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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

Acceptable POC for Greenfield HFB 7/2/19

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. Representing the Department of Public Health: HFEN, 39700 HFEN, 29917 HFEN, 34328 HFEN, 40059 HFEN, 41054 The facility census was 68. The sample size was 23.	F 000	This plan of correction prepared or executed solely because it is required by the provisions of Health and Safety Code Sections 1280 & 42 CFR et seg. This plan of correction serves as out written credible allegation of compliance for the deficiencies noted.	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 552	F 552 Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) A.1. The Director of Nursing clarified with Resident #6's physician, order for Quetiapine; (a psychotropic medication used to treat certain mental or mood disorders). The order was clarified as: "Quetiapine Fumarate tablet 25 milligram 1 tablet twice a day for behavior management related to Psychotic Disorder manifested by episodes of throwing self on the floor. Informed consent was obtained by M.D. from the resident's sister who is the responsible party. 2. The physician of Resident #6 obtained an informed consent from Resident #6's sister who is the responsible party for the psychotropic medication prescription of "Quetiapine Fumarate tablet 25 milligram 1 tablet twice a day for Behavior Management related to Psychotic Disorder manifested by episodes of throwing self on the floor Informed Consent was obtained by M.D. from the resident's sister who is the responsible party. Continued	6/5/2019 6/5/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa A. Salmas, NHA | TITLE: Administrator | (X6) DATE: 6/30/20

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.

