, and stated he was there when it occurred. Resident 47 stated he could not recall the name of his roommates. He said he did not understand why his roommate was punched. When asked if he heard the word, faggot or stupid, prior to the altercation, he stated, No, no, there were no name calling, nobody said faggot or stupid. During an interview on 8/30/22 at 11:20 a.m., Certified Nursing Assistant B (CNA B) stated she was working on the D wing when the altercation between Resident 39 and 33 occurred. CNA B stated she was surprised Resident 39 was punched on his face. She described Resident 39 as quiet and gentle, liked to keep to himself and slept the majority of the time. She stated Resident 39 was dependent on staff for provisions of care. She stated Resident 33 was a talker but was nice to staff. CNA B stated Resident 39 had no history of altercation with Resident 33. She stated liked Resident 39, and Resident 33 was also dependent on staff for provisions of care. CNA B stated she did not hear any verbal altercation, screaming or yelling prior to the discovery of the altercation. She stated she did not hear Resident 39 calling Resident 33, faggot or stupid. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 11:25 a.m., Certified Nursing Assistant F (CNA F) stated Resident 39 was under his care at the time of the altercation. He stated Resident 33 got back from his appointment around lunch time. CNA F stated he found Resident 33 in his room sitting on his WC. CNA F stated and he assisted Resident 33 to his bed. CNA F stated, after repositioning Resident 33, he turned around and noticed Resident 39's right cheek was bleeding. CNA F stated Resident 39 was silent when he asked him what happened. CNA F stated it was during this time that Resident 33 said, I did it, I punched him and I will do it again. He called me a faggot! CNA F stated, prior to this incident, he did not hear any screaming or yelling or any arguments coming from the residents' room, which is why he was surprised there was an altercation between Resident 39 and 33. During an interview on 8/30/22 at 11:40 a.m., the Infection Preventionist (IP) stated she was surprised to hear about Resident 33 punching Resident 39. The IP stated Resident 33 joked around a lot, while Resident 39 was quiet and preferred to sleep most of the time. The IP stated, placing Resident 33 with a roommate who was nonverbal and unable to defend himself, was not a very wise idea. She stated, with Resident 33's history, he might do the same thing to his new roommate (Resident 42). The IP stated, to ensure residents' safety, it would be best if Resident 33 did not have a roommate. During an interview on 8/30/22 12 p.m., the Social Service Designee (SSD) stated the altercation between Resident 39 and 33 surprised her. The SSD stated Resident 33 loved to joke around, and Resident 39 kept to himself. She stated these residents had no history of being physically or verbally abusive to staff or other residents. She stated Resident 39 had no history of calling other residents, faggot or stupid. The SSD stated it was the Interdisciplinary Team's (IDT, an approach to healthcare that integrates multiple disciplines through collaboration. These teams can help ensure patients receive the best care) decision to place Resident 33 in a room where his roommate was nonverbal and fully dependent on staff for provision of care. The SSD stated the IDT believed, since the current roommate (Resident 42) was quiet, it would be a safe option to have Resident 33 room in with him. The SSD stated Resident 42 could not talk so he could not say anything that might upset Resident 33. The SSD verified there were no reports of staff hearing any verbal altercation, yelling or screaming between Resident 39 and 33 right before the altercation occurred. The SSD stated nobody could verify whether Resident 39 did indeed call Resident 33 a, faggot or stupid, right before the physical altercation occurred. SSD stated maybe Resident 33 would not do it again because there was no risk for his roommate to be physically abused since, he does not talk. During a concurrent interview and SOC 341 record review, on 8/30/22 at 12:50 p.m., the Director of Nursing (DON) verified this report was accurate and was sent to the law enforcement agency, the Ombudsman and the State. The DON stated he was surprised to learn Resident 33 punched Resident 39. He stated Resident 33 admitted to punching Resident 39 and did so because Resident 39 called him, stupid and faggot. The DON stated Resident 39 was not able to verbalize details of the altercation except that he woke up after someone punched him. The DON stated there were no reports from other residents and staff of Resident 39 calling Resident 33 a, faggot or stupid. The DON verified there was no verbal altercation, screaming, yelling between Resident 39 and 33 right before the incident. The DON stated it was quiet, and that was why it was such a surprise. The DON verified he did not interview the third roommate, Resident 47, although he was present during the altercation. The DON stated, although the facility was not able to verify whether Resident 39 called Resident 33, stupid or faggot, the IDT decided to move Resident 33 to a room where his roommate could not talk, for safety purposes. When asked if this move was a safety concern for Resident 33's current roommate, Resident 42, the DON said, I don't think he will do it again. The DON stated the risk of Resident 33 punching his current roommate was very little. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 1:10 p.m., the Administrator stated there were no reports of verbal altercation, yelling or screaming between Resident 39 and Resident 33 prior to the altercation. She stated there were no reports Resident 39 called Resident 33, stupid or faggot. She stated it was a quiet day when this altercation occurred, and that was why it was such a surprise. She stated she did not interview the third roommate about this altercation. The Administrator stated, to prevent further incidents of abuse, the IDT decided to transfer Resident 33 in a room with a roommate who was nonverbal and dependent on staff for care. She stated, since Resident 33's current roommate, Resident 42, did not talk, he was safe to be in a room with Resident 33. When asked how the facility could ensure Resident 42's safety, when he was unable to talk, unable to defend himself and unable to call for help, the Administrator stated, I understand what you're saying. IDT will meet again to discuss room change. During a concurrent observation and interview on 9/13/22 at 11:13 a.m., Resident 33 was in bed and stated he did not like his current room because there was no sunlight. He stated his roommate always wanted the blinds shut and his curtains drawn, so there was no sunlight coming in. Resident 33 stated that it was annoying at times, and stated he discussed this with the staff but nothing happened. During an interview on 9/13/22 at 11:30 a.m., the Administrator verified the facility had a lot of empty beds. She verified Resident 33's current roommate, Resident 42, was unable to defend himself. The Administrator stated, despite this and Resident 33's history of punching his roommate, she did not think Resident 33 would hurt his roommate. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, revised 3/17, the P&P indicated the facility would ensure staff were doing all that was within their control to prevent occurrences of abuse. It also indicated the facility would identify and correct situations in which abuse was more likely to occur.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interview and record review, the facility failed to ensure: 1) Two out of two sampled residents' (Residents 351 and 44) surgical wounds were documented, assessed, and treated, to prevent complications. These failures resulted in Resident 351's re-hospitalization for wound dehiscence (partial or total separation of previously-approximated (edges of a wound fit neatly together, such as a surgical incision, and can close easily) wound edges, due to a failure of proper wound healing) and wound infection, and had the potential for Resident 44's wound to worsen or develop an infection; 2) The facility failed to properly and accurately document skin assessments for one un-sampled resident (Resident 100). This failure prevented Resident 100 from having a complete and accurate medical record; and, 3) The facility failed to ensure it used commercial-grade blood pressure monitors; instead, it used wrist blood pressure monitors intended for home use. This failure placed eight out of eight sampled residents (Residents 7, 8, 39, 3, 351,35, 151 and 46) at risk for inaccurate blood pressure readings and for potentially receiving unnecessary blood pressure medications. Findings: 1a) Review of Resident 351's Facesheet (demographics) indicated she was [AGE] years-old, and admitted to the facility on [DATE], with a diagnosis of surgical aftercare. Review of the nursing admission note indicated Resident 351 was admitted with a wound VAC (Vacuum-assisted closure, a treatment that applies gentle suction to a wound to help it heal. It's also called Negative Pressure wound therapy) on her sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis). During a concurrent observation and interview on [DATE] at 9:44 a.m., Resident 351 was lying in bed. She stated she had a surgical wound on her back. She stated she used to have a wound VAC. She stated the wound VAC had been discontinued, but she could not recall receiving surgical wound care from the nurses. She stated, I don't know if the nurses knew I have a wound on my back. