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	12/19/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on interview and record review, the facility failed to ensure four out of four sampled residents received care which met professional standards when: 1. One Resident (Resident 1) suffered a 22 day delay in treatment of urinary tract infection and 2. three residents (Residents 3, 5 and 7) did not receive medications per order which had the potential to result in a stroke, high blood pressure, and for one resident (Resident 7) who suffered breathing problems and requested to be transferred to a facility for a higher level of care through emergency transport. Findings: 1. During a review of Resident 1's, Admission Record , indicated Resident 1 was admitted to the facility on [DATE] with a history of urinary tract infection, diabetes (a chronic disease which occurs when your sugar levels are too high), acute kidney failure (sudden decline in kidney function which could be caused by infection or condition which reduce blood flow to the kidneys) and high blood pressure. During a review of Resident 1's Orders dated 10/29/24, indicated a licensed member nurse practitioner ordered for a laboratory test for urinary analysis with culture and sensitivity (test which checks for bacteria and other germs in a urine sample and determines which antibiotics (medications to treat bacterial infections) would be most effective to treat an infection). A review of the completed test result for the urinary analysis with culture and sensitivity dated 11/8/24 indicated the specimen had been collected and sent to the laboratory. On 11/11/24, the culture was resulted to have grown bacteria and indicated to be sensitive to numerous antibiotic medications and reported to the facility. On 11/22/24 the nurse practitioner indicated per the Medication Administration Record to prescribe Macrobid (an antibiotic to treat a urinary tract infection) for seven days. During an interview on 12/17/24 at 1:35 p.m. with Licensed Staff A, Licensed Staff A, stated the nurse practitioner had prescribed the laboratory test for urinalysis, culture and sensitivity on 10/29/24 but the antibiotic was not prescribed until 11/22/24 and proceeded to locate the test results. Licensed Staff A stated the specimen had been obtained and sent to the laboratory on 11/8/24 and the results came back on 11/11/24 which did not make sense to Licensed Staff A. License Staff A stated it should not have taken that long to obtain a urine sample for culture and sensitivity, and stated it was a pretty simple to obtain a urine sample. (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 - Some	During a concurrent interview and record review on 12/19/24 at 10:10 a.m., with Director of Nursing (DON), Resident 1's medical record and laboratory test results were reviewed. The DON stated, did see the urine culture and sensitivity sample was sent on 11/8/24 and the results were faxed to the facility on [DATE]. DON stated she was not aware that the staff had not obtained or sent the specimen. DON stated all her nurses should be able to obtain a urinalysis specimen. DON reviewed the medical record and stated the antibiotic medication prescribed for Resident 1 was on 11/22/24 which was 11 more days after the results were faxed to the facility. DON stated the nurse practitioner would make visits to the facility every Tuesday and Friday, missed three opportunities and missed almost two weeks to view the results and then prescribe an antibiotic medication to treat Resident 1's confirmed urinary tract infection. DON stated the risk and harm of Resident 1 walking around with a urinary tract infection for 23 days before treatment, was risk of acute kidney failure and stated that was very bad. DON further stated it should not have taken that long, and there was just no excuse. 2. During a review of Resident 7's Admission Record , dated 11/20/24 indicated, Resident 7 was admitted to the facility on [DATE] with a history of acute and chronic respiratory failure with hypercapnia (conditions that occur when there is too much carbon dioxide in the blood resulting in shortness of breath acutely and chronic where the kidneys are able to compensate), chronic obstructive pulmonary disease (COPD, progressive lung disease lung causing restrictive airflow and breathing problems), fluid overload (medical condition with too much fluid in the body, causing swelling and making it difficult to breath) and high blood pressure. During a review of Resident 7's, Medication Administration Record (MAR) , dated 11/20/24 indicated the following medication were prescribed: Amlodipine Besylate at 5:31 p.m. (prescribed to reduce high blood pressure), furosemide at 9:28 