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 _____	R 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1260 TRAVIS BLVD FAIRFIELD, CA 94533

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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health Services during a FOLLOW-UP Survey (3/22-26/12) for the ReCertification Survey completed on 1/26/12. Representing the California Department of Public Health was Health Facilities Evaluator Nurses 28521 and 27136. Census on date of entry (3/22/12) was 65 with 2 bedholds. There were 9 Sampled Residents with 5 Random Residents. Complaint Number: CA 00248894 was investigated during the survey. One deficiency was identified. Abbreviations identified in the 2567: CNA - Certified Nursing Assistant ED - Emergency Department (acute care hospital) EMR - Emergency Medical Responder EMT - Emergency Medical Technician FFD - Fairfield Fire Department MDS - Minimum Data Set U NPO - No food by mouth UTI - Urinary Tract Infections	{F 000}	"Preparation and execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged in conclusion set forth on the statement of deficiency. This Plan of Correction is prepared and executed solely because it is required by the provision of Health and Safety code Section 1280 and 42 CFR 483 ET SEG. This Plan of Correction serves as our written credible allegation of compliance for the deficiency notes. The following abbreviations used in the 2567: DON – Director of Nursing LN – Licensed Nurse M.D. – Medical Doctor MDS – Minimum Data Set NPO – non per os - (nothing by mouth) P & P – Policy and Procedure RN – Registered Nurse - Facility Administrative Staff: Administrator Director of Nursing Director of Staff Development Dietary Service Manager Activity Director Maintenance Director Medical Records Designee Business Office Manager Director of Rehabilitation. Social Service Director MDS Coordinator	4/26/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Teresa J. Calimas, NHA — Administrator — 4/26/2012

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.

RECEIVED
MAY 10 2012
By

Revised 5/8/12 mc

POC Accepted via telephone by Connie Wilson RN DHS on 5/9/12 @ 9:45a.m. mc

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Revision 1

PRINTED: 04/19/2012
FORM APPROVED
OMB NO. 0938-0391

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa J. Cadimas MHA | TITLE: Administrator | (X6) DATE: 4/26/2012

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Revised 5/8/12

RECEIVED
APR 30 2012
By

5/9/12 9:45am TC w/ Theresa Cadimas, Administrator POC accepted as corrected by 28521

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F 246	Continued From page 1 endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and document review the facility failed to accommodate one resident (Sampled Resident 109) with adequate space for his wheelchair. This had the potential of the residents needs to not be met as he could not exit or enter his room. Findings: During an observation on 3/22/12 at 11:15 a.m., it was noted that the room in which Resident 109 resided had three beds, two of which were unoccupied. Resident 109 was seated in an electric wheelchair next to his bed. An unoccupied bed was noted to be between the door and Resident 109 without space for wheelchair ingress (entrance) and egress (exit). During an interview on 3/22/12 at 11:15 a.m., Resident 109 stated that it was difficult to access his bed as one of the beds in the room, the one closest to the door, was in his way and had to be moved by hand or he would have to push the bed out of the way with his wheel chair. Resident 109 stated that the staff had seen him move the bed out of the way, but nothing had been done to accommodate him. Resident 109 also stated that he had told Unlicensed Staff R about the problem of moving the bed closest to the door so he could access his area, but nothing had changed. During a staff interview on 3/22/12 at 2:45 p.m.,	F 246	F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES - The facility will provide to the residents reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. - The unoccupied bed in the room of Resident# 109 was immediately removed by the facility staff. Resident #109 is now able to accommodate the extra large wheel chair in his room without any difficulty. Resident# 109 is satisfied with the immediate action of the facility. - Facility Staff R was immediately re-inserviced by the Administrator regarding the "must" to immediately report to appropriate facility administrative staff any resident and/or resident representative request, concerns or problems for immediate intervention/resolution. - The Administrator and Maintenance Supervisor immediately made rounds in every resident's room to find out if any is affected by the same problem as that of Resident #109 or any other problem or concern that they may have. None was noted. Continued	4/26/12