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and medical chart review, physician orders and Admission Assessment record review on [DATE] at 4:40 p.m., Licensed Nurse M (LN M) initially stated Resident 351 had clear skin and no wound. LN M stated she would know because, if there was a skin issue, the nurses would leave her a note to see the resident. LN M verified Resident 351 was not on the list of residents to be seen by the wound doctor this day. LN M verified the facility wound doctor had not seen Resident 351 since admission. LN M verified Resident 351 had no treatment order for the surgical wound. LN M verified there was a note on the Admission Assessment indicating Resident 351 had a wound vac on her sacrum. LN M also verified there was no Braden Scale skin assessment (a standardized tool to assess pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) risk for a resident. completed at the time of her admission. LN M verified there were no monitoring of Resident 351's surgical wound for signs and symptoms of infection. LN M stated the facility policy was not followed when Resident 351 did not have a Braden Scale assessment completed upon admission; there was no treatment order for the surgical wound care, and there was no monitoring of the surgical site, every shift, for signs and symptoms of infection. During an observation in Resident 351's room on [DATE] at 4:50 p.m., LN M turned Resident 351 on her right side to be able to visualize the surgical wound on her back. LN M verified the surgical wound was not covered with dry dressing, and there was a packing strip (a long, slender,continuous pieces of a fine-mesh, gauzy material intended to fill wounds that extend into the middle layer of the skin) on the lower end of her lumbar (lower back) incision. LN M measured the surgical incision then and provided this surgical wound measurement, 13.5 cm x 0.5 cm x 0 cm. During a concurrent interview and medical chart record review on [DATE] at 8:15 a.m., the Minimum Data Set (MDS, a federally mandated process for clinical assessment of all residents in Medicare or Medicaid facility) Coordinator stated he did not verify whether Resident 351 had a wound VAC upon admission. The MDS Coordinator verified Resident 351 had no weekly skin assessments completed. He stated Resident 351 should have had at least two weekly skin assessments completed since Resident 351's admission on [DATE]. He stated the facility policy was not followed if the nurses were not conducting weekly skin assessments. The MDS Coordinator verified the eMAR (electronic Medication Administration Record) did not show nurses were monitoring Resident 351's lower back incision for signs and symptoms of infection or wound dehiscence since the wound VAC was discontinued on [DATE]. He verified there was no treatment order for the surgical wound since the wound VAC was discontinued. The MDS Coordinator verified the facility policy was not followed when there was no baseline surgical skin assessment completed once the wound VAC was discontinued. He stated the facility policy was not followed when nurses failed to monitor the surgical incision site every shift. He stated these failures put Resident 351 at risk for further wound dehiscence, non-healing wounds, infection, sepsis (the body's extreme response to an infection and is a life-threatening medical emergency) and readmission to the acute hospital. During an interview on [DATE] at 8:25 a.m., Licensed Nurse G (LN G) stated the admission nurse completed the skin assessment and Braden Scale skin assessment upon admission. She stated, if these assessments were not done, the facility policy was not followed. LN G also stated the facility's policy was not followed if the nurses were not monitoring the surgical site for signs and symptoms of infection, every shift and if the nurses were not completing the weekly skin assessment. LN G stated, not monitoring the surgical site for complications every shift could put Resident 351 at risk for infection and a non-healing wound. LN G stated, not completing weekly wound assessments could result in inadequate monitoring of the wound which could result in missed opportunities to assess whether the wound was improving or getting worse or if current treatment was effective or ineffective. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:50 p.m., Licensed Nurse O (LN O) verified she admitted Resident 351 on [DATE] at 5 p.m. LN O stated the facility policy for admission included completing the nursing assessment (time of arrival, skin assessment, nutrition assessment, fall assessment, elopement assessment, pain assessment and smoking assessment). LN O verified the facility policy was not followed when Resident 351 did not have a Braden Scale skin assessment upon admission. LN O verified she did not complete Resident 351's Braden Scale skin assessment because it was the responsibility of the treatment nurse to complete it. LN O stated it was important to ensure the Braden Scale skin assessment was completed so staff were aware of any current skin issues and potential risk of further skin issues. LN O stated the findings on the Braden Scale skin assessment could then be used for care planning with the goal of addressing both the current and potential skin issues. LN O verified there was no care plan initiated for the wound VAC, upon admission. She also verified there was no care plan or treatment order initiated for Resident 351's surgical incision once the wound VAC was discontinued. LN O stated the facility's policy was not followed when there was no treatment or monitoring of the surgical incision, every shift. She stated these placed Resident 351 at risk for not receiving appropriate care, which could result in wound infection, sepsis, non or delayed wound healing and wound dehiscence. During an interview on [DATE] at 9:28 a.m., Licensed Nurse A (LN A) verified Resident 351 was sent straight to the acute hospital after her neurosurgery (a surgical specialization that treats diseases and disorders of the brain and spinal cord) appointment on [DATE]. During an interview on [DATE] at 9:33 a.m., the Director of Nursing (DON) verified Resident 351 was at [Acute Care Hospital's Name] for further evaluation of her surgical wound. During a concurrent interview and nursing note record review on [DATE] at 10:32 a.m., the Minimum Data Set Coordinator (MDS Coordinators assess and monitor proper treatment for residents in nursing homes) verified he was not able to find nursing documentation and skin assessments when the wound VAC was discontinued on [DATE]. The MDS Coordinator verified the eMAR indicated nurses were checking the wound VAC, from [DATE] to [DATE], when it was already discontinued on [DATE]. The MDS Coordinator stated nurses were probably not reading what they were signing. He stated wound VAC monitoring should have ended once it was discontinued. During an interview on [DATE] at 12:46 p.m., LN M stated the Wound Doctor saw residents with skin issues, pressure ulcers, and surgical wounds,weekly, either in person or via telehealth (video or phone appointments between a patient and their health care practitioner). LN M verified the Wound Doctor had not assessed Resident 351 since admission on [DATE], [DATE] and [DATE]. When asked why the Wound Doctor did not assess Resident 351 when he was doing telehealth to other residents with skin issues on Wednesday, [DATE], LN M stated the Wound Doctor would like to assess Resident 351 in person. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and electronic Treatment Administration Record (ETAR) weekly wound/skin documentation record review on [DATE] at 2:33 p.m., LN H stated the facility policy was not followed when there was no new skin assessment completed for Resident 351, once the wound VAC was discontinued. She stated the skin assessment should have been initiated because now they were able to visualize the wounds. LN H verified nurses were still monitoring the wound VAC from [DATE] to [DATE], when the wound VAC was already discontinued on [DATE]. LN H stated the wound VAC monitoring should have ceased after it was discontinued on [DATE]. She stated it was important to assess, treat and document accurately to ensure wounds were healing adequately with no complications. She stated, if treatments or documentation was not accurate, it could put Resident 351 at risk for non-healing wound, infected wound and ineffective treatment. During a concurrent interview and EMAR/ETAR record review on [DATE] at 3:11 p.m., the DON verified Resident 351's wound VAC was discontinued on [DATE]. He stated the wound VAC order for monitoring was inaccurate and should not even be documented on the eMAR after it was discontinued on [DATE]. The DON stated inaccurate documentation could lead to mistakes and could result in infected and non-healing wounds. The DON stated it was possible Resident 351's wound infection, and subsequent re-hospitalization , could have been prevented if there was adequate treatment and monitoring of symptoms was reported to the Medical Doctor. The DON stated nurses should have documented and assessed wound status after the removal of wound VAC. He stated, not doing a skin assessment and implementing treatment, was safety risk which could lead to wound infections, non-healing wounds, and sepsis, if not treated immediately. During an interview on [DATE] at 3:32 p.m., Licensed Nurse C (LN C) verified she received a call from the doctor to discontinue the wound VAC and initiate treatment to cleanse the surgical wound with saline and cover with a dry dressing. LN C verified she did not carry out the treatment order. She stated she did not ask the frequency nor the duration of the treatment to the doctor. When asked why, LN C was silent. LN C verified, based on facility policy, she should have documented the surgical skin status after she discontinued the wound VAC. When asked why she did not document the skin status after discontinuing the wound VAC, LN C was silent. LN C stated it was important to document wound status to ensure Resident 351's surgical wound was healing adequately with no complications. LN C stated, if the wound was being monitored for complications or signs and symptoms of infection and treatment for the surgical wound was provided, this could have decreased the risk of Resident 351's re-hospitalization for wound dehiscence and infection. During a concurrent interview and review of Resident 351's history and physical, dated [DATE], on [DATE] at 4:30 p.m., the MDS Coordinator verified the admitting doctor did not include wound infection on Resident 351's list of admitting diagnoses. The MDS Coordinator stated Resident 351's re-hospitalization could probably been prevented if staff were monitoring the surgical wound for signs and symptoms of infection and if there was a daily treatment implemented for Resident 351's surgical wound. During an interview on [DATE] at 5:04 p.m., LN M indicated re-hospitalization could probably been prevented if staff were assessing and monitoring Resident 351's surgical wound for signs and symptoms of infection and if staff were treating her surgical wound daily. