

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Vienna Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 So. Ham Lane Lodi, CA 95242	

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 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>48445</p> <p>Based on observation, interview and record review, the facility failed to ensure professional standards of practice were followed for two of 34 sampled residents (Resident 114 and 70) when:</p> <ol style="list-style-type: none"> 1. Licensed Nurse 3 (LN 3) did not wear gloves during the administration of Resident 114's Paroxetine (medication used to treat depression) per physician's order; and 2. The dose for Resident 70's Zolpidem (medication used to treat insomnia [trouble falling asleep]) was not given but was signed as administered. <p>These failures had the potential to result in contamination of the medication and exposure of Resident 114 and the LN to side effects, and confusion and inaccuracies in Resident 70's medication administration.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 114's admission records, the records indicated Resident 114 was admitted in June 2024 with diagnoses which included depression. Resident 114's Minimum Data Set (MDS, an assessment tool) indicated Resident 114 had intact cognition. <p>During a review of Resident 114's physician order dated 6/24/24, the order indicated, Paroxetine .40 MG (milligrams, a unit of measure) Give 1 tablet by mouth one time a day for depression m/b (manifested by) verbalization of declining health .Use single gloves if handling intact tablet; double gloves and gown if crushing.</p> <p>During the medication pass observation on 10/16/24 at 8:22 a.m. with LN 3 in Resident 114's room, LN 3 was observed preparing five medications which included Paroxetine. LN 3 mixed the pills in apple sauce without gloves and administered the medications to Resident 114.</p> <p>During a concurrent interview and record review on 10/16/24 at 10:14 a.m. with LN 3, LN 3 stated, I don't think we need to wear gloves for Paroxetine. LN 3 reviewed the physician order and confirmed Paroxetine order indicated to use gloves during administration and verified gloves were not used during the administration. LN 3 stated, Expectation is to follow what's ordered.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 4:12 p.m. with the Director of Nursing (DON), the DON stated, Expectation is to always follow the doctor's order, expectation is to wear gloves because that's the order.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Nursing Responsibilities, undated, the P&P indicated, Nursing services shall provide individualized care to meet the needs of each resident following current standards and regulations .Licensed nurses shall be responsible for administering medications and treatment as follows: .Medications and treatments shall be administered as prescribed .</p> <p>During a review of an online document titled NIOSH [National Institute of Occupational Safety and Health] List of Hazardous Drugs in Healthcare Settings, 2020, dated 2020, the document indicated, .NIOSH defines a hazardous drug as a drug that is: a. Is accompanied by prescribing information in the package insert that specifies special handling information .to protect workers handling the drug; or b. Is identified as a carcinogenic hazard, developmental hazard, reproductive hazard, genotoxic hazard, or other health hazard . The drugs in Table 2 meet the NIOSH definition of a hazardous drug .These drugs exhibit one or more of the type of toxicity described in the NIOSH definition of hazardous drug .paroxetine .Only met the NIOSH criteria as a developmental and/or reproductive hazard. (www.cdc.gov/niosh/docket/review/docket233c/pdfs/DRAFT-NIOSH-Hazardous-Drugs-List-2020.pdf).</p> <p>During a review of the facility's P&P titled IIA2: Medication Administration-General Guidelines, revised 1/1/23, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .4) All personnel handling hazardous drugs must be trained and competent in facility hazardous drug communication program. Personnel are assessed per facility policy and procedures and will understand proper handling, administration .of hazardous drugs .B. Administration .2) Medications are administered in accordance with written orders of the prescriber.</p> <p>2. During a review of Resident 70's admission records, the records indicated Resident 70 was admitted in June 2023 with diagnoses which included insomnia. Resident 70's MDS indicated resident had intact cognition.</p> <p>During a review of Resident 70's physician order dated 10/16/24, the order indicated, Zolpidem Tartrate Oral Tablet 5 MG .Give 2 tablet by mouth at bedtime for insomnia for 14 days .</p> <p>During a review of Resident 70's Medication Administration Record (MAR) for October 2024, the MAR indicated Resident 70's Zolpidem was administered on 10/3/24 at 8 p.m.</p> <p>During a review of Resident 70's Controlled Drug Record (CDR), dated 9/22/24, the CDR did not indicate Zolpidem was given to Resident 70 on 10/3/24.</p> <p>During a review of Resident 70's Medication Administration Note dated 10/3/24, the note indicated, Waiting for pharmacy delivery.</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 and record review on 10/18/24 at 9:22 a.m. with the DON, the DON verified Resident 70's Zolpidem was signed as administered on the MAR and stated, I don't find October 3rd on CDR. The DON further stated, [Staff] signed it in the MAR but notes indicated waiting for pharmacy .I don't know when it was delivered, whether it was delivered or not, I don't know .the MAR indicated it was given .I don't know what she was thinking .