

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  09/13/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38322</p> <p>Based on observation, interview, and record review, the facility failed to initiate a care plan for falls when one of two residents sampled (Resident 48) fell which resulted in a hematoma (collection of blood beneath the skin) on her forehead and a laceration on her right foot. This failure had the potential to place Resident 48 at risk for insufficient provision of care and services when her care givers may be unaware of the plan of care for her wounds.</p> <p>Finding:</p> <p>Review of Resident 48's face sheet revealed an admitted [DATE]. Review of Resident 48's Interdisciplinary Team note dated 9/3/24 revealed Resident 48 had fallen on 9/2/24 trying to get out of bed which resulted in a hematoma on the side of her face and a laceration on her right foot. Review of Resident 48's care plan revealed no focus area regarding the injuries that resulted from the fall. Review of Resident 48's physician orders revealed orders dated 9/2/24 to monitor the forehead hematoma and right foot laceration daily for signs of infection, but no orders for treatment for the head and foot injuries. Review of Resident 48's MDS (minimum data set, an assessment tool) dated 6/14/24 indicated Resident 48 was on hospice care.</p> <p>During an observation on 9/12/24 at 8:46 a.m., Resident 48 was sitting in her wheelchair in her room. Resident 48 had bruising on the right side of her face, and her feet were noted to be in socks and were moderately swollen.</p> <p>During a record review and concurrent interview on 9/13/24 at 9:59 a.m., MDS Assistant reviewed Resident 48's chart and stated she could not find a care plan for the foot or head wound that resulted from the 9/2/24 fall. MDS Assistant verified there should be a care plan for the wounds. When queried, MDS Assistant stated it was the responsibility of the nurse who was assigned to Resident 48 at the time of the fall to initiate the care plan. When asked the rationale for initiating the care plan, MDS Assistant stated it was important to initiate the interventions we need to do for the wounds, to set goals for the wounds, and so the care team knows the plan for the resident's wounds.</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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review and concurrent interview on 9/13/24 at 12:08 p.m., Director of Nursing (DON) stated Resident 48 was on hospice care and described the interventions the staff were using to keep her safe from falling again. DON reviewed Resident 48's care plan and verified the care plan did not include Resident 48's injuries to her head and right foot. When queried, DON stated any change of condition required a care plan, and stated whoever initiated the change of condition documentation was responsible for initiating the care plan.</p> <p>Review of facility policy and procedure, Care Planning, last revised 11/2023, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive Person-Centered Care Plan for each resident based on resident's needs to attain or maintain his or her highest practicable physical, mental and psychosocial well-being.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38322</p> <p>48660</p> <p>Based on interview and record review, the facility failed to implement all care measures specified in one resident's (Resident 345) Comprehensive Care Plan, when there was no documented evidence Resident 345 was turned and repositioned every two hours. This failure had the potential to delay wound healing.</p> <p>Findings:</p> <p>Record review of a document titled, Admission Record indicated Resident 345 was admitted to the facility on [DATE] with diagnoses of Aftercare Following Joint Replacement Surgery, Presence of Left Artificial Knee Joint, Iron deficiency Anemia (a condition in which blood lacks adequate healthy red blood cells, which are necessary to carry oxygen to the body's tissues), and Down Syndrome (a genetic disorder causing developmental and intellectual delays).</p> <p>Record review of Resident 345's care plan, initiated on 11/29/23, which focused on Resident 345's potential for pressure ulcer development indicated the following nursing intervention, Needs monitoring/reminding/assistance to turn/reposition.</p> <p>Record review of Resident 345's care plan, initiated on 11/29/23, which focused on Resident 345's Activities of Daily Living (ADL) self-care performance deficit indicated the following nursing intervention, Is totally dependent on staff for repositioning and turning in bed.</p> <p>A review of a facility document titled Document Survey Report dated May 2024, indicated there was no documented evidence staff repositioned Resident 345 on the following dates and times:</p> <p>5/6/24: 2 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/7/24: 10 p.m.</p> <p>5/8/24: 12 a.m., 2 a.m., 4 a.m.