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's policy and procedure titled, Surgical Wound Care, revised ,d+[DATE], indicated surgical wounds should be cleansed with normal saline, pat dry and covered with dry dressing unless other special treatment /instructions were given by the surgical doctor. It further indicated documentation should be maintained in the resident's medical record, including but not limited to treatment sheets, licensed note and any appropriate area. 44968 1b) During an interview and observation with Resident 44 outside of his room on [DATE] at 11:24 a.m., Resident 44 stated he had a sore on his tailbone bottom from a surgery. Resident 44 stated wound treatment should be done once a day; however, he was not getting it. Resident 44 stated the last wound treatment he received was two days ago. Resident 44 pointed out his bed linen was soiled with brownish-yellow stains from his wound discharge. During an interview with Resident 44 on [DATE] 10:23 a.m., Resident 44 stated nurses were not doing the treatment on his tailbone properly, Resident 44 stated one of the nurses would use band aid to cover the wound. During an interview with Licensed Nurse M on [DATE] at 12:46 p.m., Licensed Nurse M stated she was the primary treatment nurse for the whole facility. Licensed Nurse M stated licensed nurses were expected to provide wound treatment to residents on her days off; however, licensed nurses were not doing it. When Licensed Nurse M was asked about the risks for residents with wounds not receiving wound treatments according to doctor's order, Licensed Nurse M stated residents' wounds could worsen. During an interview with Licensed Nurse M on [DATE] at 1:04 p.m., when asked about Resident 44's wound care, Licensed Nurse M stated Resident 44 had a cyst (an abnormal pocket in the skin which usually contained hair and skin debris) removal on his tailbone. Licensed Nurse M stated the doctor gave instruction to cover the wound with foam dressing and change every day. When Licensed Nurse M was asked if band aid could be used to cover the wound, Licensed Nurse M stated Resident 44's wound should be covered with 6 cm x 6 cm (centimeter) foam dressing. During a clinical record review for Resident 44, the progress note, dated [DATE] at 4:25 p.m., indicated Resident 44 had a sacral (relating to the sacrum - the triangular bone just below the backbone) pilonidal cyst removed. During a clinical record review for Resident 44, the Treatment Administration Record (TAR) indicated a doctor's order written on [DATE], to keep the surgical site clean, dry and cover with foam dressing every day and as needed. During a clinical record review for Resident 44, the Care Plan for surgical wound created, on [DATE], indicated to keep the surgical site clean, dry and cover the with foam dressing every day and as needed when soiled or dislodged. 27532 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2) During a review of record, Resident 100's Face Sheet indicated she was readmitted from an acute hospital to the facility on [DATE], with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke affecting the right side of the body, dysphagia (difficulty in swallowing), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and adult failure to thrive. A review of Resident 100's MDS Section M (Minimum Data Set is a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes and helps nursing home staff identify health problems. Section M provides skin assessment information including the number and stage of unhealed pressure sores present on admission), dated [DATE], indicated Resident 100 was readmitted to the facility with one Stage II pressure sore or injury (open skin or an ulcer, which is usually tender and painful. The sore expands into deeper layers of the skin. It can look like a scrape, blister, or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid). Review of the weekly skin integrity assessment, dated [DATE], indicated Resident 100's Stage II pressure wound was on her sacrum (the large, triangle-shaped bone in the lower spine that forms part of the pelvis). A review of a physician order, dated [DATE], indicated to cleanse the area with Normal Saline (a sterile solution of salt and water), pat dry, apply Calmoseptine (a multipurpose ointment used to treat and prevent minor skin irritations) to sacrum, with every brief change once a day and as needed, day and evening shift. The TAR (Treatment Administration Record) indicated nurses were administering the treatment as ordered, from [DATE] to [DATE]. Continued review of Resident 100's MDS, dated [DATE], [DATE], and the MDS on discharge on [DATE], indicated Resident 100 no longer had a pressure sore during those assessment months. During an interview and concurrent review of record on [DATE], at 4:20 p.m., Licensed Nurse R stated she had been working as wound nurse in the facility for about two months. Licensed Nurse R stated she worked Tuesday and Thursday while the regular wound nurse worked the other days and weekends. Licensed Nurse R found and presented the 2022, binder of the weekly skin report. During a continued interview and concurrent review of record on [DATE] at 4:20 p.m., Licensed Nurse R showed in PCC (Point Click Care - an electronic software storing medical information of residents in the facility) where the wound nurse documented weekly skin assessments. During continued review Licensed Nurse R stated it did not look like there was weekly documentation in PCC after the initial assessment on admission. During a review, the skin report binder for 2022, contained sheets of paper indicating weekly listing of residents receiving wound care, with information on the type of wound, date the wound was first discovered and assessed, whether the wound was facility-acquired or present on admission, stage of pressure sore or injury, location, characteristics and measurements of wounds, status on assessment whether worse, improved, the same, etc. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE], at 1:12 p.m., Licensed Nurse M confirmed she did the documentation of the weekly skin assessment in the residents' charts after wound rounds with the wound doctors. When asked what the status of Resident 100's pressure sore was upon discharge to the acute hospital on [DATE], Licensed Nurse M stated she could not recall. When asked where the 2021, skin reports could be found, Licensed Nurse M responded the reports should be with Medical Records. During an interview on [DATE], at 4:04 p.m., the Medical Records Director stated she called the Wound Clinic providing the wound care to the facility. The Medical Records Director stated she asked for Resident 100's records, but the clinic informed her they did not have any records on Resident 100. When asked if the wound clinic was the same wound clinic providing wound care services in 2021, the Medical Records Director stated she would call and verify. A review of the of the binder of the Weekly Skin reports for 2021, provided by Licensed Nurse Z, indicated the binder contained the weekly wound assessments sheets for the months of January to June, but the weekly skin sheets for the months from July to December were missing. During a follow-up interview on [DATE], at 4:12 p.m., the Medical Records Director confirmed the same wound clinic was providing wound care services to the facility in 2021. The Medical Records Director stated she called the Wound Clinic again and confirmed there were no records of wound assessments for Resident 100. During an interview on [DATE], at 4:51 p.m., Licensed Nurse M confirmed she was the one who did the weekly assessments of Resident 100 on [DATE], but wondered why there were no progress notes after the initial wound assessments, until Resident 100 was discharged . Licensed Nurse M also stated she could not remember the wound doctor having seen Resident 100. When asked if she agreed the omission of documentation and monitoring were evidence of non-compliance, Licensed Nurse M nodded in agreement. A review of the Death Summary of Resident 100, dated [DATE], indicated Resident 100 was admitted to the acute hospital on [DATE], and expired on [DATE]. The death summary indicated Resident 100 was admitted for , altered mental status and profoundly abnormal laboratory, results, felt to be consistent with dehydration and failure to thrive like picture leading to acute kidney failure. Resident 100 was also found with ,a Stage III pressure injury on the right buttocks, present on admission, and an unstageable pressure injury of the left buttock, present on admission. The summary indicated the pressure injury were, probably due to her worsening debilitated state and primarily a fully bedbound status as she declined. It is unclear whether patient had been turned during her period of decline. A review of the facility Policy on Prevention of Pressure Ulcers, revised ,d+[DATE], page 1, indicated: The facility should have a system/procedure to assure assessments are timely and appropriate and changes in conditions are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. The policy also indicated information on any change in the resident's condition should be recorded in the resident's medical record. 3) During an observation on [DATE] at 3:53 p.m., Licensed Nurse S used a wrist blood pressure (BP) monitor to obtain Resident 7's BP reading. During an observation on [DATE] at 8:55 a.m., Licensed Nurse C used the wrist BP monitor to obtain Resident 151's BP reading. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the physician orders for Residents 7, 8, 39, 3, 351, 35, 151 and 46, it indicated these residents' blood pressure was being monitored every shift. During an interview on [DATE] at 11:31 a.m., the Director of Nursing (DON) verified that for the longest time, the facility had been using the wrist BP monitor to measure all residents' blood pressure. During a phone call with Equate Wrist BP monitor Customer Service on [DATE] at 12:55 p.m., a Customer Service representative verified the Equate Wrist BP Monitor 4500 series, currently being used by the facility, was intended for home use only and should not be used at Skilled Nursing Facility. During an interview on [DATE] at 11:25 a.m., the Director of Staff Development (DSD) stated wrist BP monitors should not be used at the facility. She stated she discussed this with the nurses about two months ago. The DSD stated wrist BP monitors gave inaccurate BP readings, which could compromise resident safety. She stated, for quality of care and standard of care, the facility should not be using the wrist BP monitor. During a concurrent interview and user's manual instruction review on [DATE] at 12:20 p.m., the Director of Nursing (DON) stated he was not aware of what the standard of practice was, with regards to the use of a wrist BP monitor. He verified the brand/model the facility was using was Equate wrist BP monitor and should only be used in a home care setting. He stated it should not have been used in the facility. The DON stated, using a wrist BP could yield inaccurate readings and could be a safety risk for the residents. The DON verified all residents had BP monitoring. He stated this could lead to residents receiving, or not receiving, BP medication based on inaccurate BP readings. During an interview on [DATE] at 2:45 p.m., Licensed Nurse H (LN H) stated the facility had been using the wrist BP monitor for a long time and now realized the facility should not be using the wrist BP monitor because it yielded inaccurate reading. She stated, using the wrist BP monitor was a safety risk because they might be administering BP medication for a resident who may not need it. LN H stated residents could be hypotensive (low blood pressure) and could be at risk for falls or dizziness. During a review of the instruction manual titled, Equate Wrist Blood Pressure Monitor 4500 series, model # BP3KC,d+[DATE]EWM, undated, the instruction manual indicated this machine was intended for self-monitoring of BP in adults and within a home environment.

