STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055242	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairmont Rehabilitation Hospital	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive water safety management program based on nationally accepted standards to minimize the risk of Legionella (a serious lung infection) and other opportunistic waterborne pathogens (a microorganism [bacteria] that exists in water sources or plumbing [pipes required for the water supply, heating and sanitation in a building] systems that can cause serious illness in people over [AGE] years of age and have weakened immune systems) for a census of 54 when: a. The facility did not complete and document a facility-wide assessment of potential Legionella growth areas to include flow chart, b. The facility did not implement adequate control measures, c. The facility did not establish sufficient monitoring protocols; and, d. The facility did not create an intervention plan for when control limits are not met. These failures put the residents and staff at risk of potential Legionella and other opportunistic waterborne pathogen exposure, threatening their health and well-being. Findings: (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a joint interview on 7/2/25, at 9:30 AM, with the Director of Nursing (DON) and the Administrator (ADM), the DON stated the facility was notified by a local general acute care hospital (GACH) on 5/6/25 that a resident who was sent to them from the facility tested positive for Legionella pneumophila (a severe form of pneumonia -a lung infection caused by Legionella bacteria). The DON further stated the facility contacted the local Public Health Department (PHD) for guidance on how to handle the results. The DON explained the PHD told them to test residents with respiratory symptoms (signs that like runny nose, cough, and difficulty breathing that indicate a problem with your breathing or lungs) and to test their water for Legionella. The DON stated they tested all the residents in the facility with respiratory symptoms and the roommate of the resident who tested positive. The DON further stated all results were negative. The ADM explained the PHD asked the facility to test their water and when they did, the PHD stated the sample was inadequate and needed to be done by a company certified to collect water samples. The DON explained the PHD also wanted the facility to be contracted with a company to provide certified testing and facility water maintenance in case of a positive result. The ADM stated they did not have a contracted provider at the time and requested a list of certified companies from the PHD. The ADM explained they contacted a company who came out on 7/1/25 and collected 15 different water samples from different sources and sent them to the lab for processing. The DON added the results would be available in 10-14 days. During a concurrent interview and record review on 7/2/25, at 9:37 AM, with the Infection Preventionist (IP), the facility policy and procedure (P&P) titled, Water Safety Management Program (Legionella), revised on 12/2023, was reviewed. The IP stated the P&P was based on the Centers for Disease and Prevention's (CDC) Legionella Toolkit (an actionable, detailed guide to assist facilities in developing a water safety program). The IP further stated the local PHDs, Public Health Officer (PHO) told her the facility's P&P for water safety management was not detailed enough because it lacked a full facility water supply system analysis, graphs that included the inlets and outlets of the water sources, and locations of all the water sources inside and outside of the building. The IP confirmed the P&P did not include a certified testing company contract and how to handle the water supply in the building in case of water borne pathogen outbreak. The IP further explained the PHO recommended the facility conduct a full risk assessment. When asked if the facility had previously conducted a facility risk assessment; the IP stated, I don't think so. During a concurrent observation (tour of facility's water sources) and interview on 7/2/25, at 12:25 PM, the Maintenance Director (MTD) showed the boiler room and explained the two water storage tanks held 103 gallons of water each, and they supplied all the water to the building. The cooling tower was observed outside of the facility near the boiler room. The MTD showed the shower rooms that the residents use in the facility. The MTD stated he was in the process of replacing the showerheads and the eye washing station with specialized filters on the recommendation of the certified water management company. The MTD stated preventative maintenance was important to prevent downtime and for the residents' health and safety. The MTD explained the special filters on the showerheads and eye wash station help filter opportunistic pathogens like Legionella from the water. The MTD stated it was important to test the water to prevent lung infections like pneumonia which can harm the residents and cause death. The MTD was not able to explain the facility's process for decontaminating the building water systems if necessary. The MTD confirmed they did not have an outside source contracted to decontaminate the water system, prior to notification of a positive Legionella resident on 5/6/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 7/2/25, at 3:46 PM, the DON stated her expectation for a water safety management plan was to have one in place. The DON further stated the facility did have one in place but confirmed it was not as detailed as the PHD stated it should be and it needed to include a flow chart of the water in and out of the building, where it goes, and to which water outlets, and added it needed to have their water system mapped out. The DON confirmed they did not have their water system mapped out with points of possible Legionella risk documented. The DON explained Legionella could grow and spread in water pipes and can be inhaled via steam, like in the showers. The DON further explained it was important to have a detailed water safety management program and plan in place to prevent the residents from getting Legionella pneumonia. The DON stated the risk to the residents was respiratory distress and even death. During an interview on 7/3/25, at 11:51 AM, with the local PHO, the PHO confirmed she asked the facility to develop a water management plan. The PHO stated the facility did not have a plan or policy in place based on nationally accepted standards to minimize the risk of Legionella contamination. The PHO further stated when she reviewed the Water Safety Management Program (Legionella) P&P, she stated their plan was just a copy and paste of the CDC toolkit on how to develop and implement a water safety plan with some added text. The PHO explained the CDC's Toolkit was designed to be used as a tool to help facilities develop a water safety program, not to be used as one. The PHO added the facility did not have a diagram of their water system with a flow chart of the inlets and outlets of water as it moved through pipes in the buildings and where each source of water comes from. The PHO further explained that the facility needed to have all this information as part of their water management program, and it had to be mapped out with an action plan, including who they would contact and work with to chlorinate and flush lines in case of a Legionella outbreak. A review of the facility's P&P titled, Water Safety Management Program (Legionella), revised 12/2024, indicated, .It is the policy of this facility to provide facility maintenance protocol guidelines for plant operations related to water safety management to ensure the reduction in potential for growth of Legionella .This policy will follow and reference recommended guidelines .by the Centers for Disease Control and Prevention (CDC) for program implementation referenced . A review of the CDC's online guide titled, Overview of Water Management Programs, published March 15, 2024, indicated, .Key Points .Many buildings need a water management program (WMP) for their building water system .WMPs identify hazardous conditions and outline steps to minimize the health impact of waterborne pathogens .Developing and maintaining a WMP is a multi-step process that requires continuous review .Seven steps of a Legionella WMP are to: 1. Establish a WMP team 2. Describe the building water systems 3. Identify areas where Legionella could grow and spread 4. Decide where to apply and how to monitor control measures 5. Establish interventions when control limits aren't met 6. Ensure the program runs as designed and is effective 7. Document and communicate all activities .the principle of effective water management include: Ensuring adequate disinfection .Maintaining devices to prevent .Sediment, Scale, Corrosion, Biofilm .Maintaining water temperatures to limit Legionella growth, preventing water stagnation . Once established, WMPs require regular monitoring of key areas for potentially hazardous conditions. The programs use predetermined responses to respond when control measures aren't met .Each program has to be tailored for each building at a particular point in time .In some settings, the entire building needs a WMP: Hospitals and long-term care facilities . https://www.cdc.gov/control-legionella/php/wmp/index.html