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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
	055242	A. Building B. Wing	01/09/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, and record review, the facility failed to submit a summary of investigation for an alleged resident to resident altercation to the Department within five (5) working days, as required, for one of three sampled residents (Resident 1).This failure placed Resident 1 at risk for further resident to resident altercations.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to thefacility with diagnoses including unspecified dementia (ongoing problems with memory and thinking), chronic kidney disease (long term kidney damage), other symptoms and signs involving cognitive (the brain's mental processes of acquiring knowledge, understanding, and thinking) functions and awareness.Review of Resident 5's admission RECORD, indicated Resident 5 was admitted to thefacility with diagnoses including orthopedic aftercare (care and recovery support after bone, joint, or muscle surgery or injury), displaced intertrochanteric fracture of right femur (broken upper thigh bone near the hip), history of falling, abnormalities of gait and mobility, type 2 diabetes mellitus (high blood sugar levels) and depression (mood disorder).Review of the document titled, Report of Suspected Dependent Adult/Elder Abuse, completed and submitted to the Department on 11/8/25 by the Social Services Director (SSD), indicated that on 11/8/25 at 6 AM, Resident 1 was involved in an incident in which the former roommate, Resident 5, blocked the bathroom door while Resident 1 was inside the bathroom, preventing Resident 1 from exiting the bathroom. Review of Resident 1's care plan, initiated on 11/8/25, in the section titled, Focus, indicated, .[Resident 1] At risk for psychosocial and mood changes related an incident of being locked in the bathroom by another resident.Review of Resident 5's care plan, initiated on 11/8/25, in the section titled, Focus, indicated, .[Resident 5].At risk for psychosocial and mood changes related to locking in a resident in the bathroom.During an interview on 1/9/26, at 9:49 AM, with the SSD, the SSD stated that he completed the 5-day investigation for the reportable resident-to-resident altercation involving Resident 1 and Resident 5 but did not submit the 5-day investigation report to the Department. During an interview on 1/13/26, at 1:44 PM, with the Director of Nursing (DON), the DON stated that the 5-day investigation summary for the reportable resident-to-resident altercation involving Resident1 and Resident 5 was not submitted to the Department and that there was no documentation or confirmation indicating that it was submitted. The DON further stated that she was aware the 5-day investigation summary was required to be submitted to the Department within five working days and that failure to submit the report indicated the investigation was not completed.Review of an undated facility policy and procedure (P&P) titled, Abuse Investigation and Reporting, indicated, .The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written repost of the findings of the investigation within five (5) working days of the occurrence of the incident.

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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NAME OF PROVIDER OR SUPPLIER Fairmont Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 950 S. Fairmont Avenue Lodi, CA 95240	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop and implement a comprehensive care plan (written plan that guides staff on daily care and safety based on the resident's needs) for one of three sampled residents (Resident 1) to address Resident 1's frequent and extended use of a shared bathroom, which delayed other residents' access to the bathroom.This failure resulted in dissatisfaction among those residents and placed Resident 1 at potential risk for further altercations with other residents.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including unspecified dementia (ongoing problems with memory and thinking), chronic kidney disease (long term kidney damage), other symptoms and signs involving cognitive (the brain's mental processes of acquiring knowledge, understanding, and thinking) functions and awareness. Review of the document titled, Report of Suspected Dependent Adult/Elder Abuse, completed and submitted to the Department on 11/8/25 by the Social Service Director (SSD), indicated that on 11/8/25 at 6 AM, Resident 1 was involved in an incident in which the former roommate, Resident 5, blocked the bathroom door while Resident 1 was inside the bathroom, preventing Resident 1 from exiting the bathroom. Review of Resident 1's .Brief Interview For Mental Status (BIMS) Evaluation, (BIMS, a short set of simple questions staff ask a resident to check how well they are thinking and remembering) dated 12/4/25, indicated that Resident 1 had moderate cognitive impairment (noticeable problems with memory and thinking, but able to perform some activities independently).During an interview on 1/9/26, at 11:26 AM, with Resident 2, Resident 2 stated she could not access the bathroom in a timely manner because Resident 1 was frequently in the bathroom for extended periods. Resident 2 further stated that Resident 1 was causing a problem with bathroom access and that it was not fair she could not access the bathroom when needed. During an interview on 1/9/26, at 11:35 AM, with Resident 3, Resident 3 stated that Resident 1 was confused and was not aware of how frequently she used the shared bathroom, which made it difficult for other residents to access the bathroom when needed. During an interview on 1/9/26, at 11:55 AM, with Resident 4, Resident 4 stated that Resident 1 used the bathroom frequently and stayed in the bathroom for extended periods. Resident 3 further stated she had to hold her urine and call a nurse to intervene and assist Resident 1 to complete bathroom use in a timely manner before she could access the bathroom. During an interview on 1/9/26, at 12:19 PM, with Certified Nurse Assistant (CNA) 1, CNA 1 stated that Resident 1 required staff supervision to prevent prolonged bathroom used. CNA 1 stated that Resident 1 would go to the bathroom without using the call light for assistance and would remove her personal alarm which made it difficult for staff to be aware when Resident 1 was already in the bathroom. CNA 1 further stated that Resident 1 previously experienced a conflict with Resident 5 related to bathroom use. During an interview on 1/9/26, at 12:51 PM, with Licensed Nurse (LN) 1, LN 1 stated that Resident 1 was forgetful and could not remember the timing of her bathroom use, which caused Resident 1 to use the bathroom frequently and remain in the bathroom for extended periods. LN 1 further stated that other residents who could not access the bathroom in a timely manner due to Resident 1's bathroom use had to use the shower room for toileting. During a concurrent interview and record review on 1/9/26, at 1:30 PM, with LN 2, Resident 1's care plans were reviewed. LN 2 stated that Resident 1 had previously been involved in a resident-to resident altercation with Resident 5 related to bathroom use because Resident 1 had frequent bathroom use. LN 2 further stated that Resident 1 did not have a care plan to address or prevent conflict related to Resident 1's bathroom use, which placed Resident 1 at risk for repeated resident-to resident altercations.During a concurrent interview and record review on 1/9/26, at 2:07 PM, with the Minimum Data Set Coordinator (MDS), Resident 1's care plans (continued on next page)

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