

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 11/05/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interviews and record reviews, the facility failed to ensure residents and or their Responsible Parties (RP, an individual who is designated by the resident to help with placement or take on some responsibility for the resident's well-being) were aware of any Change of Condition (COC, significant alteration in a person's health or functional status that will not usually resolve itself without further intervention) or medication order changes, for two out of two sampled residents (Residents 2 and 3), when:</p> <ol style="list-style-type: none"> 1. Resident 2 ' s RP was not notified of the change of his skin status. 2. Resident 3 was not aware he would need to continue his intravenous (IV, administered into a vein) antibiotic (ABX, drug used to treat infections-growth of germs in the body) therapy. <p>This failure could potentially lead to delayed interventions, missed opportunities for quality care, for Resident 2 and for Resident 3 feeling anxious, angry and frustrated for not knowing the treatment plan.</p> <p>Findings:</p> <p>A review of Resident 2 ' s face sheet (demographics) indicated Resident 2 was admitted on [DATE], with a diagnoses of Parkinson ' s Disease (PD, a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to movement problems), Bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior, and sleep) and Contracture (fixed tightening of muscle that prevents normal movement of the associated body part) of right and left ankle. Resident 2 ' s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents), dated 9/6/24, score was 5 out of 15, indicating severely impaired cognition. Resident 2's Minimum Data Set (MDS, a federally mandated process that helps nursing home staff identify health problems and assess a resident's functional capabilities), dated 9/6/24, indicated Resident 2 required maximal assistance up to fully dependent on staff for provision of care.</p> <p>A review of the Emergency Department (ED, department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care) Physician Note Final Report, dated 10/25/24, indicated, family just became aware of the lesions today as patient resides in a nursing home.</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
---	-------	-----------

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 11/05/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation on 11/4/24 at 1:45 p.m., Licensed Nurse (LN) B verified Resident 2 had scattered scabs and open wounds on both of his front lower legs, yellowed, thickened toenails on both of his feet, his left heel was reddened, and his back and spine was scattered with black-colored scabs.</p> <p>During an interview on 11/4/24 at 3:30 p.m., the Medical Record Director (MRD) confirmed there was no documentation nor Nurses Progress Notes to indicate Resident 2 ' s RP was notified of the decline on his current skin status and the wounds on both of his lower front legs.</p> <p>During a concurrent interview, weekly skin assessment for non-pressure sore, and Nurses Progress Notes record reviews on 11/4/24 at 4:29 p.m., the Director of Nursing (DON) verified the RP was not notified when there was a change in Resident 2 ' s wound and skin status. The DON stated Resident 2 ' s keratoses (a rough, scaly patch on the skin that develops from years of sun exposure) on both of his lower leg was not new. The DON stated these were healed. The DON stated these keratoses came and went but stated if the skin issue resolved or if it became an issue again, staff would still need to notify the RP. The DON stated there was no documentation to indicate staff notified Resident 2 ' s RP when the keratoses on both of his front lower legs became an issue again. When asked if staff had notified Resident 2 ' s RP about his yellowed thickened toenail, reddened left heel or scattered black-colored scabs on his back and spine, the DON stated there was no indication or documentation to indicate staff notified Resident 2 ' s RP about these changes. The DON stated it was Resident 2 ' s RP's right to know if there were any changes in his skin status.</p> <p>During an interview on 11/4/24 at 4:33 p.m., LN C stated RP ' s should be notified whenever there were changes in resident's condition. LN C stated worsening of wound or skin status was considered a COC and the RP should be notified per facility policy. LN C stated, if the RP was not notified of the COC, then it was a violation of resident ' s rights, and the policy was not followed.</p> <p>During an interview 11/4/24 at 5:20 p.m., LN E stated it was a resident and or RP ' s right to be notified of any change in their condition including worsening of skin status. LN E stated not notifying residents or RP's of COC or worsening of skin status could lead to confusion and residents or RP's feeling angry and upset.</p> <p>During an interview on 11/5/24 at 11:28 a.m., Certified Nursing Assistant (CNA) F stated Resident 2 ' s thickened yellowed toenails and the skin issue on his legs and back had been ongoing for months. CNA F stated the nurses also knew about it.</p> <p>During an interview on 11/5/24 at 12:04 p.m., LN G stated residents and RP ' s should be notified whenever there was a COC, their skin status deteriorated or their wounds became worse. LN G stated this was their basic right. LN G stated, not notifying them of these changes could lead to anxiety and feelings of distrust.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Change of Condition, revised 1/2024, the P&P indicated the Responsible Party would be notified that there had been a change in the resident's condition and what steps were being taken.</p> <p>(continued on next page)</p>		