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F 0689 Level of Harm - 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** 37797 Based on observation, interview and record review, the facility failed to ensure one of 16 sampled residents (Resident 35) received care and services to prevent falls. The facility: 1) failed to supervise and assist Resident 35 during transfers to and from bed, wheelchair and bathroom; 2) failed to provide Resident 35, who had dementia and did not know how to use the room's call light system, with an alternative communication system to relay calls directly to a staff member or to a centralized staff work area, relying instead on Resident 35 yelling for help from her room as a means of alerting staff she needed help; 3) failed to ensure fall prevention interventions were appropriate to Resident 35's severely impaired cognitive level when the facility's primary fall intervention was educating and reminding Resident 35 to use the call light system to ask staff for assistance before attempting to transfer; 4) failed to revise and update Resident 35's fall care plans and implement new or different interventions post falls, after the existing interventions, such as educating Resident 35 to use the call light system, proved ineffective in preventing falls; and 5) failed to implement the fall care plan intervention of placing Resident 35 in a supervised area when she was out of bed. These failures resulted in Resident 35 falling eight times over an 11-week period from 6/22/22 to 9/7/22. Two of these falls, on 7/8/22 and 9/7/22, resulted in Resident 35 sustaining head and knee injuries requiring hospital transfer and evaluations. These failures also placed Resident 35 at risk for further falls. Findings: A review of Resident 35's Facesheet indicated she was [AGE] years-old, was originally admitted to the facility on [DATE], and had diagnoses including dementia, depression, psychosis (a disease that causes delusions and hallucinations), hemiplegia (muscle weakness or paralysis in one side of the body), seizures, and bilateral cataract and macular degeneration (eyes diseases that impair vision). During an interview on 9/13/22, at 2:08 p.m., Resident 35's Responsible Party (RP) stated Resident 35 falls often at the facility, and the falls result in injuries. The RP stated Resident 35 falls when she tries to transfer to and from the bed or wheelchair, to use the bathroom. The RP stated Resident 35 calls for staff to help her transfer, but staff do not assist her. Resident 35 then tries to transfer herself without staff assistance and falls as a result. A review of facility document titled, LIST OF FALL INCIDENTS (PAST 90 DAY), provided by the facility on 9/12/22, indicated Resident 35 had eight falls over a period of 11 weeks, from 6/22/22 to 9/7/22, as follows: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	FIRST FALL: 6/22/22 SECOND FALL: 6/26/22 THIRD FALL: 7/5/22 FOURTH FALL: 7/8/22 FIFTH FALL: 7/27/22 SIXTH FALL: 8/9/22 SEVENTH FALL: 8/12/22 EIGHTH FALL: 9/7/22 A review of Resident 35's hospital records indicated at least two of the falls, the FOURTH and the EIGHTH falls, dated 7/8/22 and 9/7/22, resulted in Resident 35's hospitalization due to injuries, as follows: Emergency Department note, dated 7/9/22, at 2:10 a.m., indicating Resident 35 was brought to the hospital for evaluation after a fall in the facility: patient fell out of her wheelchair. The note indicated Resident 35 complained of pain in her arms, back and left knee, and she had a head contusion. The note indicated a brain scan revealed Resident 35 had a moderate-severe head trauma. The note indicated final diagnoses of head contusion and left knee contusion. Emergency Department note, dated 9/7/22, at 9/14 p.m., indicating Resident 35 was brought to the hospital for evaluation after a fall in the facility: staff found patient on floor. The note indicated Resident 35 reported pain in her neck and head. The note indicated Resident 35 had a forehead contusion/hematoma and a left knee contusion. The note indicated the cause of the injuries was accidental fall. A review of Resident 35's, FALL ASSESSMENT RISK evaluations, for the months June to September 2022, indicated the following eight assessments and scores: 6/26/22: Fall Score of 12 = HIGH RISK FOR FALLS 7/5/22: Fall Score of 13 = HIGH RISK FOR FALLS 7/8/22: Fall Score of 13 = HIGH RISK FOR FALLS 7/27/22: Fall Score of 15 = HIGH RISK FOR FALLS 8/9/22: Fall Score of 10 = HIGH RISK FOR FALLS 8/12/22: Fall Score of 15 = HIGH RISK FOR FALLS 8/12/22: Fall Score of 12 = HIGH RISK FOR FALLS (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9/7/22: Fall Score of 12 = HIGH RISK FOR FALLS A review of Resident 35's Order Summary Report - Active Orders as of 9/14/22 indicated Resident 35 was receiving the following four scheduled medications, all of which have side effects of lethargy, sedation and drowsiness: (1) DILANTIN (an anti-seizure medication) 100 milligrams twice a day, order dated 6/25/22. (2) QUETIAPINE (an anti-psychotic medication) 25 milligrams twice a day, order dated 6/25/22. (3) TRAZODONE (an anti-depressant medication) 25 milligrams twice a day, order dated 3/30/22. (4) ZOLOFT (an anti-depressant medication) 50 milligrams at bedtime, order dated 5/23/22. A review of Resident 35's Order Summary Report - Active Orders as of 9/14/22 also indicated a PRN (as needed) order for NORCO 10-325 milligram for pain, since 6/22/22. NORCO also has side effects of lethargy, sedation and drowsiness. A review Resident 35's, Minimum Data Set assessments (MDS - a formal assessment tool) for the previous 90 days, dated 5/15/22 and 8/12/22, indicated Resident 35 had a BIMs (Brief Interview for Mental Status - a test of cognition) score of 3 (scores of 0-7 indicate severe cognitive impairment), was dependent on staff for transfers, dressing and toilet use, had unsteady balance during surface-to-surface transfers, moving from seated-to-standing position and moving on and off the toilet, had impairment on upper and lower extremities, used a wheelchair, and had two or more falls since admission. A review of Resident 35's, FALL INVESTIGATION REPORTS and IDT POST FALL FOLLOW-UP REPORTS, for the period of 6/22/22 to 9/7/22, indicated the following: FIRST FALL: 6/22/22 Fall Investigation Report, dated 6/22/22 at 5 a.m.: @ 500 [5 a.m.] [Resident] tried to go back on bed [from bathroom] with no help when slid down on the floor next to bed with head up did not seek for help . IDT Post-Fall Follow-Up Report, dated 6/23/22: Resident was observed sitting on the floor next to her bed . Resident spontaneously got out of wheelchair unassisted did not ask for help/assistance did not use call light . New Intervention Recommended: Will provide transfer pole . will re-adjust grab bars in the bathroom. SECOND FALL: 6/26/22 Fall Investigation Report, dated 6/26/22 at 10:30 p.m.: Resident had unwitnessed fall at 10:15 p.m., resident found sitting down on floor next to her bed, according to the resident, she was trying to get into wheelchair and slid down to the floor . encourage resident to use call light to call for help when in need for assistance . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT Post-Fall Follow-Up Report, dated 6/26/22: Resident had unwitnessed fall at 10:15 p.m., resident found sitting down on floor next to her bed, according to the resident, she was trying to get into wheelchair and slid down to the floor . encourage resident to use call light to call for help when in need for assistance . New Intervention Recommended: Re-educate resident re; safety importance of calling/asking for help/assistance as needed. THIRD FALL: 7/5/22 Fall Investigation Report: No fall investigation report. IDT Post-Fall Follow-Up Report, dated 7/5/22: Facility licensed staff responded to resident calling out from her room. Resident was observed laying on the floor .Resident spontaneously got out of wheelchair. Did not call for assistance did not use call light . Resident continuously doing physical activities and performing ADL's unassisted beyond her physical ability. New Intervention Recommended: Non-skid strips applied to the floor and resident became verbally hostile . Non-skid floor strips was removed and resident calmed down . explained risks and benefits to resident . FOURTH FALL: 7/8/22 Fall Investigation Report, dated 7/8/22 at 11:23 p.m.: Resident was found in the bathroom, laying down on the floor, she was trying to get into the toilet and she slid down and hit her head . side of the head little swollen . has pain 8/10 . sent to hospital for further evaluation . IDT Post-Fall Follow-Up Report, dated 7/8/22, but signed 7/22/22: Resident spontaneously got out of wheelchair unassisted did not ask for help/assistance did not use call light . New Intervention Recommended: Re-educate resident re; safety importance of calling/asking for help/assistance as needed. FIFTH FALL: 7/27/22 Progress Note, dated 7/27/22 at 10:30 a.m. Heard resident's loud voice, found her on the floor, sitting position, next to her bed . Fall Investigation Report, dated 7/27/22 at 10:30 a.m.: Resident was found on the floor, next to her bed . IDT Post-Fall Follow-Up Report, dated 7/27/22: New Intervention Recommended: Keep an eye the resident and put her in front of nurse station, then if the resident wants to take a nap or wants to go back to bed and use the bathroom, CNA [Certified Nursing Assistant] will call or page to assist the resident. SIXTH FALL: 8/9/22 Fall Investigation Report, dated 8/9/22: 10:42 a.m.