

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 01/16/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>40903</p> <p>Based on observation, interview, and record review, the facility failed to ensure safety of bed side medication storage and use for 1 out of 10 residents (Resident 24) observed for medication administration based on facility's policy and medical doctor's orders.</p> <p>This failed practice resulted in unauthorize use of medications without a doctor's order in the facility, unsafe handling, and storage of medications in a room shared with another resident.</p> <p>Findings:</p> <p>During a medication administration observation for Resident 24, at facility's station 2 hallway, accompanied by Licensed Nurse (LN) 3, on 1/13/25, at 9:35 AM, LN 3 administered the morning medications and later at 9:56 AM measured the Blood Pressure (BP) and gave the two blood pressure medications. Resident 24 was sitting in a wheelchair and was hard of hearing. Further observation, inside Resident 24's room, there were three medications with no labels stored on top of Resident 24's bed-side table</p> <p>During a concurrent observation and interview with LN 3, in Resident 24's room, on 1/13/25, at 1:22 PM, the bed side unlabeled medications were brought to the attention of LN 3. The medications at bed side included an inhaler called Foracort 200 (a brand name for combination of two drugs for treatment of the asthma) indicating 100 out of total 120 puffs had been already used, a nose spray called Aller-FLO (or Fluticasone, a medication spray into the nose), and a second nose spray called Saline Nasal Mist (a nose spray with salt solution to moisturizer the nasal lining). LN 3 stated she did not notice the medications were stored at Resident 24's bedside and had to check if there was an order from the doctor to use the medications. LN 3 stated it was not safe to keep resident medications at the bed side without proper assessment.</p> <p>During a concurrent interview and record review on 1/13/25, at 1:35 PM, with LN 3, Resident 24's Medication Administration Record (MAR), dated 1/25, was reviewed. LN 3 confirmed Resident 24's MAR record did not contain any orders for the 3 medications stored at Resident 24's bedside.</p> <p>During an interview with Resident 24, in her room, on 1/14/25, at 8:35 AM, Resident 24 stated the medication at her bedside were her own and was prescribed by her allergy doctor and had been using them for years. Resident 24 did not know if the facility was aware of her use since she was admitted in November of 2024 and no one from the facility had explained to her the process of her using her own inhaler at the facility.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25, at 4:52 PM, the Director of Nursing (DON) stated the residents could use their own medications with a doctor's order, and an assessment of safe storage and the resident's mental status. The DON stated the risk of having medication at bed side and self-use could pose safety risk and/or medication interaction and use by another resident.</p> <p>Review of the facility's policy titled Nursing Administration: Continuum of Care, dated 2/23, in section 10 titled Nurse Assistant Procedure, indicated, .If the resident brought in any medication, give them to the charge nurse .</p> <p>Review of the facility's undated policy titled Self-Administration of Medications, the policy indicated, . Residents have the right to self-administer medications if the interdisciplinary team (team of health care professionals caring for the resident) has determined that it is clinically appropriate and safe for the residents to do so . Section 8 of the policy indicated, .Self-administered medications are stored in a safe and secure place, which is not accessible by other residents . Section 9 of the policy indicated, .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .</p> <p>Review of the facility's undated policy titled Medications brought to the facility by the Resident/Family, the policy indicated, .The facility shall ordinarily not permit residents and families to bring medications into the facility . The policy further indicated, .Resident and families must report to the nursing staff any medications that they want to bring or have brought into the facility .</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe use of facility owned smart phones (also known as cell phones) for communication with medical providers regarding resident's Protected Health Information (or PHI, refers to any individually identifiable health information about a resident) with a census of 56 residents.</p> <p>This unsafe practice could compromise residents' private medical information and violate residents' health information privacy and confidentiality.</p> <p>Findings:</p> <p>During a concurrent inspection of the facility's Station 2 medication storage areas and interview with Licensed Nurse (LN) 7, on 1/13/25, at 10:26 AM, a smart phone marked with Nurse Station 2, 209-3 . [phone number]) was noticed sitting unattended next to a computer at the station. LN 7 stated the phone was used to communicate with medical providers. When LN 7 unlocked the screen, the review of text messages communicated with different doctors and nursing staff, indicated the staff sent resident's health updates including their name, medical condition, or photos of laboratory test results, and the providers responded back with orders for medications or medical tests. The review of the photo section of the smart phone, indicated the smart phone stored 3,166 items including pictures of body parts, laboratory tests, and resident's demographic information such as names, date of birth, and medical diagnosis. Further review of the select text format communication via smart phone with medical doctors were as follow:</p> <p>1.Text communication with Medical Doctor 5 (MD) via smart phone:</p> <p>Text to MD 5 On Saturday 12/28/24 : good evening Doctor sorry to bother. I hope its not that late yet, I just want to let you know your patient [Resident 9] is back in the facility .with the following diagnosis. A copy of demographic information with a list of diagnosis was attached.</p> <p>MD 5's response: Ok Thx [thanks] .</p> <p>Text to MD 5 on Sunday 12/29/24, at 10:39 AM: Good morning [MD 5] .your [Resident 14] fell facing the floor while trying to unlocked his WC [Wheel chair] & sustained ABRASIONS to his forehead and bilateral knees. TX [treatment] nurse does the first aide tx [treatment] to affected areas. Can we req [request] Xray [creates pictures of the inside of your body] please. Thank you</p> <p>MD 5's response (no time stamp): Ok to do facial Xray. Do knees look swollen enough for Xray</p> <p>Nurses' response: It doesn't look like it Dr. but can we have the order to make please Dr thank you</p> <p>MD 5's response (no time stamp): Yes Ok Knee X-ray</p> <p>Text to MD 5 on Sunday 12/19/24 at 3:01 PM: Hi Dr [doctor] your [Resident 9] . req [request] an order for Pepcid PRN [as needed] for reflux please advise thank you.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Text communication with MD 4</p> <p>Nursing text to MD 4, 1/11/25 at 5:18 PM: Results for Chest X-ray for [Resident 47]</p> <p>Nursing Text to MD 4 on 1/11/25 at 5:36 PM: Quoted earlier text to MD 4 requesting prescription for an opioid drug called Norco for Resident 410 F/U [follow up] Pharmacy stating E-script [electronic prescription] still hasn't been received for [Resident 410]</p> <p>Nursing Text to MD 4, on 1/11/54, at 9:35 PM: Doc, May we have follow-up CXR [chest xray] for [Resident 8] She still have persistent cough. May we also order Tessalon Perls [Tessalon [NAME], or Benzonatate, is cough medicine in pill form] for her?