p.m. (prescribed high blood pressure and fluid overload), lidocaine external patch at 9:31 p.m. (prescribed for pain), Tiotropium Bromide Monohydrate inhalation aerosol solution at 10:16 p.m. (prescribed for COPD), Trelegy Ellipta inhalation aerosol (prescribed for COPD), Apixaban (prescribed to prevent strokes and blood clots) at 9:22 p.m., and Carvedilol (prescribed to treat high blood pressure) at 5:44 p.m. On 11/21/24 the following medications were not administered to Resident 7 due to unavailability as indicated in the MAR, Amlodipine, Furosemide, Lidocaine External Patch, Tiotropium Bromide Monohydrate inhalation, Trelegy Ellipta inhalation, Apixaban and Carvedilol. The medical record indicated the medications were awaiting delivery by pharmacy. During a review of Resident 7's Nursing Progress Notes , dated 11/20/24 indicated, Resident 7 was admitted to the facility at 4:45 p.m., from a higher level of care to the facility with the physician and pharmacy have been notified of the new admission. Resident 7 was described as requiring the use of oxygen through a tube going into her nose. On 11/21/24 at 10:51 p.m. Resident 7 was indicated to be very anxious, the nurse had administered a respiratory treatment and increased the flow of oxygen but Resident 7 continued to be anxious. The Nurse Practitioner was contacted who prescribed hydroxyzine, a medication to help reduce Resident 7's anxiety. On 11/21/24 at 10: 58 p.m., the nursing staff had called 911 and sent Resident 7 to a higher level of care but the progress note indicated the time, Resident 7 was transferred out of the facility was 6:07 p.m. During an interview on 12/17/24 at 10:47 am. with Nurse Practitioner C (NPC) stated Resident 7 had a history of respiratory problems (short of breath and difficulty breathing) and remembered getting the call that night that Resident 7 was transferred out to a higher level of care. NPC stated not receiving Resident 7's inhalers and her diuretic, (furosemide) would make it difficult to breath and that's why those medications were prescribed was to help her breath better. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/17/24 at 4:46 p.m. with Director of Nursing (DON), DON reviewed Resident 7's MAR, dated 11/21/24 and confirmed the following information: Amlodipine Besylate was due to be administered at 9 a.m. and was not administered, Furosemide was due to be administered at 9 a.m., and was not administered and Tiotrpium Bromide inhaler was due to be administered at 9 a.m. and was not administered due to not have been delivered by the pharmacy. DON stated after reviewing the progress notes where it indicated Resident 7 was transferred out of the facility to a higher level of care that yes the anxiety could have been related to not receiving the medications which were prescribed but not available due to not yet delivered by the pharmacy. DON stated the pharmacy delivery times were scheduled multiple times throughout the day (3-4 pm., 8-9 pm. and one more in the early morning) DON stated this was set up so residents do not miss their medication and Resident 7's medication were important, blood pressure, medications to decrease fluid and inhalers were important. During a review of Resident 3's, Admission Record , dated 11/19/24, indicated Resident 3 had been admitted to the facility on [DATE] with a history of atypical atrial flutter (a type of fast heart rate, which occurs when an electrical signal moves too fast around the heart), high blood pressure and transient ischemic attack (mini stroke or brief interruption of blood flow to the brain which causes stroke like symptoms which goes away). A review of Resident 3's MAR, dated 11/19/24 at 4:48 pm indicated the following medications were prescribed: amlodipine besylate, losartan potassium (prescribed to treat high blood pressure and low potassium), metoprolol (prescribed to treat high blood pressure), and apixaban. The MAR indicated, Resident 3 was not administered the following medications due to unavailability, Amlodipine was not administered on 11/20/24 and 11/21/24, Losartan Potassium was not administered on 11/20/24 and 11/21/24, Metoprolol was not administered on 11/20/24 and 11/21/24, and Apixaban single dose was not administered on 11/20/24. These medications had not been delivered from the pharmacy as indicated in the Medication Admission Record notes. During a concurrent interview and record review on 12/17/24 at 4:38 pm. with DON, DON reviewed Resident 3's MAR dated 11/20/24 and 11/21/24 and indicated the following medications: Amlodipine was due to be administered at 9 am and was not administered on 11/20/24 and 11/21/24, Losarten Potassium was due to be administered at 9 a.m., but was not administered on 11/20/24 and 