- I was [at] nurse station . when I heard a loud sound, I immediately went to check [Resident 35], and found her lying on floor next to her bed, wheelchair near at bedside . [Resident] non-compliant to use call light, safety instructions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT Post-Fall Follow-Up Report dated 8/9/22: Resident was observed laying on the floor at bedside . Resident apparently got out of wheelchair spontaneously without asking for help or assistance . New Intervention Recommended: no new interventions recommended. SEVENTH FALL: 8/12/22 Fall Investigation Report, dated 8/12/22 AT 10:30 a.m.: I was called by staff to see resident in her room. Went to her room found accompanied by CNA . according to CNAs report, she is helping Resident 35 transfer from chair to bed but resident slid on floor . IDT Post-Fall Follow-Up Report, dated 8/15/22, but signed on 9/7/22: CNA was assisting resident to transfer from wheelchair to the bed and resident unable to withstand standing up, CNA assisted resident to sit on the floor at bedside . New Intervention Recommended: Re educated RE; Safety including but not limited to calling for assistance as needed. EIGHTH FALL: 9/7/22 Fall Investigation Report, dated 9/7/22 at 8:56 p.m.: Resident found laying out on the floor in D wing hallway at 7:40 p.m. According to the resident she was bumped to the other wheelchair that cause her fell out from her wheelchair . complains of pain in the head and left knee 8/10 . sent out to hospital for further evaluation . IDT Post-Fall Follow-Up Report, dated 9/7/22: Resident found laying out on the floor in D wing hallway at 7:40 p.m. According to the resident she was bumped to the other wheelchair that cause her fell out from her wheelchair . complains of pain in the head and left knee 8/10 . sent out to hospital for further evaluation . A review of Resident 35's care plans indicated six fall care plans, as follows: (continued on next page)

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	09/20/2022

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	FIRST CARE PLAN, titled: Resident at risk for falling related to impaired balance, unsteady gait, history of falls. Has a diagnosis of dementia, CVA [cerebrovascular accident - stroke] with right sided hemiplegia/hemiparesis, seizure . has poor safety awareness and non-compliance with needed assistance on transfers . resident spontaneously got out of bed unassisted, did not use call light, did not ask for help or assistance. DATE INITIATED: 11/28/19, 3/18/22 & 5/03/22. Interventions: (1) Assess resident, frequent check on resident, notify MD and RP of any change in condition; (2) continue frequent visual checks; (3) health education provided to the staff to initiate assistance based on resident's routine . (4) observe resident's routine and initiate staff assistance to the resident on the times she is usually going back to bed, getting up to wheelchair and going to the restroom; (5) remind resident on safety measures: to always lock wheelchair before getting up (6) Assessment of resident (7) assess resident's mobility (8) assure floor is free of glare, liquids, foreign objects (9) bed kept in low position; (10) establish as baseline, the resident's physical, mental, psychological, and functional level; (11) give resident verbal reminders not to ambulate/transfer without assistance; (12) keep call light in reach; (13) keep environment free of clutter; (14) keep personal items and frequently used items within reach; (15) observe frequently and place in supervised area when out of bed; (16) orient resident to environment; (17) orient resident when there has been new furniture placement or other changes in environment; (18) place resident in fall prevention program; (19) provide frequent staff monitoring; (20) provide proper, well-maintained footwear; (21) provide toileting assistance @ least 2x per shift; (21) teach safety measures: locking your wheelchair before getting up; (22) notify MD and resident representative for any change in condition. SECOND CARE PLAN, titled: Resident non-compliant in using bed alarm and chair pad alarm. DATE INITIATED: 6/9/22. Interventions: (1) call light within reach; (2) encourage resident to ask for assistance when in need; (3) explained the risks and benefits of using the bed pad and chair pad alarm. THIRD CARE PLAN, titled: Resident prefers to be independent as much as possible and continues to do things for herself beyond her capacity .has multiple episodes of falls . DATE INITIATED: 6/10/22. Interventions: (1) Resident assessment; (2) Encourage resident to continue to participate with care; (3) respect resident's wishes, desires and rights; (4) Explain risks and benefits; (5) inform MD of resident's wishes; (6) Encourage resident's family to continue to come and visit; (7) Refer to psych as ordered; (8) Inform MD and RP for COC. FOURTH CARE PLAN, titled: [Resident] was observed laying on the floor at bedside . did not call for assistance/or ask for help. DATE INITIATED: 8/9/22. Interventions: (1) Resident assessment; (2) Encourage resident to ask for help or assistance as needed .; (3) Explains risks and benefits; (4) Inform MD/RP ., (5) Re-educate resident re; safety measures. FIFTH CARE PLAN, titled: Resident has assisted fall during transfer. DATE INITIATED: 8/12/22. Interventions: (1) Assessment of resident; (2) Facility staff to ask for assistance as needed; (3) Monitor resident every shift for any COC [change in condition]. SIXTH CARE PLAN, titled: Unwitnessed fall. DATE INITIATED: 9/8/22. Interventions: (1) Assessment of the resident; (2) Encourage resident to ask help for assistance; (3) hallway must be free from any clutter. During an interview on 9/15/22, at 9:08 a.m., CNA F stated Resident 35 did not know to how use the room's call light system. CNA F stated Resident 35 just shouted when she needed help, and this was how staff knew she needed assistance. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 9/15/22, at 12:18 p.m., Resident 35 was in her room and transferred herself from toilet to wheelchair, unsupervised and unassisted. During an observation on 9/15/22, at 2:52 p.m., Resident 35 was in her room sitting in her bed shouting for help and pointing to the bathroom. Resident 35 was asked to press the room's call light button, which was next to her in bed. Resident 35 continued shouting for help and pointing to the bathroom. During an interview on 9/16/22, at 9:16 a.m., CNA B stated Resident 35 did not use the call light to ask for help. CNA B stated Resident 35 yelled, help when she needed something, and this was how staff knew she needed help. During an interview and record review on 9/16/22, at 10:08 a.m., the Director of Nursing (DON) reviewed Resident 35's chart. The DON stated Resident 35 was a high fall risk, falls a lot, and has hit and injured her head and hip several times because of the falls. The DON confirmed Resident 35 had eight falls in the past 90 days on 6/22/22, 6/26/22, 7/5/22, 7/8/22, 7/27/22, 8/9/22, 8/12/22 and 9/7/22. The DON stated Resident 35 had muscle weakness and the falls happened when Resident 35 attempted to transfer herself to and from her bed, wheelchair and toilet, unassisted by staff. The DON stated Resident 35, won't use the call light, before attempting to transfer. The DON stated Resident 35 must be constantly re-educated on the use of the call light. The DON stated, for communication, staff relied on Resident 35 yelling for help when she needed staff assistance for transfers. The DON stated for each fall, the facility investigated the fall, attempted to determine the cause of the fall and addressed the causative falls, and updated the resident's care plans. The DON confirmed the six fall care plans for Resident 35, initiated on 11/28/19, 6/9/22, 6/10/22, 8/9/22, 8/12/22 and 9/8/22. The DON confirmed the fall care plans were not updated after each fall. A review of facility policy titled, Fall Risk Intervention & Monitoring, revised 12/14, indicated: It is the policy of the company based on completed fall evaluation and current data to identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and to try to minimize complications from falling. The multi-disciplinary team, including the physician, will identify appropriate interventions to reduce the risk of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. A review of facility policy titled, Falls Management, revised 12/14, indicated: The multi-disciplinary team, in collaboration with the physician, will identify pertinent interventions to try and reduce the risks associated with subsequent falls and to address risks of serious consequences of falling, following completion of the resident's fall evaluation. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In the event, underlying causes cannot be readily identified, reduced or corrected, staff will attempt various relevant interventions, based on assessment of the nature or falling episodes, until falling reduces or stops; or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance or continues to choose to exercise his/her right to walk, despite contraindications).

