STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fillmore, LLC	118 B St Fillmore, CA 93015

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44589 Based on interview and record review, the facility failed to ensure nursing professional standards of care for one of two sampled residents (Resident 1) when: 1. A graft site discharge order was not followed up with the admitting physician. 2. Removal of the sutures from a post tracheostomy (surgical procedure that help with breathing through an opening on the neck) site was not obtained per facility policies and procedures. 3. Skin assessment was not accurately done upon admission ([NAME]-coccyx (tail bone)redness, right side open area on the neck). These failures had the potential and risk for Resident 1 to develop further skin breakdown, and infections from unmonitored skin areas with issues. Findings: According to Fundamentals of Nursing, Mosby ' s sixth edition by [NAME] and [NAME]; Chapter 34, page 847, A registered nurse checks all transcribed orders against the original order for accuracy and thoroughness. If an order seems incorrect or inappropriate, the nurse consults the prescriber. Review of [NAME] and [NAME], 7thEdition, Mosby ' s Fundamentals of Nursing, page 243 in the section titled, Data Documentation indicates, Observation and recording of client status is a legal and professional responsibility. The nurse practice acts in all states and the American Nurses Association Nursing ' s Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 365 in the section titled, Informatics and Documentation, indicated Documentation is a key communication strategy that produces a written account of pertinent data, clinical decisions and interventions, and patient responses in a health record. Documentation in a patient ' s health record is a vital aspect of nursing practice. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A review of the clinical record for Resident 1, indicated, Resident 1 was admitted to the facility on [DATE], from a hospital approximately 200 miles away with diagnoses of status post hemi-glossectomy (removal of the half portion of the tongue) secondary to cancer, post tracheostomy and left arm grafted site (skin surgically removed and placed in the dissected tongue part). The Discharge summary (DS) from the discharging hospital indicated an order/instruction of Left arm wrap, to maintain ace wrap and splint in place, will replace in outpatient clinic in one week. Review of the Admission Orders of the admitting facility dated, recapped, February 2024, indicated, the order/instruction to keep left arm wrap, maintain ace wrap and splint in place, will replace in outpatient clinic in one week was not captured, and not clarified with the admitting physician when the resident was admitted to the facility on [DATE]. On 2/14/24, Resident 1 was seen by the attending physician in the admitting facility with orders for wound consult. On 2/19/24, seven days later from admission (2/12/24), and five days later from the wound consult order (2/14/24), Resident 1 was seen by the wound doctor. The wound doctor ' s notes indicated, It appears skin graft has failed on the arm, will require debridement of the parts of it, if not all eventually. On 2/27/24, Resident 1 was transferred out from the facility to a local hospital secondary to altered level of consciousness. The wound notes from the hospital, dated 2/28/24, at 12:09 a.m., showed pictures taken with the left arm post graft area with black necrotic (dead) skin around the graft site measuring 6 centimeters by length. During interview on 4/24/24, at 4:35 p.m., with the Director of Nursing (DON), the DON acknowledged, the surgeon should have been contacted on what to do with the graft site upon the resident ' s admission to the facility and orders should have been obtained or clarified with either the surgeon or admitting physician and it was not done. 2. During a review of the facility ' s policy and procedure (P&P) titled, Physician ' s Order, dated 7/2012, the PO indicated, 4. Medications, diets, therapy, or any other treatment may not be administered to the resident without the written approval from the attending physician. During a review of the respiratory therapist Progress Notes (RPN), dated 2/17/24, the RPN indicated, Scheduled trach-tube exchange .completed. Sutures removed . in part RN observed . During an interview on 4/24/24 at 4:35 p.m., with the respiratory therapist (RT1), RT1 verbalized, they got a go signal from Nursing to remove the sutures from the post-surgical area of the tracheostomy site. RT1 did not verify if there were physician ' s order for the removal of the sutures. RT1 further verbalized, Nursing is responsible to removing getting orders for suture removal. During an interview with the DON on 4/24/24 at 4:25 p.m., the DON acknowledged, there must be a physician order prior to the removal of the sutures, and it was not obtained. