

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  Fairmont Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  950 S. Fairmont Avenue Lodi, CA 95240	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents or hazards for one of four residents (Resident 2) when Resident 2, who was at high risk for falls, fell when she was left in the bathroom unattended on 8/5/24. This failure had the potential to result in Resident 2 sustaining injury including fractures (broken bones) and decreased well-being. Findings: A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility in 2024 with diagnoses which included surgical repair of left hip fracture. A review of Resident 2's Care Plan Report, dated 7/27/24, indicated .Focus. At risk for falls. Goal. Will not sustain serious injury. Interventions. Anticipate and meet needs. A review of Resident 2's Progress Notes, dated 8/5/24, indicated, .writer was called by attending CNA (Certified Nursing Assistant) to pull up resident @ 0600 [6AM]. upon entering room, resident was found sitting down inside the bathroom. resident transferred back to wc [wheelchair] by 3 person assist. resident stated that she needed to use the bathroom and received help doing so, but attending CNA had left her unattended while using the bathroom. informed attending CNA to be with resident at all times while using the bathroom. A review of Resident 2's Fall Risk Evaluation, dated 7/24/24, indicated .Score: 12. Category: High Risk. A. Mental Status: Alert/Oriented x 3 (time, place, person) .B. History of Falls. 3 or more falls in past 3 months. C. Elimination Status. Requires regular assist with elimination. A review of Resident 2's MDS (Minimum Data Set, a comprehensive care assessment tool) - Section GG-Functional Abilities and Goals, dated 8/1/24, indicated, Self-Care. Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Toileting/hygiene: The ability to maintain perineal hygiene, adjust clothes before or after voiding or having a bowel movement. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Toilet transfer: the ability to get on or off a toilet or commode. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. During a phone interview on 6/19/25, at 10:14 a.m., with the Responsible Party (RP) of Resident 2, the RP stated that she was concerned about the care Resident 2 received at the facility. The RP further stated Resident 2 was assisted to the bathroom and left alone by staff, resulting in a fall. The RP stated that she was notified by phone after the fall. The RP further stated that Resident 2 was not injured. During an interview on 6/20/25, at 12:20 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated the facility's fall protocol for residents at risk for falls was to have the call light within reach, bed in low position with wheels locked, wheelchair locks on when a resident was not mobile in the wheelchair, ambulate (walk) with assistance with gait belt if needed, stand outside the bathroom door to give the resident privacy and wait to assist the resident when done. During an interview on 6/20/25, at 12:21 p.m., with Licensed Nurse (LN) 1, LN 1 stated residents were assessed for fall risk on admission, quarterly, and after a fall incident. LN 1 stated that when residents who were at risk for falls were assisted to the bathroom; the CNAs stayed with the residents. LN 1 further stated the CNAs stayed outside the bathroom door so that the residents could have privacy. LN 1 stated the residents were instructed to call for assistance when they were finished using the bathroom. During a phone interview on 6/20/25, at 3:50 p.m., CNA 2 stated that she remembered Resident 2. CNA 2 confirmed that she remembered taking Resident 2 to the bathroom on 8/5/24. CNA 2 further confirmed that she left Resident 2's room after she helped her to the bathroom. During a phone interview on 6/20/25, at 3:55 p.m., with LN 2, LN 2 stated she remembered Resident 2. LN 2 further stated that CNA 2 assisted Resident 2 to the bathroom, then CNA 2 left Resident 2's room while Resident 2 was still in the bathroom. LN 2 confirmed that Resident 2 fell in the bathroom. LN 2 stated that she advised CNA 2 to remain with the residents with high risk for falls while they used the bathroom. LN 2 stated that staff waited outside the bathroom door so that they could give the residents privacy but be close by to assist the residents after they were finished. LN 2 stated that Resident 2 had a high fall risk and had fallen before. During a concurrent interview and record review on 6/20/25, at 3:30 p.m., with the Director of Nursing (DON), Resident 2's Electronic Medical Record (EMR) was reviewed. The DON stated residents were assessed for fall risk upon admission to the facility, quarterly, and after a fall incident. The DON further stated that if a resident that was assessed to be at high risk for falls was assisted to the bathroom, the resident was instructed to use the call light for assistance when finished. The DON explained that the staff usually waited outside the bathroom door to give the resident privacy. The DON acknowledged that leaving a resident at risk for falls in the bathroom and not waiting outside the bathroom door to assist the resident could increase</p>		