</p> <p>MD 4's response on 1/11/25 at 9:46 PM: Ok CXr 1 tab q 6 hrs prn [every 6 hours as needed]</p> <p>Nurse's response on 1/11/25 at 10:18 PM: [Resident 47] also has wt loss [weight loss] of 16.2 lbs [pounds] x 3 weeks, started on Med pass 2.0 [a nutritional supplement] .TID [three times daily]</p> <p>MD 4's response on 1/11/25, at 10:30 PM: [NAME] [thank you] Quoted chest xray results for Resident 47 and asked allergy?</p> <p>MD's response on 1/11/25 at 11:33 PM: Levaquin [an antibiotic] . daily x7 days; Flagyl [antimicrobial antibiotic X7 days .</p> <p>Nurse's response on 1/11/25, at 11:38 PM: He is on full liquid diet because of the consistent emesis [vomiting] and diarrhea. He's failed his barium swallow [a test that assess if resident can swallow solid food safely] as well .</p> <p>MD 4 later changed the antibiotic to IV form.</p> <p>Text from nurse to MD 4, on 1/12/25, at 8:56 AM: Good morning, Dr your [Resident 410] been complaining of pain 10/10 [pain severity 1 out of 10 with 10 being the most severe] but his Norco .was not delivered yet. Can you please give us a script because he was saying that he will file a complaint already for not getting it thank you</p> <p>MD 4's response on 1/12/25: Please call the Pharmacy</p> <p>Nurse's text to MD 4, on 1/12/25, at 11:45 AM: Hi Doc. RD [Registered Dietitian] had recommendations for your patients The text included the names of three residents with request to prescribe vitamin supplements and fluid restriction (restricting amount of fluid resident can take).</p> <p>Md 4's response on 1/12/25: ok</p> <p>During a concurrent interview with Licensed Nurse 7 (LN 7) and review of text message documentation between nursing staff and MD 7, on 1/13/25, at 11:49 AM, the smart phone text message with MD 7 were as follow:</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nurse text message to MD 7 on 1/5/25 at 2 PM: Text Message RCS (Rich Communication Services, a type of text communication) Sun [DATE] at 2:00 PM (in green color text); Hi doctor your [Resident 409]. She is currently on a routine regimen for lorazepam [anxiety pill and controlled medication] 1-tab 2x/day. Patient and son .would like her PRN tramadol [pain medication] to be on the same regimen as lorazepam if possible. Please advise. Thank you</p> <p>No response from MD</p> <p>Nurse Text message to MD 7 on 1/18/25 at 6:49 AM: Good Morning Doc, These are [Resident 409's] lab results. Please advise sent in green color text as SMS (or Short Message Service) and included pages of test results.</p> <p>During review of text messages between the Director of Nursing (DON) and nursing staff at facility's Station 1, on 1/13/25, at 11:42 AM, accompanied by LN 7, the smart phone text message with DON were as follow:</p> <p>Text from nurse to DON on 1/13/25: Hi [DON's first name], have been trying to get E-script from [MD 4] since this morning & [Resident 410] keeps asking for his Norco [pain medication] but pharmacy keeps saying E-script isn't in yet</p> <p>DON's response: Is this a new admit? Give me Dx [Diagnosis] and DOB [Date of birth] please</p> <p>Nurse's response: [Resident 410], DX: cellulitis of LLE [skin infection of left lower extremity; leg] [DOB]</p> <p>DON's response: When did this patient came in and from what hospital?</p> <p>Nurse response: came in yesterday from [redacted hospital name]</p> <p>DON response okay just texted him</p> <p>LN 7 stated the nursing staff were allowed to text the doctors with resident information and medical request via the facility provided smart phone.</p> <p>In an interview with the DON, in her office, on 1/15/25, at 4:52 PM, the DON stated the medical providers wanted text messages and it was easier for them to address and responded to the requests. The DON stated the orders from text messages were written as a telephone order. The DON stated the smart phone had a 7-digit code to open it. The DON stated the facility did not have a special software for secure messaging. The DON stated the facility can use the messaging option from its computer system and it was not an easy option for the doctors to access or use. The DON was not sure about the details of the facility's policy on use of smart phones with confidential health information of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a concurrent interview with facility's Administrator (Admin), in his office, on 1/16/25, at 2:20 PM, and review of the facility's policy on use of smart phones, the Admin stated the facility provided the smart phone for each nursing station to help with communication. The Admin stated the use should be limited to situations such as urgent change in condition of a resident. The Admin stated he was not sure if anyone in management were monitoring the smart phone use, or the messages or pictures communicated. The Admin stated he had not looked at the policy recently on how smart phones should be handled. The Admin stated the health care information was vulnerable to hacking (unauthorized access to a computer system or smart phones) and no one was immune to it.</p> <p>Review of the facility's policy titled Use of facility-Designated Cell Phone (or Smart Phone) for Physician Communication, with revision date of 4/24, the policy indicated, .To establish guideline for the use of facility designated cell phones for text-based communication with physicians while ensuring compliance with HIPAA (Health Insurance Portability and Accountability Act; [federal law that protects patients' health information]) requirements and safeguarding the privacy and security of patient information. The policy in the scope section indicated, .This policy applies to all employees' contractors and affiliated healthcare providers . The policy further indicated, .The use of facility designated cell phones for texting physician is permitted only when the following guidelines are adhered to. All text-based communication involving protected health information (PHI) must occur through iMessage the facility approved secure messaging application to ensure compliance with HIPAA regulations. The policy on Content Guidelines section indicated, .Limit text messages to the minimum necessary information required for effective communication. Avoid including highly sensitive details in text messages. If extensive information is required, communicate via a secure phone call or in person discussion. The policy on Storage and Retention section indicated, . PHI (or Private Health Information) should not be stored on facility designated cell phones beyond what is necessary for the communication .Any messages containing PHI must be deleted from the device once the information is transferred to the EHR or the purpose of the message is fulfilled . The facility owned smart phone or cell phone stored 3,166 items including pictures of body part, documents containing resident name, and test results.</p> <p>Review of an online article posted by The HIPAA Journal titled Is iMessage HIPAA Compliant?, dated 9/30/24, last accessed on 1/28/25, indicated, .iMessage is not HIPAA compliant and should not be used to communicate Protected Health Information (PHI) .[Smart phone brand] does not have any control over how devices are configured, so does not take any responsibility for the privacy and security of PHI however it is created, received, stored, or transmitted by [Smart phone brand] devices. [smart phone brand] will not enter into Business Associate Agreements with covered entities and business associates and specifically states in its terms of service .the fact that [smart phone brand] will not take responsibility for the privacy and security of PHI - and will not enter into a Business Associate Agreement with covered entities and business associates - means it is not possible to use iMessages to communicate PHI .