[staff] should check it, it was coded as administered .sometimes it's the process with the new nurses .the problem is if the medication was actually administered, where did you get the medication .Unfortunately, it was a wrong code .</p> <p>During a review of the facility's P&P titled Nursing Responsibilities, undated, the P&P indicated, 18. Licensed nurses shall be responsible for administering medications and treatment as follows: .The date, time, drug and dose of the drug or treatment administered shall be recorded on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) by the person administering the drug or treatment.</p> <p>During a review of the facility's P&P titled IIA2: Medication Administration-General Guidelines, revised 1/1/23, the P&P indicated, D. Documentation .1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of the medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.</p> <p>During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: .(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician . (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing - State of California Department of Consumer Affairs).</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36681</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner of a medication refusal for one of 34 sampled residents (Resident 12).</p> <p>This failure had the potential to cause negative outcomes to Resident 12's physical and mental well being.</p> <p>Findings:</p> <p>A review of the Admission Record indicated Resident 12 was admitted with diagnoses including pulmonary embolism (a blood clot gets stuck in a blood vessel in the lung blocking blood flow) and atrial fibrillation (irregular heart rhythm that may lead to blood clots if left untreated).</p> <p>A review of Resident 12's Order Summary Report indicated a physician order dated 9/26/24, Xarelto (blood thinner, treats or prevents blood clots) Oral Tablet 20 MG (milligram, unit of measurement) .Give 1 tablet by mouth one time a day for A. Fibrillation. Hold for heavy vaginal bleeding. On hold from 10/02/2024 .to 10/09/2024 .</p> <p>A review of Resident 12's care plan initiated 2/10/24 indicated, I am at risk for bleeding r/t: [related to] Xarelto use</p> <p>A review of Resident 12's Medication Administration Note indicated:</p> <p>-On 10/10 and 10/12/24, the note indicated Resident 12 chose not to take Xarelto since she's afraid she might bleed again;</p> <p>-On 10/11/24, the note indicated Resident 12 chose not to take Xarelto; and,</p> <p>-On 10/13 and 10/14/24, the note indicated Resident 12 chose not to take Xarelto. Resident 12 stated she might bleed again and she wants to talk to the [ordering physician] before taking the medication.</p> <p>In an interview on 10/15/24 at 1:40 p.m., Resident 12 stated she was just started on a blood thinner today and she was concerned about possible bleeding.</p> <p>In a concurrent interview and record review with the Director of Nursing (DON) on 10/16/24 starting at 4:43 p. m., the DON confirmed Resident 12's Xarelto was on hold for 7 days and should be resumed on 10/10/24. The DON further confirmed Resident 12 refused Xarelto for 5 days from 10/10 to 10/14/24. The DON stated this was an unusual case since Resident 12 had bleeding and her expectation was for licensed nurses to notify the ordering physician the first day Resident 12 refused to take the medication. The DON further stated the ordering physician was informed of the refusals on 10/15/24, 5 days later, and the DON added she could not find documentation that the primary care physician was notified of Resident 12's refusal to take Xarelto.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>36681</p> <p>Based on observation, interview, and record review, the facility failed to provide services to prevent pressure injuries (localized pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for 2 of 34 sampled residents (Resident 3 and Resident 37) when:</p> <ol style="list-style-type: none"> 1. Resident 3 did not have a foot cradle (device used to relieve pressure from the lower extremities by preventing blankets and linens from laying directly on the lower extremities) and sheepskin padding in place as ordered by physician; and, 2. Resident 37's foot cradle was used incorrectly when linens and towels were placed on top of the frame allowing bed linens and blankets to lay directly on lower extremities. <p>These failures had the potential to result in Resident 3 and Resident 37 developing pressure injuries.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of the Admission Record indicated Resident 3 was admitted with diagnoses including unspecified dementia (a progressive state of decline in mental abilities). <p>A review of Resident 3's physician order's indicated orders for Foot cradle in bed dated 10/11/14, Sheepskin padding to bed hand rails dated 2/5/24, and Sheepskin padding to wheelchair arm rests dated 10/30/23.</p> <p>A review of Resident 3's care plan indicated the following:</p> <p>-a care plan initiated 12/26/2019 indicated, I have impaired cognitive function/dementia or impaired thought processes [related to] Dementia.;</p> <p>-a care plan for I have a higher potential for impairment to skin r/t [related to] fragile skin . and actual impairment to skin integrity . on 9/4, I have a discoloration to my [left anterior] forearm when I bumped my arm on bed handrail during repositioning. I have blanchable redness to my bilateral heels [due to] friction of rubbing heels on bedding . on 10/12 I sustained redness to my [left] great toe r/t friction from blankets. The interventions included sheepskin padding to protect the skin while in bed and while up in a chair.