</p> <p>5/9/24: 2 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/14/24: 2 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/20/24: 2 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/22/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m.</p> <p>5/24/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/25/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/26/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/27/24: 10 p.m.</p> <p>5/28/24: 12 a.m., 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m.</p> <p>5/29/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m., 4 p.m., 6 p.m., 8 p.m.</p> <p>5/30/24: 6 a.m., 8 a.m., 10 a.m., 12 p.m.</p> <p>During an interview and record review on 9/13/24 at 9:44 a.m., the Director of Nursing (DON) stated nursing staff were trained to turn and reposition residents every two hours. The DON further stated, The golden rule is if it's not documented it's not done. After reviewing the Documentation Survey Reports for Resident 345, the DON stated there had been a gap in the required care.</p> <p>During an interview and record review on 9/13/24 at 12:37 p.m., the Director of Staff Development (DSD), stated nursing staff were trained on pressure ulcer care and prevention. The DSD stated the standard intervention for a resident with, or at risk for pressure ulcer development, was to turn and reposition every two hours. The DSD stated, If you did not document it didn't happen.</p> <p>During an interview on 9/13/24 at 2:08 p.m., Licensed Nurse L (LN L) stated we turned and repositioned every two hours to prevent pressure ulcer. If the resident was not turned and repositioned every two hours, they could have developed a pressure injury and an infection because of open skin.</p> <p>During an interview on 9/13/24 at 2:15 p.m., Licensed Nurse D (LN D) stated Certified Nursing Assistants (CNAs) and Licensed Nurses were responsible for turning and repositioning the residents. LN D stated CNAs documented turning and repositioning in the electronic medical record system. LN D stated, If not documented technically it did not happen. LN D further stated, Skin breakdown could occur if not turned and repositioned every two hours.</p> <p>Record review of a document titled, Certified Nursing Assistant Job Description, dated 12/17/21 included as an Essential Duty and Responsibility, Turn bedfast residents at least every two hours.</p> <p>Record review of a document titled, Policy and Procedure for Documentation and Charting, dated February 2023, indicated, It is the policy of this facility to provide a complete account of the resident's care .in an accurate and chronological manner.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38322</p> <p>Based on observation, interview, and record review, the facility failed to maintain safe water temperatures at resident sinks when 6 of 22 resident bathroom sinks had water that was too hot to touch. This failure caused two residents to feel afraid of getting burns and one resident to yell out in pain when a hot wash cloth touched her hands.</p> <p>Findings:</p> <p>During an observation on 9/9/24 at 10:49 a.m., the hot water from the sink in the room [ROOM NUMBER] bathroom felt very hot to the touch. The water was too hot for this surveyor to keep a finger under the stream of water for more than one second. The temperature of the hot water using the surveyor's thermometer was 118 degrees Fahrenheit (F) after 20 to 30 seconds.</p> <p>During an observation on 9/9/24 at 12:29 p.m., a staff brought a lunch tray to Resident 6, who was in her bed, and set it on the overbed table. The staff got a washcloth and turned on the faucet in the bathroom, then brought the washcloth to Resident 6 and began to wash her hands. Resident 6 yelled, It's too hot! when the washcloth touched her hands.</p> <p>During an observation on 9/10/24 at 11:30 a.m., additional water temperatures for sinks in resident rooms were tested with the surveyor's thermometer. The hot water in the shared bathroom for rooms [ROOM NUMBERS] tested at 121.1 F, the shared bathroom for rooms [ROOM NUMBERS] tested at 120.6 F, shared bathroom for rooms [ROOM NUMBERS] tested at 120.6 F.</p> <p>During an interview on 9/10/24 at 11:50 a.m., Environmental Services Supervisor and Maintenance Assistant stated Maintenance Supervisor was on vacation this week. Maintenance Assistant stated Maintenance Supervisor checked the water temperatures and filled out a log. Maintenance Assistant stated he did not know how often Maintenance Supervisor checked the water temperatures. Both Environmental Services Supervisor and Maintenance Assistant stated no one had asked them to check the water temperatures while Maintenance Supervisor was on vacation.</p> <p>During an interview on 9/10/24 at 12 p.m., CNA J stated that she has had experiences with showers and sinks having water too hot intermittently. CNA J stated that at times, the water had been too hot and it took a while to get comfortable. CNA J stated that she told the janitor but could not remember when.</p> <p>During an interview on 9/10/24 at 12:03 p.m., CNA K stated that sometimes the water was too hot, but it took a short time to adjust it comfortably.