</p> <p>(https://www.hipaajournal.com/is-i-message-hipaa-compliant/#:~:text=iMessage%20is%20not%20HIPAA%20compliant,in%20its%20Terms%20of%20Service)</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>40903</p> <p>Based on observation, interview, and record review the facility failed to ensure safe cleaning and sanitization of shared glucometer (a device used to measure blood sugar) in-between resident care for two residents out of nine residents observed for medication administration (Resident 39 and Resident 10) based on facility's policy and manufacturer specifications.</p> <p>This failure had potential to spread infection among residents and compromise resident's well-being.</p> <p>Findings:</p> <p>During a medication administration observation with Licensed Nurse 2 (LN 2), at Station 2 hallway, on 1/14/25, at 12:08 PM, LN 2 with gloved hand took the glucometer and supplies in the Resident 39's room to measure the blood sugar. LN 2 placed the glucometer on the bedside table then poked Resident 39's right middle finger with a lancet (small, sharp needles used to obtain a small amount of blood from the finger for blood sugar testing) to get the blood and soaked the test strip (a plastic strip contains chemicals to help with blood sugar measurement) with blood to measure the blood sugar. LN 2 used one Sani-Cloth-Bleach wipe (brand name for a wipe with chemicals to disinfect and kill germs on the surfaces) quickly (less than 10 seconds) to clean the glucometer outer surface once out of the Resident 39's room.</p> <p>During the subsequent medication administration observation, with LN 2, at Station 2 hallway, on 1/14/25, at 12:18 PM, LN 2 with gloved hand took the same glucometer used on previous resident and supplies into the Resident 10's room to measure the blood sugar. Resident 10 had a lunch tray in front of her while sitting on a wheelchair and was eating her food. LN 2 placed the glucometer on the bedside table then poked Resident 10's right thumb finger with lancet to get the blood and soaked the test strip with blood to measure the blood sugar. LN 2 was not able to get a result from the glucometer machine and stated she had to repeat the test. LN 2 went back to cart with new supplies and this time after putting the glucometer on bedside table, she poked Resident 10's index finger to get blood for testing. LN 2 then used one Sani-Cloth-Bleach wipe quickly (less than 10 seconds) to clean the glucometer outer surface once out of the Resident 10's room and placed it in a plastic cup.</p> <p>In an interview with LN 2 on 1/14/25, at 2:11 PM, LN 2 stated she stated she used one wipe to clean the glucometer. LN 2 stated the wipe bottle indicated 4 minutes wet time (the time for surface of glucometer remained wet to kill possible bugs on the surface) to disinfect and then allow to dry.</p> <p>In an interview with Infection Prevention nurse (IP), on 1/15/24 3:01 PM, the IP stated the nursing staff were educated to clean and disinfect the shared glucometer in-between resident use. The IP stated she had trained the nursing staff during the staff meetings and the last time was in November of 2024. The IP stated for new nurses the facility's DSD (Director of Staff Development) had been doing the initial orientation and training on infection control and glucometer care in addition to following a senior nurse. The IP stated the cleaning and sanitization of shared glucometer was a two-step process to use one wipe to clean and remove surface contaminations and then a second wipe used to sanitize and keep the outer surface wet so you can see the wetness with eye for minimum of 4 minutes per Sani-Wipe instruction to kill the germs that could not be seen with eye.</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>During a concurrent interview with IP on 1/15/25, at 3:05 PM, and review of facility's disinfecting wipe document, titled General Guidelines For Use, the document indicated Use a wipe to remove visible soil prior to disinfecting . Unfold a clean wipe and thoroughly wet surface . Allow surface to remain visibly wet for Four (4) minutes.</p> <p>In an interview with Director of Nursing (DON), in her office, on 1/15/25, at 4:19 PM, the DON stated the facility used bleach wipes and it needed to stay wet for 4 minutes to kill germs. The DON stated it was important to clean the share devices per instruction to prevent spread of the infections. The DON did not provide further detail on how the process of cleaning and sanitization should be done by the nursing staff.</p> <p>Review of the facility's policy, titled 483.80 Infection Control, dated 3/2024, the policy indicated It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases (infections that spread easily) and conditions. The policy on section 2 indicated . Patient care equipment: . It is preferred dedicated or disposable patient care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.</p> <p>Review of the facility provided instruction sheet by manufacturer of Assure Platinum glucometer (a brand name by ARKRAY, the manufacturer of glucometer), titled ARKRAY Technical Brief: Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System , dated 9/2024, the documents under Cleaning and Disinfecting FAQ (Frequently Asked Questions) indicated Can cleaning and disinfecting be accomplished with one wipe? No, Each time the cleaning and disinfecting procedure is performed, two wipes are needed. One wipe to clean the meter and the second wipe to disinfect the meter. What will happen if a blood glucose meter is not clean and disinfected after use? . It is important that long term care facility establish a program for infection control . Program include addressing the cleaning and disinfecting of blood glucose meters along with other equipment and environmental surfaces . It is also important to provide education on infection control and the proper use of products.</p> <p>A review of the Center for Disease Control (A federal agency responsible for the health and safety of people) guideline, titled Considerations for Blood Glucose Monitoring and Insulin Administration, last accessed on 1/24/25 via https://www.cdc.gov/injection-safety/hcp/infection-control/index.html, the guideline indicated Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. The guideline further indicated Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared.</p> <p>Review of the facility's undated policy, titled Glucometer Cleaning/Disinfecting, the one-page policy indicated It is the policy of this facility to ensure the glucometers are cleaned and disinfected accurately. The Procedures section indicated After each use with gloves on glucometer will be cleaned/disinfected with PDI Sani-Cloth Germicidal Disposable Bleach Wipes (brand name of wipes used at the facility). Ensure there is no dried blood spot on the glucometer. Lay the glucometer flat on a paper towel and leave open to air for four minutes until it is ready to use.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40903</p> <p>Based on observation, interview, and record review, the facility failed to ensure the prescription medication delivery manifests (delivery manifest, also known as a shipping manifest, is a legal document that listed all items being transported in a shipment) which included narcotic controlled medications (medication with risk of abuse including opioids) were signed by licensed staff upon delivery from the provider pharmacy for a census of 56 residents.</p> <p>This failed practice may contribute to unsafe medication handling and risk of drug diversion (unlawful use or abuse of medication).</p> <p>Findings:</p> <p>During a medication area inspection, at facility's Station 1, on 1/13/25, at 10:36 AM, accompanied by Licensed Nurse (LN) 6, a binder which contained the delivery sheets for prescription and narcotic medications delivery, were not consistently signed by nursing staff upon receipt from the provider pharmacy delivery driver. The individual sheets titled Packing Slip, at the bottom on each page, indicated .By signing below you acknowledge that you have received this pharmacy shipment. Please fax the signed packing slip to the pharmacy .Please notify the pharmacy within 24 hours of any discrepancy .Signature . Date . LN 6 stated they signed the paper from from the delivery driver, but was not sure why some sheets were signed, and the majority of the sheets were not signed.