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 11/05/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. A review of Resident 3 ' s face sheet indicated Resident 3 was admitted on [DATE], with a diagnosis of Hypertension (HTN, high blood pressure) and Osteomyelitis (bone infection). Resident 3 ' s BIMS, dated 10/5/24, score was 15 out of 15, indicating intact cognition. Resident 3 ' s face sheet indicated he was self-responsible.</p> <p>A review of Resident 3 ' s Electronic Medication Administration Record (EMAR, digital systems used in healthcare settings to document the administration of medications to patients) for 10/2024, indicated an IV ABX (Antibiotic) order via pump one time a day with an order date of 9/24/24 until 10/26/24.</p> <p>A review of Resident 3 ' s Physician's Order, dated 10/25/25, indicated to continue IV ABX for seven more days.</p> <p>A review of Resident 3 ' s EMAR for 11/2024, indicated an IV ABX order via pump one time a day with an order date of 10/25/24 until 11/2/24.</p> <p>During an interview on 11/5/24 at 11:48 a.m., Resident 3 stated he had an IV line on his left upper arm for infection. Resident 3 stated he was frustrated, angry and upset because nursing staff did not inform him he had to continue his IV ABX treatment. Resident 3 stated initially he was only supposed to receive IV therapy until 10/25/24, but turned out it was extended until 11/2/24, and nobody communicated this change in his order then and the reason as to why they were extending his IV ABX therapy.</p> <p>During a concurrent interview, Physician ' s Order, Nurse Progress Note, both dated 11/25 24, record review on 11/5/24 at 12:11 p.m., the Director of Nursing (DON) verified there was no indication on the Nurse Progress Note from 10/25/24, that Resident 3 was notified of the Physician ' s Order to continue his IV ABX and the reason why he needed to continue his IV ABX. The DON stated Resident 3 was responsible for himself. The DON stated Resident 3 should have been notified of the Physician ' s Order to extend his IV ABX and the reason for the order because this was a regulatory requirement and this was to ensure he understood the treatment and agreed with the treatment.</p> <p>During an interview on 11/5/24 at 12:31 p.m., LN A stated residents should always be notified of the doctor ' s order because this was their right and also to obtain their consent. LN A stated residents should be included when making health care decisions. LN A stated, if residents were not aware of the doctor ' s order, they may not understand what the need was for the certain order, they might get upset, frustrated and they may not follow the doctor ' s order.</p> <p>During an interview on 11/5/24 at 11:45 p.m., the Infection Preventionist (IP) stated residents should notified of Physician ' s Orders and the reason for that order. The IP stated this was a resident ' s right.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Resident ' s Rights, revised 1/2024, the P&P indicated, . basic right to all the residents in the facility includes to be informed of, or participate in his or her care planning and treatment.</p>		