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and concurrent interview on 9/10/24 at 12:06 p.m., Maintenance Assistant tested the hot water temperature in the sink of the shared bathroom for rooms [ROOM NUMBERS] with the facility thermometer. The temperature of the hot water reached and stayed at 118.9 degrees F after approximately 30 seconds. Maintenance Assistant verified the thermometer read 118.9 degrees F. Maintenance Assistant tested the hot water temperature in the sink of the shared bathroom for rooms [ROOM NUMBERS] with the facility thermometer. The temperature of the hot water reached and stayed at 121.8 degrees F after approximately 30 seconds. Maintenance Assistant verified the thermometer read 121.8 degrees F.</p> <p>During a record review and concurrent interview on 9/10/24 at 1:54 p.m., Administrator stated the facility did not have a policy on water temperatures for residents' bathroom sinks. Administrator stated the facility followed the guidance provided in the user manual for the electronic log platform used for tracking water temperatures. Administrator stated Maintenance Director checked the water temperatures weekly. Administrator provided a copy of this guidance and a print-out of the water temperature log for 9/8/24. Review of the water temperature log for 9/8/24 revealed the temperatures were entered by Maintenance Director and the water temperature for the shared bathroom for rooms [ROOM NUMBERS] was 111.9 degrees. The water temperature log also indicated the water temperature for the shared bathroom for rooms [ROOM NUMBERS] was 111.7 degrees. When asked about the discrepancy between the temperatures obtained by Maintenance Assistant (at 12:06 p.m.) and the temperatures documented by Maintenance Director (a difference of seven and ten degrees respectively), Administrator stated she expected water temperatures to fluctuate.</p> <p>Review of the provided electronic water temperature log platform guidance, not dated, indicated, F-689 Accidents - Water Temperatures . Purpose - The purpose of recording your water temperatures is to assure the Surveyor that your facility is remaining as free from accidental burns and scalds as possible and that any issues are addressed in a prompt and consistent manner. Common Causes - A common cause of tap water burns to the elderly include . Residents may . not check the water before touching it. Task Instructions . As the temperature of the water is taken, hold your hand under the running water at about the same time to assess how the water feels on your skin.</p> <p>39792</p> <p>46132</p> <p>During a concurrent observation and interview on 9/10/24 at 10:01 a.m.,when tested , the water temperature on room [ROOM NUMBER]'s sink was 120.2 degrees Fahrenheit (F, scale of temperature). Resident 45 stated it was too hot for her when she uses it and was scared it would burn her.</p> <p>During a concurrent observation and interview on 9/10/24 at 10:24 a.m., when tested , the water temperature on room [ROOM NUMBER]'s sink (shared with room [ROOM NUMBER]) was 118.9 degrees F. Resident 46 stated the water was too hot and very uncomfortable. Resident 46 stated she wished it was not too hot as she was scared to get burned. Resident 46 stated staff were aware and had the same observation. When asked what she meant by that, Resident 46 stated staff told her the water was too hot for them as well.</p> <p>During an interview on 9/10/24 at 11:58 a.m., LN D stated some rooms water temperature from the faucet comes out pretty hot when she uses it. LN D tated it was important to ensure temperature was not too hot because residents' skin were sensitive and thinner and they could burn easily.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 9/10/24 at 12:05 p.m., LN N placed her hand under the running water from room [ROOM NUMBER]'s faucet and stated it would be too hot for the resident. LN N stated the temperature could result to injury because resident skin was fragile.</p> <p>During a concurrent observation and interview on 9/10/24 at 12:09 p.m., LN L placed her hand under the running water from room [ROOM NUMBER]'s faucet and stated it was hot to her touch and might even be hotter for Resident 45 because of her fragile skin. LN L stated it was important to ensure water temp from the faucet was comfortable for the residents to decrease risk for injuries and burn.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46132</p> <p>Based on interviews and record reviews, the facility failed to ensure they were adequately staff when:</p> <ol style="list-style-type: none"> <li>five out of five residents (Residents 64, 47, 295, 10 and Anonymous 1) complained of short staffing and were left sitting on their urine or feces for over an hour,</li> <li>staff complaints of short staffing and difficulty completing their task timely.</li> </ol> <p>These failures resulted in residents feeling sorry for themselves, feeling frustrated, humiliated, embarrassed and worried about their safety and Resident 295 fearful she might get a wound infection.