

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Greenfield Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49849</p> <p>Based on observation, interview, and record review the facility failed to prevent accidents for one of 4 sampled residents (Resident 1) when a non-skid mesh, an intervention used to minimize risks of sliding from the wheelchair cushion and falling was not consistently implemented.</p> <p>This failure had the risk potential to increase falls and injuries for Resident 1.</p> <p>Findings:</p> <p>According to the 'Admission Record', Resident 1 was admitted to the facility in the summer of 2018 with diagnoses of epilepsy (a brain condition causing recurrent seizures) and muscle weakness.</p> <p>Resident 1's Minimum Data Set (MDS, an assessment tool), dated 4/12/24 was reviewed and indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment.</p> <p>A fall risk assessment, dated 4/15/24, indicated a fall risk score of 19. According to the Fall Risk Assessment, a score of 10 and greater was considered as High Risk for falls. The Fall Risk Assessment also indicated Resident 1 had decreased muscular coordination.</p> <p>A review of the Resident 1's 'Nurses Notes,' dated 4/20/24 indicated, Resident had unwitnessed fall . Resident was on the floor facing forward. Resident was propelling in wheelchair and fell forward. Resident hit his R [right] upper eye lid, slight bleeding noted with skin tear, on assessment resident c/o [complained of] pain in his lower back. R knee swollen with bruise and when asked resident to move his R leg resident c/o pain . Called MD [Medical Doctor]. Ok to send ER for further eval [evaluation].</p> <p>During an interview and concurrent record review with the MDS coordinator, on 8/7/24 at 1:07 p.m., the MDS coordinator acknowledged the MDS, dated [DATE], indicated Resident 1 used a wheelchair for his mobility. The MDS coordinator further stated, He mobilizes himself by scooting with his lower extremities in his wheelchair. The MDS coordinator acknowledged Resident 1 had a care plan (CP) for being at risk for fall/recurrent falls, had a diagnosis of epilepsy and muscle weakness.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with a Certified Nursing Assistant (CNA 1) on 8/7/24 at 1:15 p.m., CNA 1 stated, He (Resident 1) wheels himself in the halls .needs to be reminded not to use his feet when he wheels himself . we tell him to use his arms because his feet get stuck under his wheelchair and that is how he falls .I did not witness him fall but I did respond to help after he fell [on 4/20/24].</p> <p>During a concurrent observation and interview on 8/8/24 at 12:13 p.m., with the Director of Rehabilitation (DOR), the DOR acknowledged that Resident 1 was seen by the rehab staff for after fall screenings on 11/15/23, 12/5/23, and 4/22/24. The DOR further acknowledged he was the staff that screened Resident 1 on 12/5/23 and 4/22/24 after he fell from his wheelchair. The DOR acknowledged that the intervention to place a non-skid mesh on either side of the wheelchair cushion was to prevent Resident 1 from sliding and falling from the wheelchair. The DOR acknowledged he recommended the same intervention [non-skid mesh] on 12/5/23 and on 4/22/24 [fall occurred on 4/20/24]. The DOR stated, I recommended the same intervention because when I screened him for the fall in April, the non-skid mesh was missing. I changed the wheelchair and added a new mesh to the cushion. The DOR stated, I believe the fall happened because he was sliding on the cushion. The Dycem (a blue, non-skid mesh) prevents the cushion from sliding. The DOR stated, The CNA should have noticed the mesh was missing .it's bright blue and is easily seen.</p> <p>Resident 1's 'Fall Risk Care Plan' (CP) initiated on 08/22/21, with a target date of 10/12/24, was reviewed and did not contain an intervention for a non-skid mesh to the wheelchair to prevent the resident from sliding from the wheelchair cushion as recommended by the rehab staff on 12/5/23 and 4/22/24.</p> <p>During a concurrent interview and observation on 8/8/24 at 12:40 p.m., with Resident 1 in the dining room, Resident 1 was sitting in his wheelchair with no visible non-skid mesh. CNA 1 and CNA 2 were present during the observation and acknowledged there was no blue non-skid mesh present on Resident 1's wheelchair, either side. Both CNAs stated they were not aware the resident had a non-skid mesh to prevent him from sliding from the wheelchair cushion and falling.</p> <p>During a concurrent observation and interview on 8/8/24 at 12:55 p.m., with CNA 2, CNA 3, and the Director of Nursing (DON), CNA 2 and CNA 3 wheeled Resident 1 to his room and utilized a 'Sit- to-Stand' mechanical device to lift Resident 1 from his wheelchair to facilitate further observation of the wheelchair and underneath the cushion. The DON acknowledged there was no non-skid mesh on either side of the wheelchair cushion. CNA 3 stated, I do not see a non-skid mesh. The DON confirmed that the non-skid mesh was one of the interventions utilized to prevent Resident 1 from sliding from the wheelchair cushion and resulting to an avoidable fall.</p> <p>During an interview on 8/8/24 at 1:39 p.m., with the DON in her office, the DON stated her expectation was that the non-skid mesh would be utilized to prevent Resident 1 from sliding and falling. The DON further stated, If he slid off the wheelchair, it is a potential for another fall which could result in injury.</p> <p>A review of the facility's policy, Fall Management, revised 01/24, stipulated, It is the policy of the facility to provide a consistent process for evaluating, managing, and reducing falls to minimize risks and improve quality of life, for residents who are at risk for falls.</p> <p>(continued on next page)</p>		

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