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1200 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 1 Based on interview and facility record and policy review, the facility failed to ensure the rights of 1 of 23 sampled residents (Resident 6), when the facility failed to obtain an informed consent from Resident 6's Representative Party (RP, the person that has responsibility for all or a portion of the patient's healthcare; includes health insurance, the patient directly, a guardian or other guarantor) for administration of a medication, Quetiapine (medication used to treat certain mental or mood disorders). This failure deprived Resident 6 and her RP of the right to consider the risks, benefits, and alternatives (RBA) of the medication prior to administration, as well as the right to refuse the medication. Findings: Resident 6's Admission Record indicated Resident 6 was admitted into the facility with diagnoses which included 1) Obsessive - Compulsive Disorder (a personality disorder characterized by a preoccupation with orderliness, perfectionism, and control.) 2) Unspecified dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) with behavioral disturbance. Further review of Resident 6's medical record indicated Resident 6's relative was the designated RP. Resident 6's Physician's Order indicated on 11/22/15 "Resident is not capable of giving informed consent and/or able to participate in the treatment plan." Further review of Resident 6's MD Orders	F 552	Continued F-552 Right to be Informed/Make Treatment Decisions B. The Director of Nursing and the Registered Nurse Supervisor reviewed the resident charts of those resident's who are on psychotropic medications to ensure that physician's orders for psychotropic medication has informed consent for the use of chemical restraint obtained by M.D. from the resident, resident's representative or responsible party. C. The Director of Nursing re-inserviced the Licensed Nurses regarding the facility's Policy and Procedure on "Informed Consent of Physical and Chemical Restraints", including but not limited on the importance of obtaining an informed consent by M.D. from the resident, resident representative or responsible party and will be confirmed by the License Nurse who took the order for chemical restraint before administering the psychotropic medication to the resident. D.1. The Admission Nurse upon admission of a resident will ensure that residents who are admitted with orders of psychotropic medications will have an informed consent obtained by M.D. from the resident, resident representative or responsible party. Continued	7/6/2019 7/6/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1200 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 2 Indicated on 1/19/17, the Physician ordered "Quetiapine Fumarate Tablet 25 milligrams (mg, a medication dosage) give one (1) tablet by mouth two times a day for behavior management related to BRIEF PSYCHOTIC DISORDER M/B (MANIFESTED BY) EPISODES OF THROWING SELF ON THE FLOOR." During an interview with Licensed Nurse 3 (LN 3) on 6/6/19 at 12:45 p.m., LN 3 indicated Resident 6 was confused and had behaviors of throwing herself on the floor and attempting to clean the floor of her room. LN 3 indicated Resident 6 was prescribed Quetiapine 25 mg (a unit of measurement) by mouth twice a day for behaviors. LN 3 indicated before Quetiapine may be given an Informed Consent must be obtained and verified. LN 3 described the MD must discuss the medication's risks, benefits, and alternatives (RBA) with the RP. LN 3 indicated Resident 6's Informed Consent was obtained from Resident 6 who did not have the capacity to give consent. Resident 6's RP should have given consent. LN 3 *stated it was the responsibility of the LN to verify* that Informed consent was obtained. In an interview with the Director of Nursing (DON) on 6/6/19 at 1:45 p.m., the DON stated Resident 6 was confused and not able to give consent. Resident 6 had an RP on record who could give consent. The DON confirmed Resident 6's Quetiapine Informed Consent, obtained on 1/20/17, did not have specific behavior indications for which the medication was prescribed. The DON stated Resident 6 gave consent for Quetiapine instead of the RP on record. The DON indicated the consent obtained on 1/20/17 was not accurate.	F 552	Continued F 552 Right to be Informed/Make Treatment Decisions 2. The Director of Nursing will do an admission chart review of residents admitted with psychotropic medication to make sure informed consent is obtained by M.D. from the resident, resident representative or resident' responsible party before administering the medication to the resident. 3. The Medical Records Director of Designee will do an admission audit after each admission and a telephone order audit daily to ensure that all psychotropic medications ordered by M.D, will have an informed consent for the use of chemical restraint. The admission audit form and telephone audit form will be used for this audit. E. The Quality Assurance Performance Improvement ; (QAPI),Team will monitor systems effectiveness of the facility's Policy and Procedure on "Informed Consent of Physical and Chemical Restraint" during the quarterly QAPI meeting. This will be discussed under the agenda of Nursing Services and Medical Medical Records Services. This will be reported by the Director of Nursing and Medical Records Designee.	7/6/2019 7/6/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 3 On 6/06/19 at 10:03 a.m., in an interview with the Social Services Director (SSD), the SSD stated Resident 6's Informed Consent obtained on 1/20/17 was obtained from Resident 6 who cannot give informed consent. Resident 6 had an RP on record, and the Quetiapine informed consent should have been obtained from the RP. Review of the facility policy "Informed Consent of Physical and Chemical Restraints" with a revision date of 5/2012, indicated, "...Please be advised that medication/ restraint is not to be given or applied until the informed consent is given by the resident or resident representative with an MD order who obtained the informed consent unless it is an emergency."	