</p> <p>In an observation on 10/16/24 starting at 12 p.m., Resident 3 was sitting upright in bed while eating her pudding. Resident 3 was covered with a blanket from her waist to her feet. There was no foot cradle in bed, and there was no sheepskin padding on the bed hand rails and wheelchair arm rests.</p> <p>In a concurrent observation and interview on 10/16/24 at 12:18 p.m., the Certified Nursing Assistant 2 (CNA 2) confirmed Resident 3 had no foot cradle in bed and there was no sheepskin padding on the hand rail and the wheelchair arm rests. The CNA 2 further stated the foot cradle was requested last Friday due to redness on Resident 3's toe and heels.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/16/24 at 12:24 p.m., the Licensed Nurse 2 (LN 2) stated the foot cradle for Resident 3 will prevent pressure and the foot cradle should be used even when resident was in bed eating. The LN 2 further stated Resident 3 had the sheepskin on the wheelchair arm rests due to resident being prone to skin discoloration.</p> <p>A concurrent observation and interview was conducted on 10/17/24 at 10:35 a.m. with CNA 2 inside Resident 3's room. Resident 3 had slight redness on her left great toe and redness on both heels. The CNA 2 stated she took the sheepskin from the linen room yesterday and the LN 2 asked maintenance for a foot cradle for Resident 3 yesterday.</p> <p>In a concurrent observation and interview on 10/18/24 starting at 9:24 a.m., Resident 3 was up in her wheelchair in the main dining room. The Activity Assistant (AA) confirmed Resident 3's wheelchair arm rests had no sheepskin padding. The AA further stated she saw Resident 3 earlier today and resident was removing the sheepskin from her wheelchair.</p> <p>In a concurrent interview and record review on 10/18/24 at 10:16 a.m., the Director of Nursing (DON) confirmed Resident 3 had orders for foot cradle, and sheepskin padding for the bed hand rails and wheelchair arm rests. The DON stated her expectation was for physician orders to be followed and implemented. The DON further stated the sheepskin was used to prevent skin injury or trauma and the foot cradle was to prevent pressure on the toes. The DON added if staff observed Resident 3 removing the sheepskin, it should be documented.</p> <p>43247</p> <p>2. A review of Resident 37's Admission Record indicated Resident 37 was admitted to the facility in March 2024 with multiple diagnoses including dementia and diabetes (disorder characterized by difficulty in blood sugar control).</p> <p>A review of Resident 37's Minimum Data Set (MDS-a federally mandated resident assessment tool), Cognitive Patterns, dated 7/3/24, indicated Resident 37 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status) score of 6 out of 15 that indicated Resident 37 had severe cognitive impairment. A review of Resident 37's MDS, Functional Abilities and Goals, dated 7/3/24, indicated Resident 37 required moderate assistance for bed mobility.</p> <p>A review of Resident 37's Braden Scale for Predicting Pressure Sore Risk Original [tool used to predict the risk of pressue ulcers], dated 7/4/24, indicated Resident 37 was at moderate risk for developing pressure sores and had problem with friction and shear due to frequently sliding down in bed leading to almost constant friction.</p> <p>A review of Resident 37's Care Plan, initiated 9/1/24, indicated Focus .I have a higher potential for and actual impairment to skin integrity .r/t [related to] fragile skin, coumadin [blood thinner medication] use .Interventions I need (pressure relieving/reducing mattress, pillows, padding, etc) to protect the skin while in bed .Use caution when repositioning or transferring me to avoid friction .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/15/24 at 8:47 a.m., observed Resident 37 in bed asleep with foot cradle in place. Observed towels and linens on top of foot cradle frame weighing down the blanket causing blankets to be laying directly on Resident 37's lower legs and feet.</p> <p>During a concurrent observation and interview on 10/15/24 at 9:15 a.m. with Licensed Nurse (LN) 3, observed towels and linens on top of Resident 37's foot cradle, weighing down the blankets causing the blankets to be laying directly on her lower legs and feet. LN 3 acknowledged that the towels and linens should not have been placed on the top of the foot cradle. LN 3 stated, It defeats the purpose.</p> <p>During an interview on 10/15/24 at 9:45 a.m. with Certified Nursing Assistant (CNA) 3, reviewed that towels and linens were on top of Resident 37's foot cradle weighing the blankets down on her lower legs and feet. CNA 3 stated, I shouldn't have done that. I brought in blankets and towels for her bath and got called away to another resident and had to leave. I was in a hurry. It defeated the purpose of the foot cradle.</p> <p>During an interview on 10/17/24 at 11:42 a.m. with the DON, the DON stated the foot cradle is a nursing intervention and does not need a physician's order. The DON stated the foot cradle is used to make sure pressure is not on the lower extremities and is used if there is a wound or to make sure a wound does not develop. Reviewed observation of Resident 37 with towels and linens on top of foot cradle weighing down the blankets onto the lower extremities. The DON acknowledged, It should not have happened.</p> <p>A review of the facility's policy and procedure (P&P) titled Skin Care and Wound Management, revised 8/18, indicated .To provide routine preventive measures and care specific to resident's individual risk factors/needs .Avoid friction and shearing .Provision of other pressure redistributing devices such as pillows, linen rolls, heel and elbow protectors, roho cushions, gels cushions, splints, etc. to keep bony prominences from direct contact with one another or other unrelieved pressure .All staff will take preventative measures in an effort to stabilize or improve co-morbidities for residents at risk for skin breakdown .