</p> <p>Findings:</p> <p>During an interview on 9/9/24 at 10:40 a.m., Resident 64 stated the facility was short staffed, and it did not matter what shift, weekdays or weekends, the facility was still short staffed. Resident 64 stated he had talked to the Director of Staff Development (DSD) about the short staffing, but the DSD had no answer. Resident 64 stated due to lack of staff, Certified Nursing assistant (CNA) left him sitting on his feces for over an hour. Resident 64 stated he felt frustrated, humiliated, and embarrassed.</p> <p>A review of Resident 64 Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score, dated 7/21/24, was 15 out of 15 indicating intact cognition. Resident 64 needed assistance with toileting and personal hygiene and was incontinent of bowel and bladder per his MDS (MDS, federal mandated assessment tool).</p> <p>[NAME] an interview on 9/9/24 at 11:07 a.m., Resident 47 stated the facility was short staffed. Resident 47 stated staff had up to 13 residents to care for per shift. Resident 47 stated that was too much for staff to handle especially if the residents they were caring for were dependent like her. Resident 47 stated due to short staffing, staff were always in a rush to help her. Resident 47 stated she could not see and when staff serve her meal and they were short staffed, staff would be in a rush they would not even tell her where her food was located so she would use her hand to locate her food. Resident 47 stated she was also left sitting on her urine for long period of time which was embarrassing. Resident 47 stated short staffing also left her worried about heart attack, falls and worried about what could happen to her. Per her MDS, Resident 47's vision was highly impaired, she had a moderately impaired cognition, she required substantial assistance of staff during toileting hygiene, and was always incontinent of bladder and bowel.</p> <p>During an interview on 9/9/24 at 12:18 p.m., Anonymous 1 stated the facility was short staff. Anonymous 1 stated staff would take a long time to answer call light, about an hour. Anonymous 1 stated had experienced sitting in feces and urine for long period of time on afternoon and night shift. Anonymous 1 stated this was very humiliating and felt sorry for herself.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/9/24 at 1:30 p.m., a responsible party (RP, decision maker) for Resident 5 stated the facility was short staffed. The RP stated she comes to the facility to take care of her mom. The RP stated she would press the call button for her mom's roommate and CNA would not come until an hour later. RP stated it was heart breaking. RP stated CNAs were always in a rush and had too many residents to care for because they were mostly short staffed.</p> <p>During an interview on 9/9/24 at 3:50 p.m., Resident 295 stated staffing could be improved. Resident 295 stated there were not enough staff to care for the residents at the facility and staff does not answer call light promptly. Resident 295 stated sometimes she had to wait for up to an hour before her call light was answered. Resident 295 stated this was very frustrating and she felt helpless. Resident 295 stated she was left lying in her urine for a long time and she could feel her urine seeping through the wound on her back. Resident 295 stated she was fearful she might get a wound infection.</p> <p>A review of Resident 295's BIMS score dated 9/12/24 was 15 out of 15 indicating intact cognition. Resident 295's MDS dated [DATE] indicated she was dependent on staff during toileting hygiene and was frequently incontinent of bowel and bladder. Resident 295 had a surgical incision from her mid to lower back.</p> <p>During an interview on 9/9/24 at 5:01 p.m., Resident 10 stated the facility was short staffed. Resident 10 stated staff was always rushing and would come after an hour when you press the call light due to short staffing. Resident 10 stated he had experienced sitting on his feces and urine for a long time.</p> <p>A review of Resident 10's BIMS score dated 8/13/24 was 15 out of 15 indicating intact cognition. Resident 10 MDS dated [DATE] indicated he was dependent on staff during toileting hygiene and was frequently incontinent of bowel and bladder.</p> <p>During an interview on 9/11/24 at 9:19 a.m., LN B stated there were times the facility was short staffed. LN B stated he had come in and found residents soaked in feces or urine and that was not okay. LN B stated short staffing could lead to late response to call light, increased incidence of falls, accidents and skin impairments. LN B stated short staffing could also lead to delayed incontinence care provided to the residents which could result in wound infections especially if the wound was on the back area or the buttocks. LN B stated it was not acceptable to answer call light after 10 minutes because by then resident might have an accident already.