F 552		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726	F 726 Competent Nursing Staff CFR(s): 483.35 (a)(3)(4)(c) An order for the care of Nephrostomy Tube was obtained by the Licensed Nurse from Resident #323's primary Physician as follows: Nephrostomy tube on right flank sterile technique, cleanse with normal saline, pat dry, apply dry dressing daily. The nephrostomy tube of Resident #323 was discontinued on June 7, 2019. 1. The Nurse Consultant provided a 1:1 inservice to the Treatment Licensed Nurse who treated Resident #323 regarding the care of nephrostomy tube using sterile technique. 2.a. The QAPI Team met and approved The new facility's "Licensed Nurse Clinical Skills Checklist", adding the on the list the "Nephrostomy Tube Care." b. The Nurse Consultant inserviced License Nurse#1 & Licensed Nurse#2 regarding the care of nephrostomy tube including but not limited to the flushing of the nephrostomy tube; (solution used is saline) & (how much solution is 2-3 ml) following the facility's protocol on the care of nephrostomy tube. B. The Director of Nurses interviewed the other Licensed Nurses regarding their competency and skills for the care of nephrostomy tube. No other problem was identified similar to this deficient practice. Continued	6/6/2019 6/7/2019 6/7/2019 6/5/2019 6/5/2019& 6/28/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 4 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing staff had the competencies and skills to care for one of 23 sampled residents (Resident 323) when: 1. A sterile (free from microorganisms) dressing change was completed using clean (free of dirt, stains or marks) technique, and 2. Nurses lacked knowledge of nephrostomy tube (a thin tube passed through the skin to the kidneys to drain urine) care. This failure increased the potential for infection and/or physical harm for the resident. Findings: According to the Resident Face Sheet, Resident 323 was admitted in 2019, with diagnoses which included multiple kidney problems and urinary tract infection (UTI- an infection of any part of the urinary system). A review of the clinical record indicated:	F 726	Continued F 726 Competent Nursing Staff CFR(s): 483.35 (a)(3)(4)(c) C. The Nurse Consultant and the Director of Nursing provided an in-service to the Licensed Nurses regarding the facility's Policy and Procedure for the "Care of Nephrostomy Tube", including but not limited to the use of sterile technique when doing the treatment of a resident with nephrostomy tube and the procedure for the irrigation of a nephrostomy tube as per physician's order. D. 1. The Physician Wound Consultant during his weekly visit will check the Licensed Treatment Nurse on the care of Nephrostomy tube for Resident #323 to make sure that sterile technique is practice when doing treatment for of the nephrostomy tube and proper procedure for the irrigation of the nephrostomy tube is followed. A written report will be submitted to the Director of Nursing and the Administrator for any problem identified regarding the care of nephrostomy tube of Resident #323. Continued	7/6/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050189	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 5 An Admission Nursing Assessment, dated 6/2/19, indicated Resident 323 was alert and oriented to time, place and person. The assessment did not note the presence of the right nephrostomy tube. A Physician's Order Report, dated 6/5/19 at 12:27 p.m., reflected there was no treatment order for the nephrostomy tube dressing. 1. During an observation, on 6/4/19 at 12:50 p.m., the Treatment Licensed Nurse (TLN) was observed changing Resident 323's nephrostomy tube dressing. The TLN washed her hands, donned clean gloves and removed the soiled nephrostomy tube dressing. The TLN then washed her hands, donned clean gloves and applied a new dressing to the site. A review of the facility's, "Care of Nephrostomy Tube" policy indicated nephrostomy tube dressings were to be performed using sterile technique. During a telephone interview, on 6/5/19 at 11:50 a.m., the TLN confirmed she used clean technique when she changed Resident 323's nephrostomy tube dressing the previous day. The TLN stated she was not aware it should have been a sterile dressing change. 2. In an interview, on 6/5/19 at 9:55 a.m., the Director of Staff Development (DSD) confirmed nephrostomy tube care was not listed on the facility's Licensed Nurse Clinical Skills Competency Review form and agreed it should have been. In an interview, on 6/5/19 at 10:06 a.m., Licensed Nurse (LN) 2 stated she was not sure what she	F 726	Continued F 726 Competent Nursing Staff 2. The Director of Nursing will do a Licensed Nurse Competency Skills Check of Licensed Nurses upon hire, annually and as needed on the care of the nephrostomy tube. The licensed nurse skills check will be recorded on the facility's "Licensed Nurse Competency Checklist." Any Licensed Nurse who will be identified having problem with the nephrostomy care will be trained further with this skill. E. The Quality Assurance Performance Improvement ; (QAPI),Team will monitor systems effectiveness of the facility's Policy and Procedure on "Nephrostomy Tube Care" and will monitor the "Licensed Nurse Competency Skills Check" of each Licensed Nurse to make sure that it is complete, accurate and up to date. This will be discussed under the agenda of Nursing Services. This will be reported by the DON and DSD during the quarterly QAPI meeting.	7/6/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 6 would do if Resident 323's nephrostomy tube was clogged. LN 2 stated she thought it could be flushed but was not sure with what solution or how much. LN 2 stated she thought the treatment nurse would take care of it if needed. In an interview, on 6/6/19 at 8:48 a.m., LN 1 stated, "I can't give you an answer," when asked what she would do if Resident 323's nephrostomy tube was clogged. LN 1 confirmed she had not received any training at the facility to care for the nephrostomy tube. In an interview, on 6/6/19 at 8:45 a.m., the Director of Nurses (DON) confirmed Resident 323's nephrostomy tube dressing should have been changed using sterile technique, and at the time of the dressing change, there was no physician's order for it in Resident 323's medical record. Further, the DON confirmed nephrostomy tube care was not included on the facility's nursing competency checklist and agreed it should have been included for the facility's licensed nurses.	