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 11/05/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on observation, interviews and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Licensed Nurse (LN A) was following the Physician ' s Order for one out of two sampled residents (Resident 1), when LN A injected the long-acting insulin (injectable medication used to control blood sugar for people with Diabetes Mellitus -- DM,high blood glucose group of diseases that result in too much sugar in the blood) on Resident 1 ' s right lower abdomen at 11:18 a.m. instead of 9 a.m., per physician ' s order. 2. Ensure the nurse practitioner ' s (NP) treatment plan and recommendations on 10/31/24, were followed for one out of two sampled residents (Resident 2), when Resident 2 ' s current Electronic Treatment Administration Record (ETAR, digital systems used in healthcare settings to document the administration of treatments to patients) for 11/2024, did not reflect the NP ' s treatment plan, and Resident 2 was not on alternating pressure pad (APP, an air-flow mattress, a device that redistributes pressure to relieve pressure points and prevent bed sores) and was not using heel protectors (a device that cushions and elevates the heel to help prevent pressure injuries). <p>1a. Failure to administer medications per Physician ' s Order could put residents at risk for worsening of existing conditions, further health issues, and inadequate treatment.</p> <p>2b. Failure to follow the NP ' s treatment plan and recommendation could result in infection, delayed wound healing, further trauma to the skin, development of a pressure ulcer (PU, a skin injury caused by prolonged pressure on an area of the body), and skin and tissue damage.</p> <p>Findings:</p> <p>1a. A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE], with diagnoses of DM, Chronic Pain (pain that lasts over three months) and Hyperlipidemia (HLP, a condition in which there are high levels of fat particles (lipids) in the blood). Resident 1 ' s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents), dated 10/7/24, score was 15 out of 15, indicating intact cognition.</p> <p>A review of Resident 1 ' s Electronic Medical Administration Record (EMAR, digital systems used in healthcare settings to document the administration of medications to patients), dated 11/4/24, indicated to inject 50 units of long-acting insulin subcutaneously (inject medications between skin and muscle) one time a day for diabetic polyneuropathy (damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body, featuring weakness, numbness, and burning pain) at 9 a.m. The EMAR indicated LN A administered this insulin at 11:18 a.m. on 11/4/24.</p> <p>Further review of Resident 1's EMAR indicated she did not receive the long-acting insulin at 9 a.m., per Physician ' s Order on these dates: 8/26/24 at 10:08 a.m., 8/30/24 at 10:40 a.m., 11/1/24 at 10:50 a.m., and 11/3/24 at 11:12 a.m.</p> <p>(continued on next page)</p>		

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 11/05/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 11/4/24 at 11:16 a.m., LN A injected the long-acting insulin on Resident 1 ' s right lower abdomen.</p> <p>During an interview on 11/4/24 at 11:20 a.m., when asked what the administration time for this long-acting insulin was, LN A stated Resident 1 should have received this insulin at 9 a.m., per Physician ' s Order. LN A stated she was late in administering the long-acting insulin. LN A stated she did not follow the administration time per Physician ' s Order when she administered Resident 1 ' s long-acting insulin. When asked what the risk for could be for not following the administration time per Physician Order, LN A did not respond.</p> <p>During an interview on 11/4/24 at 11:28 a.m., LN B stated Physician ' s Orders should be followed. LN B stated medications should be administered as ordered and correct timing should be observed. LN B stated, if a medication was administered more than one to two hours after the scheduled time, then it was considered late medication administration and could result in patient harm.</p> <p>During an interview on 11/4/24 1:28 p.m., when asked if a medication was considered late administration when it was administered more than one to two hours after a scheduled time, the Infection Preventionist (IP) stated it was administered late. The IP stated not following Physician Order could be a safety risk for the resident.</p> <p>During an interview on 11/4/24 at 4:45 p.m., the Director of Nursing (DON) stated she expected the Licensed Nurses to administer resident ' s medications timely per Physician ' s Order for residents ' safety. The DON stated Physician ' s Orders should be followed. The DON stated if a long-acting insulin was administered more than one to two hours after the ordered time, then the medication was administered late, and the Physician Order was not followed.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Administering Medications, revised 1/2024, indicated medications were to be, administered in accordance with prescriber orders, including any required time frame .medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>2b. A review of Resident 2 ' s face sheet (demographics) indicated Resident 2 was admitted on [DATE], with diagnoses of Parkinson ' s Disease (PD, a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to movement problems), Bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior, and sleep) and Contracture (fixed tightening of muscle that prevent normal movement of the associated body part) of right and left ankle. Resident 2 ' s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents), dated 9/6/24, score was 5 out of 15, indicating severely impaired cognition. Resident 2's Minimum Data Set (MDS, a federally mandated process that helps nursing home staff identify health problems and assess a resident's functional capabilities), dated 9/6/24, indicated Resident 2 required maximal assistance up to fully dependent on staff for provision of care.</p> <p>A review of Resident 2 ' s Wound Progress Note, dated 10/31/24, indicated a treatment plan for the anterior (front) leg wound to be cleansed with normal saline (NS, a solution of water and salt), applied collagen powder (helps promote new tissue growth) to wound base plus calcium alginate (highly absorbent wound dressing from brown seaweed), and dry dressing, secured with kerlix wrap and tape daily (QD), and as needed (PRN) for soiling and dislodgement.</p> <p>(continued on next page)</p>		