</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 34 sampled residents (Resident 45) received care and services to address her right hand contracture (a tightening of the muscles, tendons, and skin, causing resident's fingers to bend and curl towards the palm), when the facility did not implement preventative measures to maintain the resident's hand mobility and prevent worsening of Resident 45's contracture.</p> <p>This failure resulted in Resident 45 experiencing a severe right hand contracture leading to further decline in use of her hand and had the potential to result in pain and skin problems.</p> <p>Findings:</p> <p>A review of Resident 45's Admission Record indicated the facility admitted the resident in 2016 with multiple diagnoses including hemiplegia (paralysis of one side of body) and hemiparesis (weakness of half of the body) following a stroke affecting the right dominant side).</p> <p>A review of the physician progress note dated 9/29/23 indicated Resident 45 was alert and oriented, cooperative, and interactive. The physician documented that the resident had right sided weakness with right upper extremity mild contracture.</p> <p>A review of Resident 45's Minimum Data Set (MDS, and assessment and care planning tool) dated 7/9/24 indicated she was cognitively intact. Resident 45's MDS dated [DATE], 4/8/24, 7/9/24 section O, indicated the resident did not use a brace or hand splint (medical devices that support and stretch the fingers and keep them in proper position preventing contractures).</p> <p>A review of Resident 45's clinical records did not contain any documented evidence the facility addressed the resident's right hand contracture and implemented preventative measures to maintain the resident's hand mobility and prevent further decline in her right hand.</p> <p>A review of Resident 45's clinical records failed to reveal a care plan addressing her hand contracture and measures to prevent further deterioration of the resident's hand.</p> <p>During an observations on 10/15/24 at 12:16 p.m., Resident 45 was sitting in the wheelchair in her room with her right hand held close to her body. Resident 45 was pleasant and responded to questions appropriately. Resident 45 stated she exercised her legs 2 or 3 times a week on a specialized bicycle. Resident 45 used her left arm to lift the right arm and showed her right hand closed into a fist with fingers curled tightly inside and nails digging into skin. The resident's right hand had no splint or brace. During a continued interview, Resident 45 stated her fingers curling had worsened over time and it was impossible to open her fist. Resident 45 added that it was painful to loosen the fingers when washing and drying her hand. Resident 45 stated she could not recall if the facility used any assistive devices such as brace or hand splint for her contracture.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/16/24 at 3:02 p.m., Certified Nursing Assistant (CNA 1) stated she was familiar with the Resident 45's care. CNA 1 validated that Resident 45's right side was very weak and her right hand was contracted. CNA 1 stated it was difficult to open the resident's hand and wash inside of the palm because the resident's fingers were tightly curled inside. CNA 1 stated she had never seen the resident wearing a brace or splint to manage the hand contracture.</p> <p>During an interview on 10/16/24 at 3:25 p.m., Licensed Nurse (LN 1) stated that Resident 45 was admitted to the facility several years ago after she had a stroke, had right sided weakness and right hand contracture. LN 1 stated she could not recall seeing Resident 45 wearing a brace or hand splint for her hand contracture.</p> <p>During an interview on 10/16/24 at 3:30 p.m., a unit supervisor stated that Resident 45 had been in the facility for a long time. When the unit supervisor was asked what measures were implemented to manage the resident's hand contracture, she stated, I think she had a splint a while ago, but I don't know what happened to it. The unit supervisor confirmed that there was no hand splint or brace to manage the resident's contracture.</p> <p>During an interview and concurrent records review on 10/16/24 at 3:40 p.m., PT(Physical Therapist) stated that Resident 45 received physical therapy from 10/2016 through 12/2016. Upon reviewing physical therapy notes, the PT stated that Resident 45's therapists documented the resident's right upper extremity and hand were stiff and rigid during therapy. The PT explained that those conditions placed the resident at risk for developing contractures if not treated. The PT stated she was not able to find any documented evidence Resident 45 was assessed for hand splint or brace to prevent hand contracture.</p> <p>An interview with the Director of Rehab (DR), who was a Certified Occupational Therapy Assistant (COTA) was conducted on 10/17/24 at 9:25 a.m. The COTA stated that occupational therapists handled all residents with upper extremities limitations. The COTA stated, I have never worked with her [Resident 45], never assessed her right arm and hand limitations .I was never directed to address her contracture . She has been on Omnicycle [a specialized machine to exercise] which helps for her lower extremities, nothing for upper extremities. During a continued interview, the COTA stated, We have monthly rehabilitative nursing assistant meetings and we have never discussed her right hand contracture. The COTA stated she was unable to find any documentation addressing Resident 45's right hand contracture.