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F 246	Continued From page 2 Staff R stated that Resident 109 had told her about the bed closest to the door in his room that was blocking his access. Staff R stated that she had moved the bed out of the way for Resident 109 so he could access his own area and bed. Staff R also stated that she had not passed on the information of the inaccessibility to the facility's administration. During a document review on 3/26/12, a document titled "Policy and Procedure on Resident's Personal Inventory" dated 9/2009, "The resident who requires special needs/equipment like extra large wheel chair will be accommodated. If noted that resident requires a larger space and or resident request such will be adhered with".	F 246	Continued F 246 - The Administrator, DSD and DON re-inserviced staff on 4/24/12, 4/25/12 & 4/26/12 on the "must" of complying with the policy and procedure regarding reasonable accommodation of resident individual needs and preferences including but not limited to accommodating resident's extra large wheelchair or other equipments. The facility staff were also instructed to report immediately to appropriate facility administrative staff any resident and/or resident representative request, concern or problem for immediate intervention. - The Administrator or designee will monitor by interviewing residents regarding any resident request, concern or problem including but not limited to wheelchair accessibility in resident's room during daily rounds or daily resident interaction to ensure resident's individual needs and preferences are accommodated. Any concerns identified will be acted upon by the appropriate facility administrative staff for immediate resolution. - The appropriate facility administrative staff will report result of findings of this deficient practice to the Continuous Quality Improvement meeting quarterly for four quarters then annually to ensure that interventions or systems that the facility put in place to address facility accommodation of resident individual needs or preferences are effective.	4/26/12
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services that met professional standards of quality, when a resident was given insulin prior to a meal and the meal was held without the knowledge of the resident's nurse. This had the potential of the resident to have low blood sugar which could cause a loss of consciousness, seizures, coma, and or death. Findings:			

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{F 281}	Continued From page 3 During an interview on 3/22/12 at 11:55 a.m., Licensed Staff N stated that she was the nurse for Random Resident 110. Licensed Staff N stated that she had taken the blood sugar of Random Resident 110 at 11:45 a.m. and gave him his insulin at 11:50 a.m. Licensed Staff N stated that the lunch trays should be out of the kitchen and the lunch tray for Random Resident 110 should be in his room. During a concurrent observation and interview on 3/22/12 at 12:25 p.m., it was noted that there was not a food tray in the room of Random Resident 110. Licensed Staff N asked Unlicensed Staff S where was the meal tray? Unlicensed Staff S stated that Random Resident was NPO (no food by mouth) because he was going to the hospital. Licensed Staff N stated that she new nothing of the NPO order or the transfer of Random Resident 110. During a document review on 3/26/12, the facility's "Administration of Insulin" document dated 01/2012 indicated, "To avoid an episode of hypoglycemia (low blood sugar), the RN/LVN (licensed nurses) will confirm that a resident's meal or snack has been served 5-15 minutes before and no later than 30 minutes after the insulin was given or as per manufacture's guideline".	{F 281}	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS. - Resident #110 was transferred to acute hospital as per M.D. order with no complication noted as assessed by the RN though was given insulin without meal due to the M.D. order "NPO". - Licensed Nurse Staff N was immediately called the attention by DON regarding the P & P on insulin administration emphasizing to her the meal or snack should be served 5-15 minutes before and no later than 30 minutes after the insulin was given or per manufacturer's guideline. - Unlicensed Staff S was re-inserviced by the DSD on 3/22/12 on the "must" to communicate with the Charge Nurse any change of order relayed to him by the Nurse Supervisor specifically the M.D. order "NPO" for this resident. - The Nurse Supervisor was re-inserviced by the DON on 3/22/12 on the importance of conveying to another CN any change in M.D. order including but not limited to placing resident on "NPO". Continued	3/22/12

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{F 281}		{F 281}	Continued F 281 The DON and RN supervisor checked the residents on insulin to find out if any is affected by the same problem as that of Resident #110. None was noted. - The Quality Assurance RN and DON re-inserviced all Licensed Nurses on 4/3/12, 4/6/12 & 4/26/12 on the "must" of complying with the policy and procedure on insulin administration to all residents who have insulin M.D. order for administration. It was expressed to them to observe and implement meal or snack serving to resident 5-15 minutes before and no later than 30 minutes after insulin was given to resident or as per manufacturer's guideline. This will avoid or eliminate an episode of hypoglycemia. - The DON, RN Supervisor or Licensed Nurse designee will monitor by checking anytime there is a new or change of M.D. order and by observing Licensed Nurse when administering medications to resident including but not limited to those who are taking insulin. It will be done in different shifts daily, while Pharmacy Consultant will monitor monthly during his consultation visit by observing Licensed Nurse during their medication pass and comparing M.D. order with the medication being administered to resident to ensure accuracy of medication administration. Continued	4/26/12

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{F 281}		{F 281}	Continued F 281 - Quality Assurance RN will monitor every Quality Assurance consultation visit by following LN when passing the medications and checking physician's order to see if medication matches with M.D. order. - The DON will report problems identified and resolution of problems regarding insulin administration and any problems related to communication between Licensed staff concerning M.D. to the Continuous Quality Improvement Committee. - The evaluation of the systems effectiveness of this deficient practice regarding the administration of insulin will be done quarterly for four quarters and then annually until resolved during the Continuous Quality Improvement meeting.	