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	055189	A. Building B. Wing	09/20/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observation, interview and record review, the facility: 1) failed to follow the Registered Dietitians (RD) recommendation for one of six sampled residents (Resident 11), when Resident 11 had significant weight loss of 11.7% at time of RD assessment. This failure resulted to further unplanned weight loss for Resident 11; and, 2) failed to offer and provide sufficient fluids to maintain hydration and health to six of six un-sampled residents (Residents 28, 10, 53, 100, and 102). This failure placed residents 28, 10, 53 and 102 at risk of dehydration and resulted in Resident 100's experiencing dehydration (condition that occurs when the body loses too much water from severe diarrhea and vomiting or by not drinking enough water or other fluids) and admission to the acute hospital for increasing lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness), hypernatremia (is a high concentration of sodium in the blood) and acute kidney failure (a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days) contributing to the cause of her death three days after admission. Findings: 1) During a clinical record review for Resident 11, the Face Sheet (A one-page summary of important information about a resident) indicated Resident 11 was admitted on [DATE], with diagnoses including Spastic hemiplegia (movement on one side of the body is affected), Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible to the naked eye) of left buttock and Multiple Sclerosis (progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord). During an interview with Resident 11 on [DATE] at 12:49 p.m., when asked about the food being served in the facility, Resident 11 stated he did not like the food being served most of the time. Resident # 11 stated dietary staff did not ask him what his food preferences were. Resident 11's lunch tray was served at time of interview. Resident 11's lunch tray had mashed potato, two slices of beef, carrots & peas, dinner roll, banana, a cup of dessert, apple juice and a plate of vegetable salad. Resident 11 stated he did not like the lunch served but he would eat the salad. During an interview with Resident 11 on [DATE] at 2:48 p.m., Resident 11 stated he had lost a lot of weight. Resident 11 stated he used to weigh 180 lbs. (pounds), and now he weighed 150 lbs. During clinical record review for Resident 11, the document title, Weights And Vitals Summary, indicated from [DATE] to [DATE], Resident 11 had a 14.8 lbs. or 8.9% weight loss in six months. During a clinical record review for Resident 11, the Registered Dietitian (RD) Nutritional Assessment, dated [DATE], indicated Resident 11 triggered for significant weight loss in 180 days, and his weight continued to trend down slowly. The RD note indicated Resident 11 needed additional calories for weight stability and recommended to increase Med Pass (nutritional shakes provides a convenient way to supplement calories and protein) to 120 ml (milliliter) three times a day. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During clinical record review for Resident 11, the document title, Weights And Vitals Summary, indicated from [DATE] to [DATE], Resident 11 had a 1 lb. or 0.63% weight gain in three weeks. During a clinical record review for Resident 11, the Medication Administration Record (MAR) for [DATE], indicated Resident 11 had an order, started on [DATE], for Med Pass 90 ml two times a day for supplemental nourishment. During a clinical record review for Resident 11, the Care Plan, initiated on [DATE], indicated Resident 11 was at risk for nutritional problem. One of the Care Plan interventions indicated to consult with RD and follow recommendations. During clinical record review and concurrent interview with the Director of Nursing (DON) on [DATE] at 10:47 a.m., the DON verified there was a recommendation for Resident 11 from the RD to increase the Med Pass to 120 ml three times a day. After reviewing the [DATE], MAR with the DON, he verified there was an active doctor's order, dated [DATE], for Med Pass 90 ml twice a day. When the DON was asked about the facility policy related to RD recommendations, he stated the RD would normally send him an email for her recommendations then he would notify the doctor to obtain an order. The DON stated he did not receive an email from the RD regarding the above recommendation, therefore the doctor was not notified. During an interview and concurrent record review with the MDS Coordinator on [DATE] at 9:55 a.m., when asked about their process when the facility received RD recommendations for residents, the MDS Coordinator stated nursing and the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) would discuss the recommendation and obtain orders from the doctor for implementation. When asked what would be the risk for the resident when RD recommendations were not implemented. The MDS Coordinator stated resident's weight would continue to decline. Review of the Facility policy and procedure titled, Weight Assessment and Intervention, revised in , d+[DATE], indicated, It is the policy of this facility that the nursing staff and the dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss or weight gain for our residents. Procedure indicated, With the MD order including but not limited to recommendation of RD consult, laboratory work, referral to professional services like psychologist/psychiatrist, GI consult, and the like, will be complied with. 27532 2) During a review of record, Resident 100's Face Sheet indicated she was readmitted from an acute hospital to the facility on [DATE], with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke affecting the right side of the body, dysphagia (difficulty in swallowing), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and adult failure to thrive. During an interview on [DATE], at 2:23 PM, Resident 28 stated CNAs did not fill her water pitcher until she asked. Resident 28 stated this happened every day. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:27 PM, Resident 53 stated there were CNAs who really took care of changing water pitchers, but others did not. During a concurrent observation and interview on [DATE] at 10:40 AM, an unidentified resident requested water from staff. When asked why she had to come out of her room to ask for water, the unidentified resident stated she had only a little water in her room. During an observation on [DATE] at 10:43 AM, Resident 28 had drinking water in a plastic cup with a straw on her over bed table. The plastic cup had over an inch full of water, she had no water pitcher in her room. During a consequent observation on [DATE] of the residents' rooms, the following were noted: At 10:45 AM, an empty Styrofoam cup sat on a resident's over bed table in room [ROOM NUMBER]. There was no water pitcher in the room; at 11:02 AM, all three residents in room [ROOM NUMBER] did not have water pitchers on either on their over bed table or side table; at 11:03 AM, one resident in room [ROOM NUMBER] had an empty water pitcher sitting on his bedside table. The other two residents in the room did not have water pitchers; at 11:05 AM, two residents did not have water or water pitchers on their bedside or over bed tables. During a concurrent observation and interview on [DATE], at 1:50 PM, Resident 7's water pitcher was noted to be almost empty. Resident 7 stated she liked to drink water but at times ran out of water and had to ask for refill. During a concurrent observation and interview on [DATE], at 1:53 PM, Resident 102's water was noted to be almost empty. Resident 102 stated he had to ask to get drinking water. During an interview on [DATE], at 1:54 PM, Resident 10 stated water was not provided unless you asked for it. Resident 10 stated staff did not offer. During an interview on [DATE], at 1:58 PM, CNA D stated water should be provided to every resident. If the resident did not want water, they should be asked what they want. CNA D stated it really happened that residents did not get water if they did not ask. CNA D confirmed not all CNAs were distributing water to each resident. During an interview on [DATE], at 2:25 PM, when asked how staff would know if a resident was dehydrated, Licensed Nurse A stated residents were assessed on contact. Licensed Nurse A stated if a resident was dehydrated, she would report a change in condition to the physician and write a care plan to address the dehydration. A review of fluid intake records, for the period [DATE] to [DATE], indicated Resident 100 had no record of fluid intake several days prior to her transfer to the acute hospital on [DATE]. Days where no documentation of fluid intake were [DATE],[DATE], [DATE], [DATE], [DATE], and [DATE]. On other days, [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], a notation indicated: response not required, noted, instead of the amount of fluid intake. During an interview on [DATE], at 02:04 PM, when asked what, response not required, indicated, Licensed Nurse A stated the resident maybe was out of the building. Licensed Nurse A stated the whereabouts of the resident may be checked in the Nurses notes. (continued on next page)

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	055189	A. Building B. Wing	09/20/2022