</p> <p>During an interview and a concurrent record review on 10/16/24 at 3:50 p.m., the Director of Nursing (DON) stated Resident 45 had right hand contracture. The DON acknowledged that the resident's clinical records did not contain a care plan addressing her hand contracture. The DON stated that it was her expectation that the care plan with interventions to maintain resident's hand limitations and contracture should have been initiated upon resident's admission and revised as needed. The DON added that it was important to have a care plan which provided direction on the type of treatment and care the resident required. The DON stated she could not find any documentation addressing Resident 45's right hand contracture.The DON stated the resident has been in the facility for many years and she needed to look for more records.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview with the DON on 10/17/24 at 1 p.m., the DON stated the facility focused on exercising Resident 45's lower extremities. The DON stated she was unable to find any documentation addressing the resident's right hand contracture. The DON stated her expectation was that the therapy identified and addressed the resident's right hand weakness.</p> <p>A review of the facility's 'Rehabilitative Nursing Care' policy revised 4/13, indicated, Our facility has an active program of rehabilitative nursing .The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain optimal level of self-care and independence.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48445</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper storage, usage, handling, and labeling of respiratory care equipment were consistent with the facility's policy and procedures (P&P) for one of 34 sampled residents (Resident 13) when a nebulizer (a machine that turns medicine into a mist) mask and tubing were not properly stored and replaced as ordered, and nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was used and connected to a nebulizer machine.</p> <p>These failures had the potential to result in unsafe and unsanitary delivery of respiratory treatments to Resident 13.</p> <p>Findings:</p> <p>1a. During a review of Resident 13's admission records, the records indicated Resident 13 was admitted in April 2023 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, diseases that block airflow and make it difficult to breath), shortness of breath, and dependence on supplemental oxygen. Resident 13's Minimum Data Set (MDS, an assessment tool) indicated Resident 13 had intact cognition.</p> <p>During a review of Resident 13's physician order revised 9/14/24, the order indicated, Change nebulizer mask/tubing storage bag monthly and PRN with date and initial .</p> <p>During a review of Resident 13's physician order revised 9/22/24, the order indicated, Change nebulizer mask and tubing weekly and PRN with date and initial .</p> <p>During a review of Resident 13's physician order dated 10/14/24, the order indicated, Ipratropium-Albuterol [used to control the symptoms of lung diseases such as asthma and emphysema] Solution .3 milliliter [a unit of measurement] inhale orally every 4 hours as needed for SOB (shortness of breath) or Wheezing via nebulizer.</p> <p>During a review of Resident 13's Medication Administration Record (MAR) for October 2024, the MAR indicated Ipratropium-Albuterol Solution via nebulizer was administered on 10/14/24 at 6:16 a.m.</p> <p>During a review of Resident 13's progress notes dated 10/14/24, the notes indicated, Resident had 1x (one time) episode of vomiting. Resident requesting a nebulizer treatment, given as ordered.</p> <p>During an observation on 10/15/24 at 9:42 a.m. in Resident 13's room, Resident 13's nebulizer mask and tubing were observed placed on top of the nightstand without a storage bag and the tubing was dated 9/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/15/24 at 10:13 a.m. with Resident 13 and Licensed Nurse 4 (LN 4) in Resident 13's room, LN 4 confirmed the nebulizer mask and tubing were on top of the table and not stored in a bag while not in use. LN 4 stated, It should be in a bag. Resident 13 stated, I didn't have a bag for that. LN 4 confirmed the tubing was labeled 9/22/24, and stated, We have to change this one . LN 4 further stated, [It is an] infection control issue if it's just laying in there .line [tubing] is almost a month, it's infection control issue.</p> <p>During a concurrent interview and record review on 10/17/24 at 10:27 a.m. with the Infection Preventionist (IP), the IP stated, On storage of nebulizer kits, we put them on the clean black bag after cleaning, write their name, the date of first use, we change the bag once a month .we expect the staff to follow policy on changing kits. The IP verified Resident 13's physician order indicated to change nebulization mask and tubing weekly and PRN and stated, If not changed weekly, the problem is of course infection. If not stored properly, can cause possible respiratory infection to the resident .We have to throw everything away because it's not clean anymore and contaminated with organisms or bacteria. When a picture of the tubing label was shown to the IP, the IP stated, We are not compliant with the order and the policy .the date is almost a month.</p> <p>During an interview on 10/17/24 at 3:57 p.m. with the Director of Nursing (DON), the DON stated, Expectation on nebulization mask and tubing is to follow the order, that's why it's there .They are supposed to be in the black bag, if we don't have that, we can use ziplock (resealable) bag, supposed to be labeled with resident name and date opened .seven days for the tubing and mask and PRN, 30 days for the bag and PRN .That's an infection control issue, you don't know what contaminants can be introduced to the resident.