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	01/07/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately assess and initiate timely emergency response for one of three sampled residents (Resident 1) when Licensed Nurse (LN) 3 did not call 911 after Resident 1 had a very low oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) than normal and showed signs of distress and altered level of consciousness.This failure had the potential to delay the initiation of treatment for Resident 1, which could potentially led to respiratory arrest. Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was re-admitted on [DATE] with diagnoses that included pneumonia (an infection/inflammation in the lungs) and acute and chronic respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in the body) with hypoxia (lack of oxygen in tissue).During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/30/25, the MDS indicated Resident 1 had intact cognition.During a review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 6/19/25, the POLST indicated Resident 1 was full code.During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/22/25, the SBAR indicated, Resident 1 was noted with hypoxia, altered level of consciousness and shortness of breath.During a telephone interview on 1/7/26 at 12:21 p.m. with LN 3, LN 3 stated, on 12/22/25, while administering bedtime medications, LN 3 entered Resident 1's room and attempted to wake him up and observed that something was different about his condition. LN 3 stated, Resident 1 was experiencing difficulty breathing and was on continuous oxygen. LN 3 stated, she increased the oxygen flow rate; however, his O2 sat remained low. LN 3 further stated that although Resident 1 was responsive, his responses were inappropriate, and his behavior was not consistent with his baseline. LN 3 also stated that she contacted the on-call physician, who gave an order to send Resident 1 to the emergency room.During a review of Resident 1's Nurse's Notes (NN), dated 12/22/25, the NN indicated, at approximately 9 p.m. the nurse entered Resident 1's room to administer medications and found him awake, was able to take medication but repeatedly saying the same sentence. The NN indicated, LN 3 asked Resident 1 if he was okay, and he opened his eyes and closed them again. The NN indicated, Resident 1's O2 sat was at 84% (normal values for a healthy adult on room air is 95% to 100% measured by a pulse oximeter [small, clip-on device that non-invasively measures blood oxygen levels] indicating sufficient oxygen in the blood. Levels below 90% suggest significant hypoxemia [lower-than-normal levels of oxygen in the blood] requiring medical attention), while on 3 liters of oxygen via nasal cannula, the oxygen was increased to 4 liters; however, the O2 sat remained low, around 82-83%. The physician was called at 9:30 p.m., and an order was received to send the resident to the emergency room for hypoxia. A (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-emergency transport was called, arrived at 9:45 p.m. and Resident 1 was transferred out of the facility at 10 p.m.; there was no documented evidence that staff changed the the nasal cannula into a non-rebreather mask (a medical device delivering high concentrations [up to 95%] of oxygen in emergencies).During an interview on 1/7/26 at 12:33 p.m. with Director of Nursing (DON), DON stated respiratory distress-including shortness of breath, difficulty of breathing, and O2 sat below 88% accompanied by a decreased level of consciousness-requires activation of the emergency response system which is calling 911. The DON confirmed that Resident 1's condition at that time warranted a 911 transfer due to an O2 sat of 84% and altered mental status.During a concurrent telephone interview and record review on 1/7/26 at 1:06 p.m. with Nurse Practitioner (NP), NP stated, based on her review of Resident 1's case, the resident should have been transferred via 911 (emergency medical transport) due to the clinical indicators of a medical emergency. NP explained that Resident 1 was already hypoxic, not fully responsive, and continued to desaturate despite being on oxygen. NP emphasized that in situations involving low O2 sat and altered mental status, immediate emergency care is required, which skilled nursing facilities (SNFs) are not equipped to manage such acute medical conditions. The NP reviewed the ER records, which indicated Resident 1 had a Glasgow Coma Scale (GCS-scoring system used by doctors to measure decrease in consciousness) score of 7 (severely altered state of consciousness) upon arrival-significantly lower than his baseline of 15 (normal GCS score)-and was intubated due to acute respiratory failure. NP further stated that if care had been delayed longer, Resident'1 clinical progress could have been poorer, and he may have required a prolonged stay in the intensive care unit.During an interview on 1/7/26 at 2:47 p.m. with Resident 1, Resident 1 stated that he did not refuse to go to the hospital, as he was not fully aware of what was happening at that time.During a review of Resident 1's History and Physical (H&P) document from the acute care hospital, dated 12/23/25, H&P indicated that Resident 1 was transferred to acute care hospital for altered mental status and acute respiratory failure. H&P indicated, upon arrival resident (1) had a significantly decreased GCS score and was not protecting his airway, Resident 1 was subsequently intubated.During a review of the facility's policy and procedure (P&P) titled, Emergency Procedures, dated 7/12, the P&P indicated, .to provide immediate medical care to a resident whose condition indicates a need. if the services of a paramedics are needed, activate facility notification system.During a review of the facility's P&P titled, Change of Condition, dated 7/12, the P&P indicated, .licensed nurse will initiate proper first aid measures until emergency response personnel/911 arrive on the scene.According to the California Nursing Practice Act, .The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following. Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition. (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures .