

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2025
NAME OF PROVIDER OR SUPPLIER  Fairfield Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1255 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47465</p> <p>Based on interview and record review, the facility failed to provide respiratory care services according to professional standards of quality for one resident (Resident 1), when Resident 1 arrived to the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) center with an empty oxygen tank.</p> <p>This failure decreased the facility's potential to safely provide Resident 1's oxygen therapy.</p> <p>Findings:</p> <p>A review of an admission record indicated Resident 1 was admitted to the facility in May 2024 with diagnoses including respiratory failure (a condition where there's not enough oxygen in the body) and pneumonitis (inflammation of the lung tissue).</p> <p>A review of Resident 1's Care plan report, dated 5/22/24, indicated Resident 1 required continuous oxygen every shift.</p> <p>A review of Resident 1's physician orders, dated 5/21/24, indicated Resident 1 was scheduled for dialysis on Monday, Wednesday, and Friday with pick up time from facility at 12:45 p.m. and chair time for dialysis at 1:15 p.m. The order further indicated Resident 1 should receive oxygen via nasal cannula two liters per minute continuously every shift.</p> <p>A review of Resident 1's Dialysis Form, dated 5/31/24, indicated Resident 1's pick up time for dialysis was 12:45 p.m.</p> <p>During an interview on 3/3/25 at 2 p.m. with the transport driver, the driver stated the trip from the facility to the dialysis center took about five to 10 minutes and Resident 1 fainted in the van upon arrival to dialysis center. The driver further stated he quickly got Resident 1 inside the dialysis center, staff gave her oxygen and told him the oxygen tank was empty.</p> <p>During an interview on 3/3/25 at 11:36 a.m. with the Dialysis Center Administrative Assistant (DAA), DAA stated Resident 1 passed out upon arrival to the center and needed oxygen.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2025
NAME OF PROVIDER OR SUPPLIER  Fairfield Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1255 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/3/25 at 4:30 p.m. with the Administrator (ADM), Resident 1's Late Entry Note, dated 6/8/24, and Dialysis Form, dated 5/31/24, were reviewed. The note indicated Resident 1 arrived at the dialysis center on 5/31/24 and needed oxygen right away. The nursing home oxygen tank was checked and was found to be empty. ADM stated there was no documentation about the status of the oxygen tank prior to leaving the facility and her expectations were that oxygen tanks should be checked before use.</p> <p>A review of the facility's policy and procedure titled, Oxygen Therapy, revised 2/23, indicated, It's the policy of this facility to administer oxygen in a safe manner under physician's orders .</p>		