</p> <p>During a review of the facility's P&P titled IIB8: Oral Inhalation Administration, revised 1/1/23, the P&P indicated, Purpose .To allow for safe, accurate, and effective administration of medication using an oral inhaler .or nebulizer .W. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it .X. Change equipment and tubing per manufacturer's recommendations.</p> <p>1b. During a review of Resident 13's physician order revised 4/23/23, the order stated, Oxygen at 2 liters/minute [a measurement of volume] via nasal cannula every shift for COPD.</p> <p>During a review of Resident 13's MAR for October 2024, the MAR indicated oxygen was administered via nasal cannula on 10/18/24 day shift.</p> <p>During an observation on 10/18/24 at 10:11 a.m. in Resident 13's room, nasal cannula was observed hanging on top of the nightstand without storage bag and connected to nebulizer machine.</p> <p>During a concurrent observation and interview on 10/18/24 at 10:13 a.m. with the IP in Resident 13's room, the IP confirmed the observation and stated, Tubing should be in a bag .I'll change it because it's already contaminated. The IP confirmed the nasal cannula was connected to nebulizer machine and stated, That's the wrong one.</p> <p>(continued on next page)</p>		

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<p>F 0695</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 10/18/24 at 11:42 a.m. with the DON, the DON verified Resident 13 had orders for oxygen 2 liters via nasal cannula and was administered in the morning of 10/18/24. The DON stated, We use oxygen concentrators for oxygen therapy. When a picture of nasal cannula connected to nebulizer was shown, the DON stated, What in the world? I can't think that a nurse can do it, I can't really imagine, I just don't see it but connecting a nasal cannula, connected to nebulizer?</p> <p>During a review of the facility's P&P titled Oxygen Administration, revised 10/2010, the P&P indicated, 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter .b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose .7. Check the tubing connected to the oxygen cylinder to make sure it is free from kinks .9. Place appropriate oxygen device on the resident .</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>48445</p> <p>Based on interview and record review, the facility failed to ensure pain management was provided consistent with professional standards of practice for one of 34 residents (Resident 34) when doses of Resident 34's PRN (as needed) pain medication were given without adequate indication.</p> <p>This failure had the potential to increase Resident 34's risk of exposure to side effects and dependence on pain medication.</p> <p>Findings:</p> <p>During a review of Resident 34's admission record, the record indicated Resident 34 was admitted in September 2024 with diagnoses which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of half of the body), and disorders of bone density (amount of minerals in the bone) and structure. Resident 34's Minimum Data Set (MDS, an assessment tool) indicated Resident 34 had moderate cognitive impairment.</p> <p>During a review of Resident 34's Pain Assessment, dated 9/5/24, the assessment indicated Resident 34 was able to self-report pain and could comprehend use of numerical pain scale. The assessment further indicated Resident 34's goal for pain management on a scale of 1-10 is 1.</p> <p>During a review of the facility provided document titled Descriptive Pain Grid, undated, the document indicated the 0-10 Numerical Pain Scale was implemented for residents who are verbal and alert with 0-1 as no pain, 2-4 as mild pain, 5-7 as moderate distressing pain, 8-9 as severe pain, and 10 as excruciating pain.</p> <p>During a review of Resident 34's physician order dated 9/7/24, the order indicated, Hydrocodone-Acetaminophen (Norco, used to treat moderate to severe pain) Oral Tablet 10-325 MG (milligrams, a unit of measure) .Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain .</p> <p>During a review of Resident 34's Medication Administration Record (MAR) for September 2024, the MAR indicated Resident 34's Norco was given on 9/7/24 at 8:46 p.m. with pain level of 3, on 9/8/24 at 4:01 p.m. with pain level of 1, on 9/9/24 at 7:50 p.m. with pain level of 1, and on 9/30/24 at 7:08 p.m. with pain level of 3.</p> <p>During an interview on 10/17/24 at 10:13 a.m. with LN 4, LN 4 stated, We ask where the pain is, use the pain scale 1-10, moderate pain is usually around 5-7. If the complaint is 1/10, I won't give Norco if the order is moderate pain. I'll check if there is an order for Tylenol [medication used for minor aches and pains] .but not Norco .because it is usually for moderate to severe pain.</p> <p>During an interview on 10/17/24 at 10:41 a.m. with LN 5, LN 5 stated, I'm very careful with narcotics, it affects [residents] a lot .will not give Norco if pain is 1/10 because it is not moderate pain at all. If it was given unnecessarily, it's a narcotic, the resident will sleep most likely, might have possible respiratory or breathing issues, and possible dependence.</p> <p>(continued on next page)</p>		