F 726		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812	F 812 Food Procurement, Store/ Prepare/Serve-Sanitary CFR(s): 483.60 (l)(1)(2) The facility Administrator will continue to ensure that the facility kitchen staff will maintain a sanitary kitchen environment at all times. A.1. The Registered Dietician; (RD), immediately provided a 1:1 in-service to the Head Cook regarding the facility's Policy and Procedure with cross-contamination. The Head Cook will not place food from refrigerator/freezer on to the floor and the delivered food items will also not be placed on the floor but will be placed on clean carts or kitchen counters. 2. The Administrator contacted the Representative of the facility contracted food supplier; (Sysco), via telephone and requested that the food items when delivered in the facility should be placed on a palette and not directly on the floor. 2a.The Head Cook immediately discarded the leftover crushed pineapple stored in a plastic container with a date of 5/29/19 written on the label. b. The RD immediately re-inserviced the Head Cook on the facility's Policy and Procedure on "Food Safety Rules" with emphasis on storage of perishable foods only within three days. Continued	7/6/2019 6/3/2019 6/3/2019 6/3/2019 6/3/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 7 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to store food in a sanitary manner when: 1. Boxes and cases of food items were noted to be placed directly on the floor, 2. Food items in refrigerator were being stored past the "use by date," and 3. Not all staff entering the kitchen used a head covering or hairnet to secure their hair. These failures could have contributed to food contamination contributing to potential food-borne illness. Findings: 1. On 6/3/19 at 8:30 a.m., accompanied by the Head Cook (HC), a brief tour of the kitchen was conducted. Upon entering the kitchen, there were several cases of food items observed that had been placed directly on the kitchen floor. The boxes and cases of food were stacked by the back entrance door, in the dry food storage area and in front of the freezers. When the HC was asked about the boxes on the floor, she said she was trying to find a place to put them. The HC was observed removing boxes of frozen tilapia fillets from the refrigerator and cases of	F 812	Continued F 812 Food Procurement, Store/ Prepare/Serve-Sanitary CFR(s): 483.60 (i)(1)(2) c. A form/sign was posted on the outside of the kitchen refrigerator door stating; "DISCARD FOOD LEFTOVERS WITHIN THREE DAYS." 3.a. The RD and the Administrator Provided a 1:1 in-service to the Maintenance Supervisor regarding The use of hairnet in the kitchen when he is performing maintenance work. He needs to adhere to this rule to maintain a condition in the kitchen. b. The Maintenance Staff added a hairnet box to the outside of the kitchen by the kitchen front door. B. The RD immediately inspected the kitchen to see if there were more boxes on the floor, inspected the kitchen refrigerators and freezers for food items stored past the "use by date" and checked if all kitchen staff were wearing hairnet or head covering to secure their hair. No other problem identified similar to these deficient practices. C. The RD re-inserviced the Dietary Staff regarding the facility's Policy and Procedures on the following: 1. "Food Safety Rules" with emphasis on: a. Cross-contamination of not placing food items directly on the floor. Food items must be stored six inches off the floor. Continued	6/2/2019 6/4/2019 7/1/2019 6/3/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055159	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1280 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 8 milk, placing them directly on the floor by the refrigerator; then observed putting them back into the refrigerator, coming in contact with and contaminating the refrigerator racks. When asked what she was doing, she said she was rotating the milk and bringing the older dates forward. When the Registered Dietician was informed in a subsequent interview of the cases of food items being placed on the kitchen floor, the RD responded that she will, "need to in-service kitchen staff." Review of the facility's policy titled, Food Safety Rules, revised on 12/14, indicated that, "...shelves should be clean and sanitary." And further confirmed that all food items, "...must be stored at least six inches off the floor." 2. On 6/3/19 at 8:30 a.m., accompanied by the HC, the contents of the facility's kitchen refrigerator was inspected. Crushed pineapple was observed stored in a plastic container with a date of 5/29/19 written on the label. When the HC was asked what the date meant, she responded that it was the date the can had been opened, the leftovers placed in the container and stored in the refrigerator. When the HC was asked how long leftover food items are good for, she responded that it was good for, "five (5) days." However, when the same question was asked of the RD, in a subsequent interview, she responded that, "It is good for only 3 days." When informed that her kitchen staff say left overs are good for 5 days, the RD responded, "they have to be re-trained." Review of the Facility's policy titled, Food Safety Rules, revised on 12/14, it indicated the following, "Do not leave leftovers in the refrigerator for more	F 812	Continued F 812 Food Procurement, Store/ Prepare/Serve-Sanitary CFR(s): 483.60 (i)(1)(2) b. Discard food leftovers stored in the kitchen refrigerators or freezers for more than three days. 2. "Personnel Adherence to Sanitary Procedures" with emphasis on kitchen staff or any other personnel entering the facility kitchen to wear a hairnet, approved hats or head coverings at all times. D.1. The Dietary Service Manager or Designee will monitor daily and will record on the "Kitchen Sanitary Practices Log" the issues identified in the facility kitchen during this annual survey such as: a. Boxes and cases of food items were directly on the floor. b. Food items in refrigerator were being stored past the "use by date" and c. Not all staff entering the kitchen used a head covering or hairnet to secure their hair. 2. The RD will monitor during twice a month during visits and will record on the "Sanitation and Food Safety Checklist", the same issues in the facility kitchen mentioned above; (#1). Continued	7/6/2019 7/6/2019 7/6/2019 7/6/2019