</p> <p>In an interview with Director of Nursing (DON), in her office, on 1/14/25, at 2:23 PM, the DON stated the staff signed a copy of the delivery sheet for the driver and were not required to sign the facility copy.</p> <p>Review of the facility's undated policy titled Controlled Substances, the policy indicated, .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Section 8 of the policy indicated, .Controlled substances are reconciled upon receipt . Section 9 of the policy indicated, .Upon receipt: the Nurse receiving the medication and the individual delivering the medication verify the name, dose, and quantity of each controlled substance being delivered. Both individuals sign the controlled substance record of receipt .</p> <p>Review of the facility's undated policy titled Accepting Delivery of Medications, the policy indicated, .All staff shall follow a consistent procedure in accepting medications .Before signing to accept the delivery, the nurse must reconcile the medication in the package with the delivery ticket/order receipt . Section 4 of the policy indicated, .A Nurse shall sign the delivery ticket, indicating review and acceptance of the delivery, and shall keep copy of the delivery ticket. Both the receiving nurse and the delivery agent must sign any notation about errors .</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>50161</p> <p>Based on interview, observation, and record review, the facility failed to ensure the safe use of psychotropic medications (mind altering drugs) for one of five residents (Resident 44) selected for unnecessary medication use when:</p> <ol style="list-style-type: none"> 1. Resident 44's documented diagnosis of bipolar disorder (a chronic mood disorder which causes intense shifts in mood, energy levels and behavior) in the medical record for use of aripiprazole (a drug used to treat mental health issues) was not reflected in the medical doctor's progress notes, History and Physical (H&P), and previous hospitalization record; and 2. Resident 44's mental health consult and mental health medication adjustments were not carried out, nor communicated to the primary Medical Doctor (MD) 1, the Director of Nursing (DON), the licensed nursing (LN) staff, and the Resident Representative (RP, individual responsible for making healthcare decisions on behalf of resident). <p>These failures could contribute to unsafe use of mind-altering medications and the inaccurate diagnosis could lead to unnecessary use of medications with adverse consequences.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 44's electronic medical record, titled ADMISSION RECORD, indicated, Resident 44 was admitted to the facility with diagnosis including but not limited to: Parkinson's disease (a movement disorder of the nervous system which worsens over time), dementia (a brain disorder which causes memory loss, confusion, problems with language, and changes in behavior), encephalopathy (a change in brain function due to injury or disease), psychosis (disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what is not), anxiety disorder (excessive fear or worry about a specific situation), major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), and bipolar disorder (mental health condition which causes extreme mood swings). <p>Review of Resident 44's electronic medical record, titled Medication Administration Record (MAR, where nurses document what and when ordered medications were administered), dated 9/24 and 1/25, indicated the following orders for mind altering medication as follow:</p> <p>ARIPiprazole Oral Tablet 2 MG [a psychotropic mind-altering medication, MG is milligram, a unit of measure] Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER .; Start date 8/28/24 .</p> <p>Mirtazapine Oral Tablet 15 MG [a drug used to treat depression] Give 1 tablet by mouth at bedtime for M/B [manifested by] POOR FOOD ORAL INTAKE related to MAJOR DEPRESSIVE DISORDER; Start Date 8/28/24 .</p> <p>Sertraline HCI Oral Tablet 50 MG [drug used to treat depression] Give 1 tablet by mouth in the morning related to MAJOR DEPRESSIVE DISORDER, . m/b verbalization of sadness; Start date 8/28/24 .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The September 2024 MAR document indicated the medications listed above were ordered on 8/27/24 and the 1/2025 MAR indicated aripiprazole order start date changed to 9/30/24.</p> <p>Review of Resident 44's Physician Physical and History, dated 8/29/24, written by MD 1, the record indicated the past medical history for Parkinson disease, depression, and high blood pressure among others. The record further indicated, .The resident .Has the capacity to understand and make decisions [checked] . MD 1's H&P did not include diagnosis of bipolar disorder for the use of the mind-altering drug aripiprazole.</p> <p>Phone call and message left for MD 1, on 1/16/25, at 12:32 p.m., during the Department visit was not answered or returned.</p> <p>During a review of Resident 44's medical record, titled History and Physical (H&P), from Hospital A, dated 8/22/24, written by MD 8, the record indicated Parkinson's disease, anxiety, and depression as the only mental health diagnosis. MD 8 did not include a diagnosis of bipolar disorder as current or past medical history.</p> <p>Review of Resident 44's paper chart titled Physician Progress Notes, written by MD 3 who admitted the resident at a previous facility for one day, dated 8/26/24, the record under medication list indicated, . Medications .aripiprazole 2 mg tablet .Give 1 tablet by mouth at bedtime for Bipolar/Depression/Psychosis . The Resident 44's record under Assessment and Plan (final diagnosis and plan for care moving forward) indicated, Parkinson disease, hypertension (high blood pressure), anxiety, and depression as the main diagnosis. The Assessment and Plan section further indicated, .Major Depressive Disorder, recurrent . continue mirtazapine 45 mg [antidepressant, mg stands for milligram] and aripiprazole 2 mg [mood altering drug] at bedtime. Assess mood daily using standard scale . The MD 3's assessment did not include a diagnosis of bipolar disorder for use of aripiprazole.</p> <p>During a concurrent interview and record review on 1/16/25, at 10:40 a.m., Resident 44's medical record was reviewed with the MDS Coordinator (MDS stands for Minimum Data Set, which is a federally mandated tool used in skilled nursing facilities for comprehensive assessment of a resident's health, diagnosis, and care needs; MDS coordinator is a nurse that compile data for transmitting to the federal government). The MDS Coordinator stated she used admission records including doctor's H&P, previous hospitalization , and MD's progress notes to input the diagnosis in the MDS database. The MDS Coordinator stated she did not have access to any mental health visit or progress notes as the social services staff were protecting them. The MDS Coordinator acknowledged the bipolar diagnosis, which was documented in the MDS records, was not listed, or addressed by MD 1's H&P, hospital's records, and the previous facility's assessment of Resident 44's final diagnosis.</p> <p>Review of Resident 44's Psychiatric Visit Progress Report, dated 9/10/24, written by the telehealth (a way to receive healthcare remotely using technology like the internet, computers, and video conferencing) Nurse Practitioner (NP), the Assessment section indicated the following:</p> <p>.Diagnostic Impression: DEMENTIA .Per Facility Records .ANXIETY DISORDER .Per Facility Records . MAJOR DEPRESSIVE DISORDER .Per Facility Records .PSYCHOSIS .Per Facility Records .BIPOLAR DISORDER .Per Facility Records .