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 11/05/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 2 ' s Wound Progress Note, dated 10/31/24, also indicated the NP ' s recommendation of aggressive offloading (reduce or redistribute pressure), use of APP, heel protectors and to offload heels on pillows.</p> <p>A review of Resident 2 ' s EMAR for 11/2024, did not show the NP ' s wound treatment plan for the anterior leg to cleanse the wound with NS, apply collagen powder to wound base plus calcium alginate, apply dry dressing, and secure with kerlix wrap and tape daily (QD), and as needed (PRN) for soiling and dislodgement.</p> <p>A review of Resident 2's Physician Order Summary (POS, a table view of a patient's orders that includes information such as the order item, category, frequency, status, and when the order was entered) for 11/2024, was missing the wound NP ' s treatment plan for the anterior lower leg and recommendations of aggressive offloading, using an APP and use of heel protectors.</p> <p>During an observation on 11/4/24 at 11:45 a.m., Resident 2 was lying on a regular mattress, not wearing heel protectors, and the heels were not offloaded by pillows.</p> <p>During a concurrent observation on 11/4/24 at 1:45 p.m., LN B verified Resident 2 had open wounds on both of his front lower legs. LN B also verified Resident 2 was not lying on an APP, was not wearing a heel protectors and the heels were not off loaded by pillows. LN B stated Resident 2 ' s treatment on his right lower leg was to cleanse with NS and to apply A and D (ointment) and for left lower extremity to cleanse with NS and apply medihoney (medical-grade honey products for the management of wounds and burns).</p> <p>During an interview on 11/4/24 at 2:40 p.m., LN B stated the wound NP ' s treatment plans and recommendations were treated as Physician's Order and should be followed and implemented for faster wound healing and to prevent further skin issues.</p> <p>During a concurrent observation and interview on 11/4/24 at 2:50 p.m., the Infection Preventionist (IP) verified Resident 2 was not lying on an APP, his feet were not offloaded with pillows, nor was he using heel protectors. The IP stated, when the wound NP developed treatment plans and made recommendations, nurses considered those as a valid order that would need to be carried out and followed. The IP stated not following the NP ' s treatment plan and recommendation of aggressive offloading, using heel protectors and an APP could put Resident 2 at risk to developing a PU, delayed wound healing, the wound to worsen and a new wound to develop.</p> <p>During a concurrent observation and interview on 11/4/24 at 2:55 p.m., Certified Nursing (CNA) D verified Resident 2 was not lying on an APP, his feet were not off loaded with pillows, and he was not wearing heel protectors. CNA D stated Resident 2 was at risk for further skin issues and would need his heels to be offloaded. CNA D stated it would benefit Resident 2 if he was lying on an APP to prevent wounds from developing.</p> <p>(continued on next page)</p>		

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 11/05/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation, interview and Wound Progress Note, dated 10/31/24, record review on 11/4/24 at 4:12 p.m., the DON verified the wound NP recommended aggressive offloading, heel protectors and an APP and wound treatment plan for the anterior leg to cleanse the wound with NS, apply collagen powder to wound base plus calcium alginate, dry dressing, secure with kerlix wrap and tape QD, and PRN for soiling and dislodgement. The DON stated the NP wound treatment plan and recommendations should be followed to prevent Resident 2's further skin breakdown. The DON stated there was an extra APP in the facility and was not sure why Resident 2 was still not using an APP. The DON stated it appeared like the nurses did not read, did not carry out, and did not follow the wound NP's treatment plan and recommendations.</p> <p>During a telephone interview on 11/4/24 at 5:06 p.m., the Director of Staff Development (DSD) stated he went on rounds with the NP on 10/31/24. The DSD stated the NP ' s treatment plan and recommendations were considered as a valid Physician ' s Order and should be followed. The DSD stated he received the treatment plan and recommendation from the wound NP himself but had the nurse on light duty transcribed it.</p> <p>During an interview on 11/4/24 at 5:14 p.m., the DON stated the NP ' s wound treatment plan and recommendations were not carried out.</p> <p>During a concurrent interview and POS, dated 11/2024, record review on 11/4/24 at 5:20 p.m., LN E stated she recalled talking to the DSD about the NP treatment plan and recommendations. LN E verified the NP ' s treatment plan and recommendations were not carried out. LN E stated NP's treatment plan and recommendations should be treated as valid Physician ' s Orders and should be followed.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Administering Medications, revised 1/2024, indicated, .medications are administered in accordance with prescriber orders.</p> <p>A review of the facility ' s P&P titled, Medication and Treatment Order, revised 1/2024, the P&P indicated, medications shall be administer only upon the written order of a person duly licensed and authorized to prescribe such medications in this state .</p>		

