

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  02/05/2025
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>46132</p> <p>Based on observation, interviews and record reviews, the facility failed to practice appropriate infection prevention and control measures for one out of six sampled residents (Resident 1), when his Foley catheter (FC- a hollow tube inserted into the bladder to drain or collect urine) drainage bag was left on the floor.</p> <p>This failure had the potential to cause Resident 1 to experience a urinary tract infection (UTI- an infection in the bladder/urinary tract).</p> <p>Findings:</p> <p>A review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in August of 2024 with diagnoses of muscle weakness, essential hypertension (HTN- high blood pressure) and neuromuscular dysfunction of the bladder (nerves controlling bladder function are damaged leading to impaired bladder control).</p> <p>A review of Resident 1 ' s Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 11/9/24, indicated Resident 1 had no memory problem.</p> <p>During a concurrent observation and interview on 2/5/25 at 12:08 p.m., Resident 1 ' s FC drainage bag was noted on the floor. Resident 1 stated his FC drainage bag had been on the floor since this morning and added, this happens from time to time.</p> <p>During a concurrent observation and interview on 2/5/22 at 12:22 p.m., Unlicensed Staff A verified Resident 1 ' s FC drainage bag was on the floor and stated this was not acceptable as the drainage bag should be hung away from the floor for infection control. Unlicensed Staff A added, keeping the FC drainage bag on the floor put Resident 1 at risk for infections.</p> <p>During an interview on 2/5/22 at 1:27 p.m., the Director of Staff Development (DSD) stated a FC drainage bag should not be left on the floor and added, the FC drainage bag on the floor put Resident 1 at risk for infections.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 2/5/25 at 2:31 p.m., the Director of Nursing (DON) stated the FC drainage bag should be kept off the floor to prevent bacteria from entering the catheter. The DON confirmed the FC drainage bag on the floor put Resident 1 at risk for a UTI.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled, Indwelling/Foley Catheter, revised 11/2024, the P&amp;P indicated, .be sure the catheter tubing and drainage bag are kept off the floor .</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>46132</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure two out of six sampled residents (Resident 1 and Resident 2) had their call light (a device used to communicate with staff when assistance is needed) within reach.</p> <p>This failure could impair the residents' ability to call for assistance when needed, potentially leading to safety concerns and delays in getting necessary care.</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in August of 2024 with diagnoses of muscle weakness and neuromuscular dysfunction of the bladder (nerves controlling bladder function are damaged leading to impaired bladder control).</p> <p>A review of Resident 2's Face Sheet indicated Resident 2 was admitted to the facility in October of 2022 with diagnoses of hyperlipidemia (HLP- high cholesterol) and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a concurrent observation and interview on 2/5/25 at 12:05 p.m., Resident 2's call light was noted to be wrapped around the left side rail of the bed and out of the reach of Resident 2. Resident 2 stated she did not know she had a call light and would usually yell help! help! for someone to come. Resident 2 added, she wanted a call light, so she did not have to yell for help.</p> <p>During a concurrent observation and interview on 2/5/25 at 12:08 p.m., Resident 1's call light was not observed near him. Resident 1 stated he did not know where his call light was and when he needed help, he had to yell help! for someone to come.</p> <p>During a concurrent observation and interview on 2/5/25 at 12:22 p.m., Unlicensed Staff A verified Resident 2's call light was wrapped on the left side rail of the bed and was not within her reach. Unlicensed Staff A stated this was not acceptable and added, the call light should always be within residents' reach. Unlicensed Staff A stated he had witnessed Resident 2 yelling for help a few times when she was needing assistance.</p> <p>During a concurrent observation and interview on 2/5/25 at 12:25 p.m., Unlicensed Staff A verified Resident 1 did not have his call light within reach when it was found on the floor by the foot of his bed.</p> <p>During an interview on 2/5/25 at 1:05 p.m., Licensed Staff B stated the call light should always be within residents' reach for safety and to ensure staff were alerted if residents' needed help.</p> <p>During an interview on 2/5/25 at 1:27 p.m., the Director of Staff Development (DSD) stated call lights should always be within the residents' reach and not having the call light within the residents' reach could put residents at risk for accidents and not meeting their needs.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/5/27 at 2:31 p.m., the Director of Nursing (DON) stated call light should be within residents ' reach at all times, as the call light was how residents communicate with staff when they needed assistance and not having the call light within reach could result in delay of care, unmet resident needs, and accidents.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled, Call light/Bell , revised 1/2024, the P&amp;P indicated, .call light only be out of reach during resident care to prevent injury and during the time when resident was out of bed, but would immediately be within reach after care or when resident is back to bed . place the call device within residents reach before leaving room .</p>