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 44's Psychiatric Visit Progress Report did not include independent mental health diagnosis and the NP used the facility provided records to obtain patients history and diagnosis.</p> <p>During an observation and interview on 1/16/25, at 11:49 a.m., Resident 44 was observed sitting in her wheelchair in her room. Resident 44 stated she had been living at the facility for five months. Resident 44 stated her mental health diagnosis' included Parkinson disease and memory loss. When asked if she had a psychiatrist (a medical doctor who specializes in mental health and can diagnose and treat), Resident 44 stated she did but had not seen him for three or four months. When asked if she had ever been diagnosed with bipolar disorder, Resident 44 stated no.</p> <p>During a phone interview with NP on 1/16/25, at 12:38 p.m., the NP stated she used the facility documents to obtain the patients history and diagnosis. The NP stated the bipolar diagnosis was a core psychiatric diagnosis which required a comprehensive review of resident's history and other clinical factors. The NP stated she would have referred the patient out to a neuropsychiatrist (a medical professional who treats mental disorders and conditions that are caused by psychiatric factors) for further examination. The NP stated clinically her expectation was that the facility did their due process and based their diagnosis on the patient's clinical record.</p> <p>During a phone interview, with MD 2, on 1/17/25, at 12:07 p.m., MD 2 stated Resident 44 was a patient of his and he was her psychiatrist for the last few years. MD 2 stated he had a visit with Resident 44 on 10/21/24 and stated she was diagnosed with major depressive disorder and anxiety. MD 2 stated he had never diagnosed Resident 44 with bipolar disorder. MD 2 stated it was best practice for a patient not to have two separate psychiatrists treating them at the same time. MD 2 stated this was due to the risk of adjusting a patient's medications and the psychiatrists not being aware of what the other doctor was prescribing or treating the patient with. MD 2 stated a patient having two separate psychiatrists treating them could have the potential for the psychiatrists to contradict each other and lead to problems with their doses of medications, including increases and decreases of medication doses.</p> <p>In a phone interview with Resident 44's Representative (RP), on 1/21/25, at 11 AM, the RP stated her mother (Resident 44) was never diagnosed with Bipolar or Psychosis mental health diagnosis.</p> <p>2. Review of Resident 44's electronic medical record titled Medication Administration Record, dated 9/24 and 1/25, indicated the following orders for mind altering medication as follow:</p> <p>ARIPiprazole Oral Tablet 2 MG .Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER .; Start date 8/28/24.</p> <p>Mirtazapine Oral Tablet 15 MG .Give 1 tablet by mouth at bedtime for M/B POOR FOOD ORAL INTAKE related to MAJOR DEPRESSIVE DISORDER; Start Date 8/28/24.</p> <p>Sertraline HCl Oral Tablet 50 MG .Give 1 tablet by mouth in the morning related to MAJOR DEPRESSIVE DISORDER . m/b verbalization of sadness; Start date 8/28/24.</p> <p>Further review of the record indicated these medications had continued up to 1/16/25.</p> <p>(continued on next page)</p>		

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<p>F 0758</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 1/16/25, at 10:40 a.m., with the MDS coordinator and the SSD (Social Services Director), in the SSD's office, the SSD stated the facility used psychiatric (mental health) services through telehealth. The SSD stated the mental health progress notes written by telehealth doctors were emailed to the SSD and the facility's Administrator (ADM). The SSD stated the mental health progress notes and records did not go into the resident's medical record chart (paper or electronic) due to confidentiality of mental health records. The SSD stated if the mental health progress notes and consults contained medication orders or required actions by the attending physician, the SSD would provide them with a copy of the mental health consult. The SSD stated the clinical staff, medical records, MDS Coordinator, and Licensed Nurses (LN) did not have access to these records, and they needed to contact him to look at the records if needed. The SSD stated he was available every day around the clock to provide the document which resided in his email. The SSD acknowledged records not being in the resident's electronic or paper chart could have posed a barrier to the attending physician's timely care and accessibility of the health record to front line licensed staff providing care.</p> <p>During a concurrent interview, with the MDS Coordinator and the SSD, on 1/16/25, at 10:57 a.m., and record review of Resident 44's mental health consult, dated 9/10/24, in the SSD's office, the SSD printed the mental health consult from his email. The SSD confirmed the psychiatric consult notes for Resident 44 were not documented or stored in the electronic or paper medical chart. During review of Resident 44's psychiatric consult notes, written by NP, it was confirmed the psychiatric progress notes listed two recommendations of reducing Mirtazapine 15 mg to 7.5 mg and reducing Sertraline 100 mg to 50 mg. The SSD confirmed and acknowledged the NP's recommendations were not carried out or reflected in the resident's medical record including, Resident 44's progress notes or the MAR. The SSD confirmed the mental health consult was not shared with medical doctor or the Director of Nursing. The MDS Coordinator stated she did not have access to resident's psychiatric progress notes unless she asked the SSD to see them. The SSD stated he only provided the mental health progress notes for the Licensed Nurses or doctor to review if there were new orders or an action needed to be taken. The SSD acknowledged if the records were not in the resident's chart it could affect the continuity of care. The SSD acknowledged the risk to the resident if the information was not shared with the LN or attending physician was new orders would not be carried out and information was not shared. Further review of Resident 44's medical record, the SSD confirmed Resident 44 had a primary psychiatrist (MD 2) and was seen by him on 9/23/24. The SSD stated he had never contacted MD 2 and did not inform the telehealth psychiatric provider that Resident 44 was under MD 2's care. The SSD stated coordination of care among health care providers would have helped optimized care for Resident 44.</p> <p>During a concurrent interview and record review on 1/16/25, at 11:37 a.m., with the Medical Record Director (MRD) and Medical Record Assistant (MRA), the MRD stated since 2023 all medical records were uploaded into the resident's electronic health record (EHR). The MRD stated psychiatric consults stayed with the social worker due to confidentiality reasons and medical records does not get a copy.</p> <p>During an interview on 1/16/25, at 1:24 p.m., LN 4 stated she had heard about residents receiving psychiatric telehealth in the facility. LN 4 stated she had not seen progress notes in any residents' chart. LN 4 stated doctors ask the LNs about their patients psychiatric or mental health status regularly. LN 4 stated it would be helpful to know what the doctor's plan was for residents, residents medication use, and having the (mental) health progress notes would be helpful.