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 11/05/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure proper infection protocol was provided for one out of two sampled residents (Resident 1), when licensed nurse (LN) A reused an alcohol wipe (a sterile wipe saturated with a high concentration of alcohol used to clean the skin and prevent infection) to wipe Resident 1 ' s abdomen after insulin (injectable medication used to control blood sugar for people with Diabetes Mellitus -- DM, high blood glucose group of diseases that result in too much sugar in the blood) administration. This failure put Resident 1 at risk for risk for infection by introducing germs and bacteria into broken skin.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE], with diagnoses of DM, Chronic Pain (pain that lasts over three months) and Hyperlipidemia (HLP, a condition in which there are high levels of fat particles (lipids) in the blood). Resident 1 ' s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents), dated 10/7/24, score was 15 out of 15, indicating intact cognition. Resident 1 ' s functional abilities indicated she was dependent on staff for provision of all care.</p> <p>A review of Resident 1 ' s active Physician Order Summary (POS, a table view of a patient's orders that includes information such as the order item, category, frequency, status, and when the order was entered) as of 11/4/24, indicated to inject 50 unit of long-acting insulin subcutaneously one time a day for diabetic polyneuropathy (damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body, featuring weakness, numbness, and burning pain) with an order date of 6/22/24.</p> <p>During a concurrent observation and interview on 11/4/24 at 11:16 a.m., LN A cleansed Resident 1 right lower abdomen with an alcohol wipe. LN A then folded the used alcohol wipe and placed it on the tray table at Resident 1 ' s bedside. LN A injected the insulin on Resident 1's right lower abdomen. Resident 1 requested LN A to wipe the injected site with an alcohol wipe because the injected site felt hot. LN A wiped Resident 1 ' s abdomen with an alcohol wipe. LN A verified she reused the alcohol wipe she had used earlier when she cleansed Resident 1 ' s abdomen prior to the insulin administration. When asked if it was acceptable to reuse an alcohol wipe, LN A stated, No. LN A stated she reused the alcohol wipe because Resident 1 requested her to wipe her abdomen with alcohol wipe after she injected the insulin on her abdomen, but she did not bring an extra alcohol wipe. LN A stated Resident 1 got upset easily if her requests were not met as soon as she requested them. LN A stated this was not an excuse and knew reusing an alcohol wipe was an infection control issue. LN A stated reusing an alcohol wipe could result in infection.</p> <p>During an interview on 11/4/24 at 11:28 a.m., LN B stated to not reuse an alcohol wipe due to risk of cross contamination and infection.</p> <p>(continued on next page)</p>		

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 11/05/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/4/24 at 1:28 p.m., the Infection Preventionist (IP) stated once an alcohol wipe was used, it could not be reused later regardless of whether it was to be used on the same patient. The IP stated that a used alcohol wipe was already considered contaminated and reusing it again, especially on an area where you had injected an insulin, where there was a broken skin, could be a risk for cross-contamination and infection.</p> <p>During an interview on 11/4/24 at 4:33 p.m., LN C stated reusing an alcohol wipe on an area where there was a broken skin, such as after injecting the abdomen with insulin, could introduce bacteria to open skin.</p> <p>During an interview on 11/4/24 at 4:45 p.m., the Director of Nursing (DON) stated it was not appropriate to reuse alcohol wipe on broken skin because of the risk for infection.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Infection Prevention and Control Program, undated, the P&P indicated, .important facets of infection prevention include educating staff and ensuring they adhere to proper techniques and procedures .</p>