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During consecutive interviews on [DATE], at 02:56 PM and 3:23 PM, Licensed Nurse A stated the notation, response not required, was what CNAs documented in response to a follow-up prompt in Point Click Care (PCC - an electronic recording system used in the facility) after a resident refused fluid. Licensed Nurse A stated she gave Med Pass and tried to offer fluids several times if a resident refused fluids and added, I am sure the CNAs offered several times. When asked what else she could do to prevent dehydration, Licensed Nurse A stated she would refer the resident to the physician who could give laboratory orders or an order for intravenous (IV) fluids. During an interview on [DATE], at 2:33 PM, Licensed Nurse X, who worked morning shift in ,d+[DATE], stated she could tell if the resident was dehydrated when the resident was weak and not drinking water with medication. Licensed Nurse X recalled Resident 100 was on crushed medication and thickened fluids, and there were times Resident 100 refused medication and fluids, but she almost always was able to get Resident 100 to take her medication. When the fluid intake record was reviewed on the days she worked on [DATE] and [DATE], Licensed Nurse X stated the thickened fluid she gave during medication administration was not documented. Licensed Nurse X further stated she did not receive a report from a CNA about any problem in Resident 100's fluid intake. When asked what she would have done to prevent dehydration, she stated she would have called and informed the physician to obtain an order for IV fluid or send the resident out. During an interview on [DATE], at 4:13 PM, Licensed Nurse Y, who worked afternoon shift on [DATE], stated she recalled Resident 100 refusing medication and fluids. Licensed Nurse Y stated, if the resident was refusing fluids, she would give fluids little by little as tolerated. The fluid intake record was reviewed with Licensed Nurse Y, and when asked if the record would reflect the total intake for the day, she responded, Yes. When dates were pointed to her where Resident 100 had no record of fluid intake, she stated she was not aware and added the CNA should have reported the problem. When asked how the CNAs knew how much fluids the nurses gave, Licensed Nurse Y stated the nurses recorded it in the Intake and Output (I&O) record. During a follow-up interview on [DATE], at 4:38 PM, Licensed Nurse Y stated there would be no record of the fluid taken in with medication from the medication or treatment chart, unless there was I&O monitoring. A review of the hospital record under, Death Summary, dated [DATE], it indicated Resident 100 was admitted to the acute hospital on [DATE], and expired on [DATE]. The probable cause of death was metabolic (all the physical and chemical processes in the body that convert or use energy) disorder with cardiac arrhythmia (irregular heartbeat that occurs when the electrical signals in the two upper chambers of the heart fire rapidly at the same time) due to profound hypernatremia, due to dehydration and failure to thrive, associated with progressive encephalopathy (any diffuse disease of the brain that alters brain function or structure). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility document titled, Hydration Policy and Procedure (P/P), revised in ,d+[DATE], indicated it was the policy of the facility to encourage fluid intake to maintain the resident's hydration. The policy and procedure further indicated: Each resident would be provided with a container of fresh cooled water located at the residents' bed side table unless contraindicated, fluids would be offered to residents during socialization, the kitchen staff would prepare and stock the hydration cart prior to hydration round times between meals at 10:00 AM, 2:00 PM, and 8:00 PM, Restorative Nursing Aides (RNA) would obtain the cart from the kitchen and start distributing refreshment or fluid/water to the residents, residents noted with any sign and symptoms of dehydration would be assessed immediately by the licensed nurse, the physician would be notified for any order or interventions in addition to the hydration program. A review of the undated facility document titled, Clinical Protocol for Hydration, indicated under assessment and recognition, for the physician and staff to identify significant risk for subsequent fluid and electrolyte imbalance; for example, individuals who were not eating or drinking well.

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	055189	A. Building B. Wing	09/20/2022

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44968 Based on observations, interviews, and records review, the facility failed to implement measures to reduce the risk of disease and infection transmission, when: 1. Four of ten sampled residents (Residents 20, 5, 43 and 26) did not receive annual PPD (Purified Protein Derivative - a method used to diagnose silent (latent) tuberculosis (TB) infection). This failure had the potential risk for elderly residents to be undiagnosed with silent TB and, without treatment, could result in fatal TB infection, exposing other residents, staff, and visitors, of the infectious disease. 2. Certified Nursing Assistants (CNA) did not perform proper hand hygiene before and after providing care and passing food trays, to four of four residents (Residents 1, 18, 19 and 39). This failure had the potential to result in a spread infections and/or transmission of diseases to the residents. 3. The air conditioning unit's vent in the kitchen, was not regularly cleaned. This failure had the potential to contaminate the food being prepared in the kitchen, putting residents at risk for food-borne illness. 4. The facility failed to adequately sanitize vital signs monitors when staff used one piece of sanitizing wipe to sanitize multiple vital signs monitors. This failure had the potential to result in spread of infections and/or transmission of diseases to the residents. 5. The facility failed to clean two out of two respiratory inhalers, per manufacturer's guideline. This failure had the potential risk for accumulation of bacteria and debris, which could cause respiratory infection and inadequate medication delivery for the residents. Findings: 1. During clinical record review for Resident 20, the document titled, Clinical-Immunizations, indicated Resident 20 received an annual PPD on 6/20/21. During clinical record review for Resident 20, the Medication administration Record (MAR) did not indicate Resident 20 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 5, the document titled, Clinical-Immunizations, indicated Resident 5 received an annual PPD on 6/20/21. During clinical record review for Resident 5, the Medication administration Record (MAR) did not indicate Resident 5 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 43, the document titled, Clinical-Immunizations, indicated Resident 43 received an annual PPD on 6/20/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During clinical record review for Resident 43, the Medication administration Record (MAR) did not indicate Resident 43 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 26, the document titled, Clinical-Immunizations, indicated Resident 26 received an annual PPD on 7/01//21. During clinical record review for Resident 26, the Medication administration Record (MAR) did not indicate Resident 26 was not scheduled for an annual PPD for September 2020. During record review and concurrent interview with the IP on 9/19/22 at 12:19 p.m., after reviewing the document titled, Clinical-Immunizations, the IP verified Resident 20, Resident 5, Resident 43 and Resident 26, were overdue for an annual PPD testing. When the IP was asked about the purpose of PPD, the IP stated PPD was done to screen residents for tuberculosis. When the IP was asked about the risk for residents who were not tested for TB, the IP stated, residents who were positive and not showing symptoms of TB, could not get the proper care/treatment they needed and potentially spread of the disease to other residents, staff, and visitors Review of the Facility policy and procedure, revised in 7/2012, indicated, Resident will have Mantoux/Skin test (injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm) or chest x-ray (produces a black-and-white image that shows the organs in the chest) as required, to ensure that health and safety of the resident and other residents in the facility are looked after .In this connection facility will comply with MD order regarding the Mantoux/Skin test and/or Chest x-ray upon admission if the resident cannot or does not have a copy of the recent 90 days Mantoux/Skin and/or Chest x-ray done from an accepted institution and yearly thereafter. 2. During an observation on 9/14/22 at 12:37 p.m. on D wing hall, CNA B and CNA F were passing meal trays to residents, without performing hand hygiene before entering a resident room. During an observation on 9/14/22 at 12:41 p.m., CNA F was delivering the tray to Resident 39. CNA F did not offer Resident 39 to wash his hands. Resident 39 started picking up the food with his bare hands and started eating. During an observation on 9/14/22 at 12:42 p.m., CNA F started feeding Resident 1 without washing his hands. Resident 1 was not offered to wash his hands. During an observation on 9/14/22 at 12:44 p.m., CNA B was delivering the tray to Resident 18 without performing hand hygiene before entering Resident 18's room. Resident 18 was not offered hand hygiene. During an observation on 9/14/22 at 12:50 p.m., CNA F came out of a resident room, did not perform hand hygiene after leaving the room, and before grabbing the lunch tray for Resident 19. Resident 19 was not offered hand hygiene. During an interview with CNA P on 9/14/22 at 4:20 p.m., when asked about hand hygiene, CNA P stated he would performed hand hygiene only before entering the bathroom. When CNA P was asked if hand hygiene was required when passing food trays to residents, CNA P stated they used gloves when passing food tray. CNA P stated he would offer hand hygiene to independent residents only if they wanted to wash their hands. (continued on next page)