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with DON and record review, on 1/16/25, at 1:35 p.m., the DON stated the facility used telehealth mental health services for residents needing psychiatric care. The DON stated patients were welcomed to use their own mental health provider because they would know the resident's history and know what medications they were taking. The DON stated if a resident had an order for a psychiatric consult the SSD would communicate with telehealth services, and once the resident was seen, an email containing the telehealth progress notes was sent to the SSD. The DON stated the SSD will then forward the emails to her. The DON stated if the psychiatric progress notes contained orders the SSD would give it to the admissions Case Manager (CM), who was a LN, and the CM would inform the Attending Physician (AP). The DON stated the AP will notify the resident representative (RR) and put the psychiatric progress note in the resident's medical record. The DON stated it was her expectation the SSD was printing the psychiatric progress notes to be uploaded into the resident's electronic health record by medical records. The DON stated it was her understanding psychiatric progress notes were being uploaded to the electronic medical record and stated it was important for LN's to have access to these records. The DON stated all the attending physician and LN's should have access to psychiatric progress notes which would provide awareness of the residents condition. The DON stated having access to all medical records was important for continuity of care. The DON confirmed she did not receive Resident 44's psychiatric progress note, dated 9/10/24, from the telehealth mental health provider and the SSD did not forward the email with telehealth consult notes to her. The DON stated the SSD should not be reviewing psychiatric physician progress notes or making clinical decisions regarding residents. The DON stated the SSD had no clinical license and the CM should be doing this. The DON stated confidentiality of mental health documents applies to all medical documents and stated keeping the mental health documents out of the resident's chart would be a failure to disseminate information to the clinical team. The DON stated Resident 44's bipolar diagnosis was based on her transfer from another assisted living facility and her expectation was for the diagnosis to be verified by the attending physician.</p> <p>Review of the facility's policy titled Content of Medical Records, dated 2/23, the policy indicated, .List of content of the medical record .Current Diagnosis, Statement that the patient was informed of his/her medical condition, Physician Progress Notes .Consultation Reports .</p> <p>Review of the facility's policy titled Medication (Drug) Regimen Review (MRR), dated 12/24, indicated, . Definitions . Definitions are provided to clarify terminology related to pharmaceutical services and management of each resident's medication regimen for effectiveness and safety . Irregularity refers to the use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, and excessive doses, and/or in the presence of adverse consequences as well as the identification of conditions that may warrant initiation of medication therapy . Unnecessary drug is defined as medications ordered .In excessive dosage .Without adequate indications for its use .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's document, titled Job Description Social Services Manager, dated 11/2021, indicated, . Maintain a quality working relationship with the medical profession and other health related facilities and organizations .Delegate authority, responsibility, and accountability to other responsible department personal . Coordinate social services activities with other departments as necessary .Assure that social service progress notes are informative and descriptive of the services provided and of the resident's response to the service .Qualifications .Must have, as a minimum, a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology .</p> <p>Review of the facility's document, titled Job Description Licensed Vocational Nurse/Licensed Practical Nurse, dated 12/17/21, indicated, . the primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the resident's attending physicians or the Medical Director of the facility, with an emphasis on assessment, illness prevention and health care management. You will assist in modifying the treatment regimen to meet the physical and psychosocial needs of the resident, in accordance with established medical practices and the requirements of the state and the policies and goals of this facility .Consult with the physician concerning resident evaluation and assist the Director of Nursing Services in planning and developing the nursing services to be performed for the resident .Initiate requests for consultation or referral. Respond to requests from the resident physician or nursing staff . Examine the resident and his her records and charts to distinguish between normal and abnormal findings in order to recognize early stages of serious physical, emotional or mental problems . Determine when to refer the resident to a physician for evaluation, supervision, or directions Prepare and administer medications as ordered by the physician . Review medication cards for completeness of information, accuracy and the transcription of the physicians order . Chart all communications with the resident's attending physician regarding the resident, the resident's treatment or the response that treatment .</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>40903</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with the census of 56 residents. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of 2 errors out of 30 opportunities which resulted in a facility wide medication error rate of 6.67% in two out of 10 residents (Resident 5 and Resident 10) during medication administration observation.</p> <p>These failures could contribute to unsafe medications use, medication error, and not following the doctor's orders.</p> <p>Findings:</p> <p>1. During a medication pass observation, with Licensed Nurse 1 (LN 1), at facility's Station 2 hallway, on 1/13/25, at 8:49 AM, LN 1 offered Resident 5 the morning pills including 7 medications along with nutritional supplement. Resident 5 chose to take only 4 of her medications with her own coffee already on her side table. Resident 5 refused to take 3 of the pills including a laxative called Docusate, Vitamin C and her Multivitamin pills. When out of room, LN 1 discarded the 3 pills into a small medication disposal bottle.</p> <p>Review of Resident 5's electronic medical record, titled Medication Administration Review (or MAR, a legal document for medications ordered by the doctor and administered by nursing staff to a resident), for January 2025, the MAR record was accessed, on 1/13/25 at 4:18 PM, indicated the 3 refused pills were documented as given. The MAR record for docusate (a laxative), multivitamin w/ minerals, and Vitamin C all had a checkmark sign above nurses' initials indicating it was administered. There were no nursing notes in Resident 5's records on medication refusal.</p> <p>In a concurrent interview with LN 1, at the nursing Station 2, the next day on 1/14/25, at 1:54 PM, and review of Resident 5's medical record, LN 1 stated that he had forgotten to document refusal. LN 1 stated he documented the administration in computer when he popped the pills into a cup prior to going into resident's room. LN 1 stated the standard procedure was to ask the resident three times before documenting refusal. LN 1 confirmed he documented docusate was administered, when Resident 5 refused the medication on 1/13/24. LN 1 stated he will make correction to the chart for refusal of docusate administration after the Department surveyor interview.</p> <p>(continued on next page)</p>