</p> <p>During an interview on 9/11/24 at 10:10 a.m., the Staffing Coordinator (SC) stated she also works as a CNA and was in fact working on the floor as a CNA today. The SC stated she mostly worked on the floor as a CNA when needed or when the facility was short staffed. The SC stated the facility does get short staffed because of call offs. SC stated depending on how many CNAs called off, the residents assigned to them would be divided among the CNAs left on the floor. When asked what the risks for the residents could be then if the facility was short staffed, she stated, it becomes a safety issue. SC stated short staffing could lead to decreased quality of care. SC stated it could also affect how fast staff answered the call lights.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/11/24 at 12:20 p.m., the Director of Staff Development (DSD) stated call lights should be answered immediately. When asked what a reasonable time frame for staff was to answer a residents call light, the DSD stated it depends on whether the CNA was busy helping another resident. When asked if it was reasonable to answer call lights between 20 minutes up to an hour later, the DSD stated no. The DSD stated not answering the call light promptly could lead to accidents and falls. the DSD stated it was important to ensure facility was adequately staffed to ensure safe and quality care were provided for the residents.</p> <p>During an interview on 9/12/24 at 5:28 p.m., the Infection Preventionist (IP) stated it was important to have adequate staffing to provide good care for the resident and to provide resident needs safely. IP stated short staffing could result in late provision of care, late response to call light and sometimes could lead to falls and accidents . When asked what the facility's policy on call light was, the IP stated call light should be answered as soon as possible. When asked if it was reasonable for staff to answer a call light between 20 minutes up to an hour later, the IP stated no.</p> <p>During an interview on 9/13/24 at 11:08 a.m., Restorative Nursing Aide G (RNA G) stated she had been pulled to work on the floor as a CNA especially if the facility was really short staffed. RNA G stated she gets pulled to work on the floor at least once a week. RNA G stated short staffing could lead to negligence, staff could not provide quality care to the residents, staff could not provide care to the residents safely and staff might not answer call light promptly. RNA G stated call light should be answered as soon as possible. When asked if it was acceptable and reasonable to answer call light after 20 minutes or 1 hour later, RNA G stated no.</p> <p>During an interview on 9/13/24 at 1:34 p.m., the Director of Nursing (DON) stated staffing was based on census, facility assessment, admissions, acuity and depending on resident's needs. The DON stated short staffing put the residents at risk for not meeting their needs, risk for falls and not providing care for the residents. The DON stated short staffing could possibly affect response time to call light resulting in late provision of care. The DON stated the facility did not have a Staffing policy and procedure but uses the Facility Assessment as the policy when staffing the facility.</p> <p>The facility did not have a policy and procedure specific for staffing.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled Call Light/Bell, revised 2/2023, the P&amp;P indicated calls for assistance should be answered within a reasonable time frame and as soon as possible .urgent requests for assistance should be addressed immediately.</p> <p>48660</p>		

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  09/13/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38322</p> <p>Based on observation, interview, and record review, the facility failed to store and prepare food in a sanitary environment when: 1. Ice packs for resident pain relief were stored in a refrigerator for food, 2. A dietary aide did not correctly test the sanitizer bucket, and 3. A cook did not correctly describe the cool down process. This failure could potentially lead to food-borne illness in vulnerable residents.</p> <p>Findings:</p> <p>1. During an observation and concurrent interview on 9/12/24 at 2:33 p.m. with Dietary Manager, the Station 1 refrigerator for residents' food had a sign taped to the front that indicated For Resident Food Only. The refrigerator contained a six-pack of Ensure labeled with a resident's name and a bottle of Snapple with a resident name on it. The freezer compartment contained multiple white ice packs with the words Cold Pack in blue print on them. When queried, Dietary Manager stated the ice packs were for if a resident had a headache or something. When asked if ice packs should be in the refrigerator for resident food, Dietary Manager stated her department was just responsible for keeping it clean and recommended speaking to nursing about where the ice packs should be stored.