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<p>F 0697</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 10/17/24 at 3:27 p.m. with LN 1, LN 1 verified Resident 34 received Norco on September 7, 8, 9, and 30, 2024, and confirmed she gave the doses. LN 1 stated, I asked [Resident 34] if she wants Norco or Tylenol, she usually requests Norco .Moderate [pain] for me is 1-5 or 6 and severe [pain] is 7-10 .I haven't seen pain scale chart on my cart. LN 1 further stated, Resident requested it .I did not notify the doctor .the resident could become dependent on it, or the medication will not work anymore.</p> <p>During a concurrent interview and record review on 10/17/24 at 3:42 p.m. with the Unit Supervisor (US), the US confirmed Resident 34 received Norco on September 7, 8, 9, and 30, 2024, and stated pain levels were mild when the Norco doses were given on those dates. The US stated, I go by the number, if that's me, it should be Tylenol, then I'll follow up .They are going to be dependent on Norco, if you offer Tylenol, they will ask for Norco because they are getting dependent on it.</p> <p>During a concurrent interview and record review on 10/17/24 at 3:57 p.m. with the Director of Nursing (DON), the DON stated, The pain scale is embedded in the eMAR (electronic MAR), the system will ask the nurse, it will pop-up before giving the medication and the nurse will select the level of pain .System will not let you give the medication without selecting the pain level. It has numbers and it tells you what level of pain it is. The DON verified Resident 34 had an order for Norco for moderate to severe pain as needed. The DON confirmed Norco was given for pain levels of 1 to 3 on September 7, 8, 9 and 30, 2024, and stated, I don't think that's moderate. The DON confirmed that Norco was given without indication and stated, The medication was given, it could be unnecessary .Even if the resident wants Norco, doctor should be notified . because it's not within the doctor's order .Expectation is to always follow the doctor's order.</p> <p>During a review of the facility's policy and procedure (P&P) titled IIA2: Medication Administration-General Guidelines, revised 1/1/23, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .2) Medications are administered in accordance with written orders of the prescriber.</p> <p>During a review of the facility's P&P titled Pain Management, revised 5/2022, the P&P indicated, .To assure an accurate assessment and management of the resident's pain and response in a timely manner with administration of pain medication or non-drug intervention as appropriate for the resident .It is the policy of this facility to assess all residents for pain on admission; each time vital signs are monitored, when pain medication is given and as indicated .The licensed nurse shall assess the resident's pain utilizing one of the pain scales located on e MAR .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41838</p> <p>Based on observation, interview, and record review, the facility failed to ensure food storage and service was in accordance with professional standards for food service safety, for the 139 residents who ate facility prepared meals when:</p> <ol style="list-style-type: none"> 1. The cook's refrigerator was found with the temperature varying anywhere from 42-50 degrees Fahrenheit; 2. The three-door freezer (used for meats) had ice buildup behind the second and third doors, around the top of the door frame; 3. The three-door freezer had an open box of vegetarian meatballs that was exposed to the air; 4. Three fans were found with discolored blades; 5. Two metal shelves in cook's preparation area found with rusted areas; and 6. Four cutting boards found with black staining and deep grooves on cutting surfaces. <p>These failures had the potential of leading to food borne illness for the 139 residents eating facility prepared meals.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the initial kitchen tour on 10/15/2024 at 8:15 a.m., the temperature for the cook's refrigerator was found varying between 42 degrees Fahrenheit (F, a unit of measurement) for the internal thermometer and 50 degrees F for the external thermometer. During a concurrent interview with the Dietary Services Supervisor (DSS), the DSS confirmed the observation and stated that he believed the high temperature was due to the refrigerator being opened multiple times during the breakfast preparation. <p>During a revisit to the kitchen on 10/16/24 at 10:02 a.m., the cook's refrigerator internal thermometer read 44 degrees F. A cottage cheese and fruit cup located in the refrigerator had a temperature of 43.4 degrees F. The DSS concurred that the temperature was too high and asked staff to discard the cottage cheese cups.</p> <p>During a revisit to the kitchen on 10/17/2024 at 8:31 a.m., the cook's refrigerator was observed. The outside temperature read 36 F, and the inside temperature was found at 46 degrees F. The DSS confirmed the observation during temperature check.</p> <p>A review of facility policy titled Procedure For Refrigerator Storage dated 6/14/23 from Health Menus Direct, LLC. 2023 indicated that 1. Refrigerator- 41 degrees F or lower . 4. Refrigerator doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations.</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 - Some</p>	<p>Review of the United States Food and Drug Administration Food Code section 2-103.11 on Person in Charge indicated that upon delivery, all food must be appropriately stored in a safe and secure manner . For example, time/temperature control for safety foods must be stored within refrigeration units and held at temperature of 41 degrees F or below.</p> <p>Review of the United States (US) Food and Drug Administration (FDA) Food Code section 4-501.11 on Good Repair and Proper Adjustment indicated that Proper Maintenance of equipment to manufacturer specification helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violation of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures.</p> <p>2. During a concurrent observation and interview on 10/15/2024, within the initial kitchen tour at 8:56 a.m. with the DSS in the kitchen, the 3-door freezer was noted with ice buildup around the top of the door frame. The DSS confirmed the observations.