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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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a medication administration observation, with Licensed Nurse 2 (LN 2), on 1/14/25, at 12:02 PM, LN 2 went to Resident 10's room to measure the blood sugar level. Resident 10 was in bathroom and LN 2 moved on to go to Resident 39's room. LN 2 measured Resident 39's blood sugar and medications were administered, at 12:08 PM on 1/14/25. LN 2 then moved on to Resident 28's room, at 12:13 PM, on 1/14/25, to administer two medications. LN 2 next went to Resident 10's room, at 12:18 PM on 1/14/25, to measure her blood sugar. Resident 10 was observed eating her lunch which was pasta spaghetti. LN 2 proceeded to measure the blood sugar by poking right thumb finger to get blood which gave her an error message. LN 2 then repeated the procedure by poking Resident 10's right index finger to get blood sugar measurement. LN 2 further proceeded to give Resident 10 insulin (a drug injected under the skin and used to treat high blood sugar) injection per doctor's dosing scale.</p> <p>During review of Resident 10's MAR record, dated 1/2025, the record indicated the insulin order as follow:</p> <p>Insulin Aspart (short acting insulin) . Inject as per sliding scale: . subcutaneously (inject under the skin) three times a day . ***GIVE 5-10 mins BEFORE MEALS***</p> <p>-Order Date 11/04/24</p> <p>Further review of blood sugar measurement and insulin administration indicated the insulin was not administered 5-10 minutes before lunch.</p> <p>In an interview with the Director of Nursing (DON), in her office, on 1/15/25, at 4:52 PM, the DON stated the blood sugar measurement and insulin administration should follow doctor's order. The DON stated the staff that delivered the food tray should have worked with the nurse for coordination. The DON stated the blood sugar measurement could have been adversely affected if resident already consumed a meal.</p> <p>Review of the facility's policy, titled Medication Administration, dated 1/2020, indicated It is the policy of this facility to accurately prepare, administer and document oral medications. The policy did not address medication refusal and the nursing responsibility.</p> <p>During review of the facility's undated policy, titled Insulin Administration, the policy under purpose indicated To provide guidelines for the safe administration of insulin to residents with diabetes. The policy in section 3 indicated The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161</p> <p>Based on interview, observation, and record review, the facility failed to ensure safe medication storage practices in the medication room (a locked room used to store medications and supplies) and one out of six medication carts (a mobile cart stored medication and supplies for immediate use), and medication refrigerator when:</p> <ol style="list-style-type: none"> 1. Medication Cart 2 in Station 2 stored undated inhalation medication called Ipratropium/Albuterol (or DuoNeb, an inhalation solution used to treat breathing problems); 2. Medication Closet 1 in Station 1, in the active storage areas, stored expired test tubes (A blood test tube is a sterile, vacuum-sealed tube used to collect and store blood samples for medical testing); and 3. Medication refrigerator in Station 2 contained an opened and undated vial of Aplisol (or Tuberculin Purified Protein Derivative [PPD] a testing agent used to diagnose Tuberculosis or [TB], a serious lung disease) and an expired container of Golytely liquid (a solution used to prepare the colon for medical procedures) bottle for a resident that never used it. <p>These failed practices could contribute to unsafe and spoiled medication use in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview with Licensed Nurse (LN) 3, on [DATE], at 9:35 a.m., in the facility's Station 2 unit, the Medication Cart 2 stored an inhalation medication called DuoNeb out of its foiled wrap and was undated. The product label on the foil box indicated .Protect from light. Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week . The packets did not have resident name, date, and time it was opened. LN 2 acknowledged the findings. 2. During a concurrent observation and interview LN 6, on [DATE], at 10:04 a.m., the facility's medication room (closet) 1 at Station 1, stored one unopened package of blue top test tube. It was observed the expiration on the test tubes was [DATE]. LN 6 acknowledged the finding. 3. During a concurrent observation and interview with LN 7, on [DATE], at 11:19 a.m., in facility's Station 2 unit, the Medication Refrigerator stored one vial of Aplisol. The manufacture specification on the packaging indicated, .Once entered [opened], vial should be discarded after 30 days . It was observed the vial was opened and undated. LN 7 acknowledged the finding. <p>During a concurrent observation and interview with LN 7, on [DATE], at 11:19 a.m., in facility's Station 2 unit, the Medication Refrigerator stored one expired and unused container of Golytely liquid bottle for a resident that never used it. The label on the container was dated [DATE]. The manufacturer label on the container indicated Throw away (discard) unused Golytely solution within 48 hours (2 days). LN 7 confirmed the finding.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE], at 4:19 p.m., the Director of Nurses (DON) stated the vials with the blue top stored in medication room Closet 1 in Station 1 were used for labs to test blood for coumadin levels in residents. The DON stated they were sent to the facility by the laboratory and explained they were sent the wrong test tubes. The DON stated the risk for the residents if the expired test tubes were to be used during blood collection, would be they might not work, and the test results might not be accurate. The DON stated in terms of the Tuberculin, the expectation was for the nurse to write the date the medication was opened on the vial and stated the medication was only good for a certain number of days after opening. The DON stated the risk to the resident would be the Tuberculin would not be effective. The DON stated in regard to the inhaler solution DuoNeb, the medication was packaged in foil, and when first opened, the medication must be dated by the LN. The DON stated the risk to the resident if this was not done was the medication might not be as effective.</p> <p>Review of a facility policy and procedure (P&P) titled, Storage of Medications, undated, indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .</p>		

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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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47368</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe food storage and production in accordance with professional standards of food safety for the 56 residents who received prepared food from the kitchen when:</p> <ol style="list-style-type: none"> 1. Open food packages (one bag of bran cereal, one bag of biscuit mix, and a five-gallon storage bin with about two-gallons of rice) were not labeled with a use by date; and, 2. Wet plate covers were stacked together. <p>These failures had the potential to expose residents to food borne illnesses (refers to illness caused by the ingestion of contaminated food or beverages).</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE], at 8:47 a.m., in the kitchen accompanied by the Dietary Manager (DM), the following findings were observed:</p> <ol style="list-style-type: none"> 1. a. An opened clear plastic bag containing bran cereal was not labeled with a use by date. The DM stated the bag should have been labeled with a use by date. 1.b. A five-gallon storage bin with about two-gallons of rice was not labeled with a use by date. The DM confirmed the rice was not in the original packaging and there was no use by date. 1.c. An opened clear plastic bag containing biscuit mix was not labeled with a use by date. The DM further stated it should have been labeled with a use by date once the box was opened by kitchen staff. The DM explained the risk was not knowing how old the food was. 2. During an observation on [DATE], at 1:01 p.m., the Dietary Aid (DA) was observed pulling two clean loads of plate covers out of the dishwasher and stacked the wet plate covers on the table countertop. <p>During an interview on [DATE], at 1:33 p.m., with the DA, the DA stated dishes should be dried before being stacked and put away. The DA further stated the plate covers were stacked wet upside down to make more room for more washed dishes.</p> <p>(continued on next page)</p>