</p> <p>During an observation and concurrent interview on 9/12/24 at 3:42 p.m., when queried, Licensed Nurse D looked at one of the ice packs from the Station 1 refrigerator and stated the ice packs in the Station 1 refrigerator were for when residents asked for an ice pack, and gave the example of a resident who had had a knee replacement surgery and needed the ice pack for pain relief.</p> <p>During an interview on 9/12/24 at 3:46 p.m., when asked if ice packs for pain relief should be in the refrigerator for resident food, Registered Dietitian stated, No there should not be ice packs in the refrigerator for food.</p> <p>2. During an observation and concurrent interview on 9/12/24 at 2:33 p.m., when queried, Dietary Aide E stated the sanitizer buckets used for cleaning the food preparation surfaces in the kitchen were changed every two hours. Dietary Aide E demonstrated the process for testing the sanitizer in the buckets for the proper concentration. Dietary Aide E got a test strip, dipped it in a sanitizer bucket for one second, and held the strip up to the test strip bottle. When asked what the strip should read, Dietary Aide E stated she needed to ask, and went to Dietary Manager to ask her. When queried, Dietary Aide E verified it was part of her duties to test the sanitizer buckets.</p> <p>Review of facility policy and procedure Quaternary Ammonium Log Policy, dated 2023, indicated, Policy: The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. Procedure: . The solution will be replaced when the reading is below 200 ppm (parts per million). The replacement solution will be tested prior to usage. Read instructions on . the test strips for proper concentration .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Fairfield Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1255 Travis Blvd Fairfield, CA 94533	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. During an observation and concurrent interview on 9/12/24 at 2:41 p.m., when queried, [NAME] F opened the binder that contained the cool-down log and described the process for cooling down food to a safe temperature for storage. [NAME] F stated that at the end of the process, the food temperature should be 41 degrees. When asked what she would do if the food was 45 degrees at the end of the process, [NAME] F stated, I'm not sure, let me ask, and asked Dietary Manager who stated the food would be discarded.</p> <p>During an interview at 9/12/24 at 3:46 p.m., when queried, Registered Dietitian stated it was best practice for staff to know the answers to questions regarding testing sanitizer buckets and the cool-down process.</p> <p>Review of facility policy and procedure Cooling and Reheating of Potentially Hazardous (PHF) or Time/Temperature Control For Safety (TCS) Food, dated 2023, indicated, When cooked PHF or TCS food will not be served right away it must be cooled as quickly as possible. Discard cooked, hot food immediately when the food is . Above 41 [degrees Fahrenheit] and more than 6 hours into the cooling process.</p>

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NAME OF PROVIDER OR SUPPLIER  Fairfield Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1255 Travis Blvd Fairfield, CA 94533	
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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38322</p> <p>Based on observation, interview, and record review, the facility failed to keep the trash area clean. This failure could potentially result in an infestation of rodents or other vermin.</p> <p>Finding:</p> <p>During an observation and concurrent interview on 9/12/24 at 2:30 p.m., when asked where the kitchen trash was disposed, Dietary Manager went out to the trash area outside the kitchen back door. The trash area had two dumpsters. Dietary Manager stated one dumpster was for garbage and one for recycling. Behind the dumpster for garbage was a large [NAME] that was full of many pieces of garbage such as drink cups, napkins, and plastic bags. When asked about the [NAME] full of garbage, Dietary Manager stated the garbage was coming from the building next door. The dumpster for garbage was low to the ground with approximately two inches of clearance under it. Shoved underneath the dumpster were plastic bags with napkins, straw wrappers, and plastic utensils in them, such as would be used to eat take-out food. When asked about the trash shoved under the dumpster, Dietary Manager stated it looked like plastic bags and stated she would ask the waste company to clean them when they come back. When queried, Dietary Manager stated the waste company came at 4 a.m.</p> <p>During an interview at 9/12/24 at 3:46 p.m., when queried, Registered Dietitian stated it could be beneficial to keep vigilant with sanitation around the trash area.</p> <p>Review of facility policy and procedure, Trash Collection area, last revised 2/2023, indicated, It is the policy of this facility to keep trash collection area clean as it is a potential feeding ground for vermin and rodents. Procedures: 1. The area must be swept and kept clean on a regular basis.</p>		