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

PRINTED: 08/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 than three days." 3. During an observation and concurrent interview on 6/4/19 at 2:53 p.m., the MS was in the kitchen without a hair net on while staff were preparing food. When the MS was asked if he should have a hairnet on, he stated, "Yes, I just forgot because I was in a hurry to fix the cooler." During a concurrent interview on 6/4/19 at 2:53 p.m., the Kitchen Staff 1 (KS 1) confirmed the MS was present in the kitchen without a hair net on while they were preparing food. Review of the facility's policy and procedure titled, "Personnel Adherence to Sanitary Procedures" revised on 12/2014, indicated, "It is the policy of this facility that the food services personnel shall follow appropriate sanitary procedures... Hair nets or approved hats, covering all of the hair, must be worn during the food production..." During an interview on 6/4/19 at 3:10 p.m., the Director of Nursing (DON) confirmed the staff is expected to follow the facility's policy and procedure to maintain sanitary conditions when in the kitchen.	F 812	Continued F 812 Food Procurement, Store/ Prepare/Serve-Sanitary CFR(s): 483.60 (l)(1)(2) E. The Quality Assurance Performance Improvement ; (QAPI),Team during the quarterly QAPI meeting will monitor systems effectiveness of the facility's Policy and Procedure on "Food Safety Rules" and "Personnel Adherence to Sanitary Procedures" with emphasis on: a. Boxes and cases of food items were directly on the floor. b. Food items in refrigerator were being stored past the "use by date" and c. Not all staff entering the kitchen used a head covering or hairnet to secure their hair. This will be discussed under the agenda of Dietary Services and will be reported by Dietary Service Manager and/or the Registered Dietician.	7/6/201
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	SEE NEXT PAGE 11	