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	09/20/2022

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 9/14/22 at 4:45 p.m., Certified Nursing Assistant P (CNA P) was supposed to help reposition Resident 351. He verified he did not perform hand hygiene (HH, a term used to cover both hand washing using soap and water, and cleaning hands with waterless or alcohol-based hand sanitizers) prior to donning and doffing gloves. CNA P stated he should have performed HH prior to donning and doffing gloves, for safety and infection control. He stated HH is important to keep residents safe from sickness and infections During an interview with CNA V on 9/20/22 at 9:15 a.m., when asked about facility policy on hand hygiene, CNA V stated staff should wash their hands before and after resident care, emptying catheter bags and urinals, passing food trays, and feeding residents. CNA V stated she would offer residents a washcloth to wash their hands before meals. During an interview with the Infection Preventionist (IP) Nurse on 9/20/22 at 9:25 a.m., when asked about facility policy on hand hygiene, the IP stated staff were expected to wash their hands before and after entering residents room, before and after providing resident care, before and after passing meal trays and feeding residents, before and after medication pass, and before and after gloves use. Review of the Facility policy and procedure titled, Handwashing/Hand Hygiene, with no effective dated indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents; after removing gloves; before and after assisting a resident with meals. 3. During an observation on 9/14/22 at 9:44 a.m., in the kitchen, the air conditioning (AC) unit's vent above the freezer, was covered with dust. During an interview with Dietary Cook AA on 9/14/22 9:45 a.m., when asked about maintenance of the air conditioning unit, Dietary Cook AA stated he could not remember when the last time the vent was cleaned. Dietary Cook AA concurred dust could accumulate, and it could contaminate the food during food preparation. During an interview with the Dietary Supervisor on 9/14/22 10:21 a.m., the Dietary Supervisor stated the Maintenance Director told her the last time the vent was cleaned, was last month. The Dietary Supervisor stated she had instructed maintenance to clean the vent after food preparation. The Dietary Supervisor stated, dust from the vent could spread and contaminate the food during food preparation. During an interview with the Maintenance Director on 9/14/22 at 3:11 p.m., when asked how often they cleaned the air conditioning unit above the freezer in the kitchen, the Maintenance Director stated, cleaning of AC vent was once a month. The Maintenance Director was not able to provide a copy of a tracking log confirming when the AC vent was cleaned. Review of the Facility policy and procedure titled, Infection Control Policies/ Practices/ Programs, revised in 6/2012, indicated, It is the policy of this facility that the primary principle of this facility's infection control policies, practices and programs are to establish guidelines to abide by to provide a safe, sanitary and comfortable environment and to assist in preventing the development and transmission of diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility policy and procedure titled, Maintenance Service, with no effective date, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include but are not limited to: providing routinely scheduled maintenance service to all areas; Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments. 46132 4. During a concurrent interview and medication pass observation for Resident 26 on 9/13/22 at 3:53 p.m., Licensed Nurse S verified she only used one piece of sani-cloth plus (a disposable wipe that kills bacteria and viruses within two minutes of surface contact) to collectively sanitize the wrist BPs, glucose strip (small, plastic strips that help to test and measure blood glucose levels) bottle, thermometers and pulse oximeters (an electronic device that measures the saturation of oxygen carried in the red blood cells) after use. During a medication pass observation for Resident 151 on 9/14/22 at 8:55 a.m., Licensed Nurse C verified she only used one piece of sani-cloth plus to collectively sanitize the BP wrist monitors, thermometers and pulse oximeters after use. 5. During a concurrent observation and interview on 9/20/22 at 9:13 a.m., Licensed Nurse A verified she held Resident 46's Diltiazem 24 ER (medicine used to treat high blood pressure and prevent chest pain) with her bare hands. LN A verified she should not be touching medications with her bare hands, for infection control. LN A verified she forgot to perform HH prior to donning and after doffing gloves. LN A verified she administered Spiriva (medicine used to control symptoms of Chronic Obstructive Pulmonary Disease [COPD], a chronic inflammatory lung disease that causes obstructed airflow from the lungs, by relaxing the airways and keeping them open) and Albuterol (a medication used to treat or prevent bronchospasm, a tightening of the muscles that line the airways in the lungs) inhaler to Resident 46. LN A verified she did not clean the Spiriva nor Albuterol after Resident 46 used them. She stated she only cleaned the inhalers if they were dirty. She stated, in this case, the inhalers were not dirty, so she did not clean them. LN A stated she were not aware of how to clean Spiriva's handihaler device or Albuterol's plastic actuator. LN A verified she did not wipe the mouth piece with tissue after every use. LN A stated she was not aware of the last time the Spiriva inhaler was cleaned. She stated, not cleaning the inhalers after use was an infection control issue. She stated, if a handihaler device and mouthpiece were not cleaned, there could be build-up of medication, and blockage could occur causing inadequate delivery of medications. During an interview on 9/20/22 at 9:54 a.m., the Infection Preventionist (IP) stated staff should be using one disinfecting wipe for each vital signs monitor. The IP stated she was not aware of any policy and procedure regarding cleaning of inhalers. She stated the expectation was for nurses to wipe the inhalers with a tissue after use, for infection control. The IP stated, not cleaning the inhalers and not sanitizing the vital signs monitor correctly, could put residents at risk for acquiring infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/20/22 at 10:10 a.m., The Director of Nursing (DON) stated he expects the nurses to clean the inhalers after every use. If this was not being done by the nurses, then the standards of practice were not followed. He stated, cleaning the inhalers was necessary for hygienic purposes and infection control. The DON stated he expected the nurses to use one sanitizing wipe for each vital sign monitors. He stated, not sanitizing the vital sign monitors effectively and not cleaning the inhalers, could put residents at risk for infections. During a telephone interview on 9/20/22 at 10:18 a.m., the facility's Registered Pharmacist stated nurses should be cleaning the inhaler devices and should keep an eye for medication build-up. He stated, not cleaning the inhalers could result in medication build-up which could lead to infections. During an interview on 9/20/22 at 10:24 a.m., Licensed Nurse H (LN H) stated the facility policy was for nurses to clean the inhalers after use, with a tissue. She stated it was important to clean the inhalers after use for infection control. LN H stated residents could end up with respiratory infections if the inhalers were not cleaned after use. During a review of Spiriva's instruction sheet, undated, it indicated, after taking the daily dose, it was recommended to remove any Spiriva capsule pieces or powder, by turning the handihaler device upside down and gently but firmly, tapping it. It also indicated to rinse the complete inhaler with warm water to remove any powder, then leaving the dust cap, mouthpiece and base open to air dry. It further indicated the outside of the mouthpiece may be cleaned with moist tissue. During a review of Albuterol Sulfate Inhalation Aerosol medication guide, undated, it indicated cleaning the device was very important to keep the plastic actuator clean so the medicine would not build-up and block the spray. It also indicated to wash the actuator at least one time each week, by holding the actuator under the faucet and running warm water through it for about 30 seconds.