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the clinical record for Resident 1, indicated a admitted [DATE], with the diagnoses of status post hemi-glossectomy secondary to cancer, post tracheostomy and left arm grafted site. On 2/27/24, Resident 1 was transferred out from the facility to a local hospital secondary to altered level of consciousness. During a review of the hospital records dated 2/28/24 at 2 a.m., indicated a massive moisture associated skin damage (MASD) located on the sacro coccyx area of Resident 1, extending to the perineal, to the lateral thighs. The hospital photos of the site taken on 2/28/24 at 2 a.m., revealed deep ripened, red colored skin, with slightly peeled off skin, on the sacro coccyx area of the resident which was staged at 2 ((two) - skin damaged to second layer of skin). The clinical record in the facility of Resident 1 was further reviewed. No Weekly Skin Integrity Assessment (WSIA) was located for 2/12/24 (admission), 2/17/24 (the week after admission) and 2/26/24 (the day prior to discharge) was documented only as sacro coccyx redness without further description of the site. During a review if P&P titled Wound Care, dated 12/2024, The P&P indicated, The following information should be recorded on the resident ' s medical record: .6. All assessment data, i.e. (that is) wound bed color, size, drainage, color, pain, etc.) obtained when inspecting the wound .). During an interview on 4/18/24, at 1:39 p.m., with the admission nurse (RN 3), RN 3 acknowledged, the incomplete details of the documentation of the reddened areas on Resident 1 ' s sacro coccyx area. During another interview on 4/22/24, at 2:01 p.m., with the treatment nurse (RN 4), RN 4 verbalized, when assessing the wound, the nurse must indicate the location, measurement, wound description, wound bed color, wound size, discharge, odor, and for redness on pressure location must indicate if redness is blanchable (skin remains white or pale than normal when pressed) or non-blanchable (redness of the skin does not turn white when pressed) when pressing redness remained or a MASD. During an interview on 4/24/24 at 4:35 p.m., with the DON, the DON acknowledged the detailed documentation of Resident 1 ' s skin redness should be in place but was not done.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44589 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) had an accurate documentation of Resident 1 ' s tracheostomy (a procedure that help with breathing through an opening on the neck) site skin condition. This failure had the potential for Resident 1 ' s skin condition to be unmanaged and posed a risk for the delay in treatment. Findings: During a review of the facility's policy and procedure (P&P) titled, Surgical Wound Care, dated 7/12, the Surgical Wound Care indicated, It is the policy of this facility to care for all types of wounds and prevent possible complications .4. Assess the surgical wound site for signs of infection like skin irritation, swelling, redness and drainage . During a review of Admission Nursing Assessment (ANA), dated 2/13/24, the ANA indicated, Resident 1 was admitted with tracheostomy with redness on the surrounding area of the tracheostomy stoma (opening). During a review of the document titled, Skilled Charting, dated 2/13, 2/14, 2/18, 2/18, 2/20, 2/21, 2/22, 2/23, 2/24, 2/25, 2/26, and 2/27, the Skilled Charting indicated, Resident 1 had redness on the stoma trach site. Further review of the Skilled Charting, dated 2/26, and 2/27, the Skilled Charting indicated, Resident 1 had a developing chin area skin inflammation. During a review of Respiratory orders Administration Record (RAR), dated 2/2024, the RAR indicated, Resident 1 was monitored every shift for signs and symptoms of infection - redness, swelling (inflammation), drainage from stoma. The RAR further indicated, the there was no signs and symptoms of infection on trach site from 2/13 to 2/27. During an interview on 4/24/24, at 4:25 p.m., with the Director of Nursing (DON), the DON acknowledged the inaccurate documentation in Resident 1 ' s clinical record.