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1200 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	F 880 Infection Prevention & Control CFT(s): 483.80(a)(1)(2)(4)(e)(f)0 A1a. The Laundry Personnel immediately removed the disposable brief trash that was accidentally placed inside the soiled linen hamper. b. The Administrator labeled the laundry hampers, one laundry hamper has a label of "Soiled Linen Only" and the other laundry hamper has a label of "Trash Only"; (soiled disposable brief trash), on each unit; (Unit A,B,C & D). 2. The Director of Staff Development; (DSD), and CNA1 immediately repositioned Resident #72's urinary drainage bag so that it will not be touching the floor and put a urinary drainage bag holder. B. The Infection Control Nurse, DSD and Administrator made rounds: 1. Checked all the other laundry hampers in the units to ensure that disposable brief trash were not mixed with the soiled linens. No other problem identified similar to this deficient practice. 2. Checked all residents with foley catheter make sure that no other urinary drainage bag were touching the floor. All other urinary drainage bag have holders for privacy. No other problem identified similar to this deficient practice. Continued	6/4/2019 6/4/2019 6/5/2019 6/4/2019 6/5/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sanitary practices and an odor free environment for a census of 68 residents, when: 1. The staff put soiled disposable briefs (trash) that should have been thrown into separate waste containers, inside the soiled laundry hampers. This caused the facility to have an odor of stool. 2. The facility failed to ensure one resident's urinary drainage bag (Resident 72) was not touching the floor. These failures put the residents at risk for spread of infection and airborne illnesses. Findings:	F 880	Continued F 880 Infection Prevention & Control CFT(s): 483.80(a)(1)(2)(4)(e)(f) C. The DSD provided in-service to the CNAs and the DON to the Licensed Nurses the facility's Policy and Procedure on Infection Control Practices with emphasis on "Handling Soiled Linens"; (separating soiled linens & disposable brief trash), in different laundry hampers and "Foley Catheter Care."; (urinary drainage bag should have privacy holder & should not touch the floor). D. The Infection Control Nurse and DSD & DON will monitor the infection control practices of all staff during daily rounds and the Charge Nurses will monitor the infection control practices of the CNAs every shift during rounds, including but not limited to checking that the disposable brief trash are not mixed with the soiled linen laundry hamper and that no foley catheter urinary drainage bag is touching the floor. Any problem identified will be corrected immediately by the staff assigned; (DSD, Charge Nurse, DON or Infection Control Nurse), by providing further training to the staff related to the facility's Infection Control Practices. The training will be documented on the in-service training record. Continued	7/6/2019 7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055169	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 1. During interviews at the Resident Council Meeting on 6/2/19 at 10:45 a.m., Resident 66 and Resident 223 stated the staff mixed soiled disposable briefs (trash) into the soiled laundry bins which made the hallways smell like stool. During an interview on 6/4/19 at 2:46 p.m., the Laundry Aide (LA) stated she would separate soiled disposable briefs (trash) from soiled laundry that were mixed together in the same laundry hamper. She said the disposable soiled briefs (trash) should have been put into the trash container and not mixed with soiled laundry that was to be sorted in the dirty laundry room. During an observation and concurrent interview on 6/4/19 at 3:02 p.m., Certified Nursing Assistant 2 (CNA 2) put soiled briefs (trash) into the soiled linen bin with other dirty linen. When asked if this was ok she stated "This is how we do it." Review of the facility's policy and procedure titled, "Handling Soiled Linen", revised on 7/2012, indicated, "It is policy of the facility to provide a process for the [Sic] safe and aseptic handling, washing, and storage of linen...Deposit soiled briefs or underpants in specially designated laundry hampers or waste containers..." During an observation and concurrent interview on 6/4/19 at 3:06 p.m., there were 2 soiled laundry hampers that were mixed with soiled briefs (trash) and soiled linen. When the DON was asked if this was considered sanitary, she stated, "No, the staff should not mix trash with soiled linen." The DON also confirmed the laundry bins smelled like stool.	F 880	Continued F 880 Infection Prevention & Control CFT(s): 483.80(a)(1)(2)(4)(e)(f) E. The Quality Assurance Performance Improvement ; (QAPI),Team will monitor systems effectiveness of the facility's Policy and Procedure on "Handling Soiled Linens" and "Foley Catheter Care" during the quarterly QAPI meeting. This will be discussed under the agenda of Infection Control Practices reported by the Infection Control Nurse and DSD.	7/6/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055169	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1200 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 2. Resident 72 was admitted into the facility with multiple Diagnoses which included problems with kidneys and need for a urinary catheter (a tube device inserted into the bladder to drain urine). Resident 72 was admitted into the facility from the acute care hospital with a urinary catheter attached to a urinary drainage collection bag. On 6/5/19 at 1:35 p.m. Resident 72 was seen asleep in bed. A urinary drainage bag was connected to the resident's catheter and drained clear amber colored urine. The urinary drainage bag was observed on the floor by his bedside. Upon further observation, the urinary drainage collection bag was not enclosed in a privacy bag (an opaque bag used that enclosed and covered the urinary drainage collection bag from being viewed directly). In a concurrent interview with Licensed Nurse 4 (LN 4), he observed and verified Resident 72's urinary drainage bag was on the floor. LN 4 confirmed the urinary drainage bag must be covered with a privacy bag and must not touch the floor. During a concurrent interview with Certified Nurse's Assistant 1 (CNA 1) he confirmed Resident 72's urinary drainage bag was on the floor. CNA 1 stated the urinary drainage bag must be covered with a privacy bag and must not touch the floor. In an interview with the Director of Nursing (DON) on 6/5/19 1:50 p.m. the DON confirmed Resident 72's urinary drainage bag must not touch the floor to prevent urinary tract infections and must be covered with a privacy bag for dignity issues.	F 880		

