Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 08/10/2024
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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39792 49933 Based on interview and record review the facility failed to ensure services met professional standards for one resident (Resident 10) of eight sampled residents when: 1. Licensed Staff B (LS B) administered Tacrolimus (a medication used in the prevention and treatment of organ transplant rejection) 0.5 milligram (mg) (medication to prevent the activity of the immune system) without a prescriber's order. 2. Tacrolimus 4.5 mg dose was changed by LS B without discussion with transplant coordinator (health professional who manages the organ transplant care); and, 3. Resident 10's weekly Tacrolimus lab was not done and carried out per prescriber's order. This failure decreased the facility's potential to administer medications safely to residents. Findings: A review of an Admission Record indicated Resident 10 was admitted to the facility in early 2024 with multiple diagnoses which included dementia (loss of cognitive functioning - thinking, remembering, and reasoning) and history of heart transplant. Resident 10's Minimum Data Set (MDS, an assessment tool), dated 5/28/24 indicated, mild memory problems. In a review of Resident 10's clinical record indicated the following: -[Hospital] Health Care Discharge orders indicated: Tacrolimus. Take 4.5 mg dose each morning and 5 mg dose each evening. Check Tacrolimus level on Tuesday, 5/5/24. Discuss results with your transplant coordinator as dose adjustments may be needed. -[Hospital] Health Care Discharge orders also indicated: Follow weekly CBC [Complete Blood Count, a blood test] , CMP [Comprehensive Metabolic Panel, a blood test], Magnesium, Phosphorus and Tacrolimus level starting Tuesday 3/5/24. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of medication administration record (MAR), dated March, 2024 and April 2024, weekly Tacrolimus labs were not done. The only lab results in Resident 10's clinical record were dated 5/9/24, 5/16/24 and 5/30/24. -A review of MAR records from March, April and May 2024 indicated Tacrolimus 0.5mg was administered to Resident 10 without an order. During a phone interview on 8/9/24 at 9 a.m., LS B stated she received a telephone order from Nurse Practitioner (NP) on 3/21/24 to decrease Tacrolimus dose to 0.5 mg. There was no documented evidence of a prescribed order for Tacrolimus 0.5 mg from a provider. During a phone interview on 8/9/24 at 9:30 a.m., NP stated she did not order Tacrolimus 0.5 mg and the medication should have been discussed with the transplant coordinator for dose adjustments per hospital discharge orders. During a review of Resident 10's laboratory results from 3/2/24 to 5/22/24, Resident 10's records indicated Tacrolimus levels were only taken on 5/9/24, 5/16/24 and 5/30/24. The weekly lab orders were not followed starting 3/5/24. During a review of Resident 10's laboratory requisition dated 5/16/24, indicated Resident 10's Tacrolimus result was, 4. The expected range was 5-20 which would indicate the medication was at a therapeutic level in Resident 10's body. During an interview on 6/3/24 at 3:05 p.m., LS A was asked where the weekly laboratory test results were located within the medical record. The LS A stated she could not find the laboratory requisition (results) documents. The LS A confirmed the CBC, CMP, Magnesium, and Phosphorus test resulsts were not conducted for Resident 10 between 3/22/24 and 5/16/24, when Resident 10 collapsed at dialysis and was transferred to a higher level of care. During an interview on 8/8/24 at 9:30 a.m. with LS C, LS C confirmed there were no weekly labs done per order. The LS C confirmed there were only documented tacrolimus lab results. During an interview on 8/8/24 at 10:21 a.m., with the Director of Nursing (DON), DON confirmed and stated she did not find any written order for Tacrolimus 0.5mg for Resident 10. She also confirmed NP did not give that order and further stated there was no documented evidence of nursing progress notes in the clinical record. The DON stated her expectation was nurses who received a verbal order should document it on paper. The DON stated it was the expectation of nursing staff to confirm the prescriber's order if there were any changes or new medication orders. During a review of the facility's policy and procedure titled, Medication and Treatment Orders, dated 01/24, indicated, Orders for medications .will be consistent with principles of safe .order .Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe .Drug and biological orders must be recorded on the physician's order sheet in the resident's chart .is written, dated and signed by the person lawfully authorized to give such an order .Verbal orders must be recorded immediately in the resident's chart by the person receiving order .