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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>During an interview on [DATE], at 2:38 p.m., the DM stated staff should wait until dishes were air dried before putting them away. The DM confirmed that plate covers were stacked while wet and stated it posed a risk of contaminating the food and causing bacterial growth. The DM further stated when food was transferred from its original container or package to another bag or bin for storage, it should be labeled with the name of the product, date it was opened, and a use by date. The DM stated the risk for staff not putting a use by date was the product being used passed its used by date therefore affecting the products quality and nutritional value. The DM added this could have posed a risk to the residents of receiving food that was of low quality, nutritional value, and taste. The DM confirmed wet, stacked plate covers could have caused sickness to the residents.</p> <p>During an interview on [DATE], at 4:18 p.m., the Director of Nursing (DON) stated staff should not be stacking and overlapping dishes before drying. The DON added if dishes were still wet it could grow bacteria in the moist warm environment which can cause illness to the residents. The DON further stated staff should put an open date, expiration date, and name of the food item if it was removed from the original package and stored in another container or package. The DON further stated staff could have used expired food which could have caused illness in the residents of the facility.</p> <p>During a review of an undated facility policy titled, DISHWASHING, the policy indicated, . Dishes are to be air dried in racks before stacking and storing .</p> <p>Review of the facility policy titled, LABELING AND DATING OF FOODS, dated 2023, indicated, .All food items in the storeroom need to be labeled and dated .The Use By date signifies the date in which food must be consumed or discarded .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40903</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff followed infection prevention practices and the required Enhanced Barrier Precaution (or EBP, an infection control strategy used in healthcare settings, particularly nursing homes, to reduce the spread of infection by requiring healthcare workers to wear gowns and gloves during high-contact resident care activities) guideline when the Intravenous (or IV, Into the Vein) line was used to administer IV antibiotic in one out of 10 residents observed for medication administration (Resident 47).</p> <p>This failed practice could contribute to unsafe medication use and spread of infection into Resident 47's blood stream.</p> <p>Findings:</p> <p>During a medication administration observation, with Licensed Nurse 5 (LN 5), at Station 2 hallway, on 1/13/25, at 11:51 AM, LN 5 gathered Resident 47's IV antibiotic and supplies in a plastic bin and entered the room with gloved hand, no gown and her mask was worn below her nose. Resident 47's room was marked by a posted sign, at the wall next to the door, indicating Enhanced Barrier Precaution or EBT room, which had written instruction and specification on what to do before entering the room. LN 5 placed the plastic bin at Resident 47's bed sheet, prepared the antibiotic bag by attaching tubing to the bag and hanged it to a pole. LN 5 then accessed the IV line (means open the covering cap for injection), which she stated it was a Mid-Line (a type of IV line that is used to administer IV medication), by flushing it with saline (sterile salt water). LN 5 then connected the antibiotic tubing to the mid-line and set up the pump to flow the medication inside the Resident 47's blood.</p> <p>In an interview with LN 5, at the nursing Station 2, on 1/13/25, at 1 PM, LN 5 stated she was aware of EBT sign, the requirements and forgot to wear gown prior to entering the room. LN 5 stated not wearing gown could have exposed the resident to unwanted infection when accessing the blood line for IV medication administration.</p> <p>During a concurrent interview with LN 5 and record review of Resident 47 electronic medical record orders, on 1/14/25, at 11:22 AM, the record indicated the Mid-line was inserted on 1/12/25 at 12 noon and EBP orders were initiated in the computer the next day on 1/13/25. LN 5 stated EBT precaution was necessary to prevent infection in the IV line and blood stream.</p> <p>In an interview with Infection Prevention nurse (IP), on 1/15/24 3:01 PM, the IP stated the nursing staff were educated on importance of following EBP to prevent spread of infection during staff meetings and last training was in December of 2024. The IP stated the door sign required staff to wear gown and gloves when performing high contact resident care activities such as accessing IV line and Mid Line.</p> <p>In an interview with the Director of Nursing (DON), in her office, on 1/15/25, at 4:19 PM, the DON stated she expected the nursing staff to follow the EBT precautions when entering a room. The DON stated the nursing staff should put on both gloves and gown before entering the room for high-risk contact such as accessing IV line for medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Enhanced Barrier Precaution sign posted on Resident 47's room, on 1/13/25, at 1:05 PM, indicated Enhance barrier Precautions require staff to wear a gown and gloves while performing high contact care activities with all residents who are at a higher risk of acquiring or spreading a Multi Drug Resistant Organism (or MDRO, when a germ became resistant to antibiotic and hard to cure). These include the following residents: . Resident with an indwelling medical device (means when an external device connected to inside of the body), including Central venous catheter (or CVC an IV line connected to blood stream and used for IV medication administration) . This is based on new recommendation from Central Center for Disease Control (or CDC, a government agency responsible for people's health) to protect our residents and staff . These germs can be transferred from one resident to another on staff hands if they aren't cleaned . A gown and glove can keep the germs from getting on staff clothing . and can prevent transfer to other residents.</p> <p>Review of the facility's policy, titled 483.80 Infection Control, last revised on 3/2024, indicated Enhance Barrier Protection (EBT): used in conjunction with standard precautions and expand the use of PPE (or Personal Protective Equipment such as gloves, mask or gown) through the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDRO to staff hands and clothing then indirectly transferred to residents or from resident to resident . The use of gown and gloves for high contact resident care activities is indicated when contact precautions do not otherwise apply for nursing home residents with: . Indwelling medical devices include, but not limited to, central line, peripherally inserted central catheter (IV lines that inserted and extended from arm to near the heart veins) .</p>		