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055139	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 A review of Centers for Disease Control (CDC) Catheter-associated Urinary Tract Infection; "Specific recommendations... Keep collecting bag below level of bladder at all times (do not rest bag on floor)." http://www.cdc.gov/hicpac/cauti/001_cauti.html	F 880		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bedrooms measured at least 80 square feet per resident in 28 shared rooms. This failure had the potential to limit the personal belongings of each resident and compromise their ability to move freely and receive adequate care in their rooms. Findings: During and observation with the Maintenance Director (MD) on 6/4/19 starting at 10 a.m., the following rooms were observed to not meet the minimum space requirement for each resident: Room Occupancy Req'd/Actual Sq. ft./Res 1 2 beds 160 / 143 71.5 2 4 beds 320 / 255 63.75 3 2 beds 160 / 143 71.5 4 2 beds 160 / 143 71.5 5 2 beds 160 / 143 71.5	F 912	F 912 Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) Please see letter to CDPH Licensing and Certification Department Santa Rosa, CA district for the Bedroom Measurement Waiver dated June 26, 2019 sent to the department via Certified Mail.	6/26/2019

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	053109	A. BUILDING _____ B. WING _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 012	Continued From page 15	F 012		

6	2 beds	160 / 143	71.5
7	2 beds	160 / 143	71.5
8	4 beds	320 / 280.8	70.2
9	4 beds	320 / 280.8	70.2
10	2 beds	160 / 143	71.5
11	2 beds	160 / 143	71.5
(Currently used as a rehab room)			
12	2 beds	160 / 143	71.5
14	2 beds	160 / 143	71.5
15	2 beds	160 / 143	71.5
16	2 beds	160 / 143	71.5
17	2 beds	160 / 143	71.5
18	3 beds	240 / 231.6	77.2
20	2 beds	160 / 143	71.5
21	4 beds	320 / 280.8	70.2
22	2 beds	160 / 143	71.5
23	2 beds	160 / 143	71.5
25	2 beds	160 / 143	71.5
26	2 beds	160 / 143	71.5
31	2 beds	160 / 143	71.5
34	4 beds	320 / 306.8	76.7
35	4 beds	320 / 260	65
36	4 beds	320 / 243.1	60.8
37	4 beds	320 / 283.4	70.9

In an interview with Resident 8 on 6/4/19 at 9:50 a.m., she stated, "I like my room [3-A]. It's a good enough space for me. My scooter is at home, so it's [room size] okay." Resident 8 further stated the staff has been able to get her out of the room without any difficulties.

In an interview with Resident 1 on 6/4/19 at 10:20 a.m., she stated, "It's small for 4 beds, but they moved one resident and the other resident died. So, there are two of us with plenty of space now. Go take a look at my room [8-C] and how I've decorated it."

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 912	Continued From page 16 During a concurrent observation on 6/4/19 at 10:20 a.m., Resident 1's room had many decorations on the wall and on her medium sized dresser. Resident 1 appeared to have enough living space in her room for personal belongings, along with the other occupied bed and two vacant beds (a total of four beds in the room). In an interview with Resident 33 on 6/4/19 at 12:30 p.m., he stated, "I like my room [35-C], and I have been living here for seven years. There is enough room in here." During a concurrent observation on 6/4/19 at 12:30 p.m., Resident 33 was sitting up in his wheelchair and eating lunch near a large window in his room. There were two additional residents in the room who appeared comfortable in bed. In an interview with Resident 2 on 6/4/19 at 12:45 p.m., he stated, "This room is big enough for me to receive care from the nurses here." During a concurrent observation on 6/4/19 at 12:45 p.m., Resident 2 was being assisted with his lunch by a nurse. The two beds in the room were against the walls in an L-shape, and the room was free from clutter. During additional resident interviews on 6/3/19-6/6/19, the other residents did not express dissatisfaction with the size of their rooms. In an interview with the Director of Nurses (DON) on 6/4/19 at 4 p.m., she stated, "The building is old, and the rooms were this size before the 80 sq ft [sq ft, a unit of measurement] regulation had been in effect. We have had room waivers every year since the regulation came out. We try to	F 912		

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

PRINTED: 06/19/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 912	Continued From page 17 give everyone space when we are able to, like now, since the census is down to 98." Based on the findings during the Recertification survey, the Department recommends the continuation of the room size waiver for rooms 1, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 16, 17, 20, 22, 23, 25, 26, and 31 housing 2 residents. The Department recommends the continuation of the room size waiver for room 16 housing 3 residents. The Department recommends the continuation of the room size waiver for rooms 2, 8, 9, 21, 34, 35, 36, and 37 housing 4 residents.	F 912		