11/21/24, Metoprolol Tartrate was due to administered at 9 am, but was not administered on 11/20/24 and 11/21/24. DON stated the medications should have been delivered prior to the 9 am administration time on 11/20/24 and definitely by the next day (11/21/24). DON stated, if the facility does have an admission and there isn't a nurse scheduled to take care of this assignment, then the nurse assigned to the room where the new admission would reside would handle the new admission process including the tasks associated of faxing the orders to the pharmacy and then calling the pharmacy as a follow up to ensure receipt of the resident's medication orders. During a review of Resident 5's Admission Record dated 12/9/24, indicated Resident 5 was admitted to the facility on [DATE] with a history of high blood pressure, atrial fibrillation (a type of irregular heart beat where the upper chamber of the heart beats rapidly and irregularly), subdural hemorrhage (life- threatening condition where blood pools between the brain and skull putting pressure on the brain) and chronic heart failure (long term condition when the heart can't pump enough blood throughout the body). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's MAR dated 12/10/24 indicated the following medications were prescribed on 12/9/24 at 6:28 p.m., Metoprolol Succinate (prescribed to treat high blood pressure), and Potassium Chloride (prescribe as potassium supplement) were not administered at 9 a.m. as prescribed. The notes in the Medication Administration Record indicated the medications were awaiting delivery by pharmacy. During an interview on 12/17/24 at 4:02 pm with Licensed Staff D, Licensed Staff D stated that the pharmacy would deliver medication for new admission residents within 2-4 hours but there are times when a new resident would have not had their medications because some nurses do not send the information to the pharmacy like they should, and it happens a lot. During a concurrent interview and record review on 12/17/24 at 4:02 pm. with Licensed Staff E, Licensed Staff E reviewed Resident 5's MAR dated 12/9/24 and 12/10/24 and confirmed the medications were ordered at 6:28 p.m. on 12/9/24 and that would not be enough time for the pharmacy to prepare and deliver the medications before the timed 9 a.m. dose on 12/10/24. Licensed Staff E stated the metoprolol and potassium medications due at 9 a.m. on 12/10/24 should have been delivered to the facility and been administered to Resident 5. Licensed Staff E stated the pharmacy would make multiple scheduled deliveries throughout the day, at 11:30 am., early in the morning, then 7:30 am and there would be a call to confirm that they (pharmacy) had received the orders (for medications). The facsimile order sheet dated 12/9/24 timed at 7:09 p.m. was observed and Licensed Staff D stated, see, we should have gotten these meds, so I don't know why we didn't . During an interview on 12/19/24 at 10:10 am with DON, DON stated Resident 5 did not receive his medications (metoprolol and potassium) due to the medication not being delivered from the pharmacy. DON stated there was a discussion with the pharmacy representative and no indication that residents were no receiving their medications when first admitted to the facility. DON stated the pharmacy scheduled delivery times corresponded with the administration times, meaning the delivery should be around 5- 6 a.m. so the medications are at the facility for the medications due to be administered at 9 a.m. DON stated the facility could order medications to be delivered STAT or as soon as possible and that would move up the delivery time to 30-45 minutes. DON stated if the nurse who had attempted to administer a medication and the medication was not available in the medication cart then they should check the medication room to see if it had been delivered. A review of the facility's policy and procedure titled, Specimen Collection dated 1/24, indicated Our facility will collect specimens in accordance with established nursing service procedures. A review of the facility's policy and procedure titled, Physician's Order on Resident's Admission , dated 1/24, indicated, To make sure that all needed medications of residents per MD's order are all accurate and carried out. A review of the facility's policy and procedure titled, Medication Orders and Receipt Record , dated 1/24, indicated, The facility shall document all medications that it orders and receives .Medications should be ordered in advanced, based on the dispensary pharmacy's required lead time .The receiving nurse shall record medication orders received on the receipt record. The receiving nurse shall verify each delivered medication and check off the order form .