</p> <p>A review of facility policy and procedure (P&P) titled Procedure For Refrigerator Storage dated 6/14/23 from Health Menus Direct, LLC. 2023 indicated that 4. Refrigerator doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations.</p> <p>A review of the US FDA 2022 Food Code, section 3-305.11 titled Food Storage indicated (A) Except as specified in (B) and (C) of this section, Food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination;</p> <p>Review of Refrigerated Design Technologies (solutions.rdonline.com) discussion on ice buildup indicated that Icing can prevent freezers from operating properly, causing compressors to work overtime in order to keep temperatures at ideal conditions. When frost forms and excessive defrost cycles are required, this inevitably causes energy bills to rise as temperatures are kept low . Frost and icing can also cause freezer burn. This ultimately damages the integrity of food. As ice crystals form on an operation's valuable ingredients, they damage the flavors, aromas and even the safety of food products being stored in the freezer.</p> <p>3. During a concurrent observation and interview on 10/15/2024, within the initial kitchen tour at 8:56 a.m., with the DSS, the three-door freezer had an opened box of vegetarian meatballs that was exposed to the air and had visible ice buildup (freezer burn) on the surface. The DSS confirmed the observations and removed meatballs from the freezer.</p> <p>A review of the facility's P&P titled, Procedure For Refrigerator Storage, dated 2023, indicated, 13. Food that has been freezer burnt must be discarded.</p> <p>A review of the US FDA 2022 Food Code, section 3-305.13 titled Vended Time/Temperature Control for Safety Food, Original Container indicated that The possibility of product contamination increases whenever food is exposed. In addition, time/temperature control for safety foods . Once the original seal is broken, the food is vulnerable to contamination.</p> <p>A review of the US FDA 2022 Food Code, section 3-307.11 on Miscellaneous Sources of Contamination indicated that Food shall be protected from contamination .</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 - Some</p>	<p>4. During a concurrent observation and interview on 10/15/2024 within the initial kitchen tour at 9:15 a.m., a fan in the tray preparation room was found with discolored blades. The fan was positioned so that it blew down on the clean trays and eating utensils. The DSS confirmed the observation of the dusty blades and stated that the fans were to be cleaned by the maintenance department.</p> <p>During a revisit to the kitchen on 10/16/24 at 9:09 a.m., a fan in the cook's area by the window that residents visit was noted to have a dark, fuzzy coating on the blades. Later, during this same visit to the kitchen at 9:40 a.m., the fan in the dish room was observed to have a fuzzy, dark film on the outer blades.</p> <p>A review of facility P&P titled, Section 8 Sanitation, dated 8/1/2023 indicated, 11. All utensil, counters, shelves, and equipment shall be kept clean, maintained in good repair .</p> <p>A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>5. During a concurrent observation on 10/15/2024 within initial kitchen tour at 9:21 a.m., two metal shelves in the cook preparation area were found with rusted areas on the surface of up to 8 inches by 12 inches in diameter.</p> <p>During an interview on 10/17/24 at 3:11 p.m., with the DSS, the DSS concurred that rust on surfaces interfered with the cleaning and sanitizing of items, which could lead to cross contamination of food.</p> <p>A review of the facility's P&P titled, Section 8 Sanitation dated 8/1/2023 indicated, 11. All utensil, counters, shelves, and equipment shall be kept clean, maintained in good repair .</p> <p>A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>6. During a concurrent observation and interview on 10/16/2024 at 9:35 a.m., four cutting boards were found with black staining and deep grooves on the cutting surfaces. The DSS confirmed the observations.</p> <p>A review of the facility's P&P, titled, Section 8 Sanitation, dated 8/1/2023, indicated, 11. All utensil, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped area.</p> <p>A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section 4-501.12, titled Cutting Surfaces, 1/18/23 version, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.</p> <p>50351</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Vienna Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 So. Ham Lane Lodi, CA 95242	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838</p> <p>Based on observation, interview, and record review the facility failed to provide consistent guidance to staff regarding food brought to residents from outside sources.</p> <p>This failure had the potential of unsafe food items being distributed to the 139 residents leading to choking risk, allergic reactions, and food borne illness.</p> <p>Findings:</p> <p>During a review of facility policy and procedure (P&P) on [DATE] at 1:18 p.m., from the survey binder titled Food Brought To Resident By Family/Friends/Activity Department revised [DATE] indicated that 6. Cooked left-over food be discarded after two (2) hours bedside. The policy did not include procedures for storing food for residents.</p> <p>During an interview with the Quality Assurance (QA) nurse on [DATE] at 3:20 p.m. in unit 2, the QA nurse stated that family can bring food into facility for resident. Food brought for the resident would be stored in the resident refrigerator. The QA nurse showed where the resident refrigerator was located in the hospitality suite. An observation of signage on the resident refrigerator indicated All staff must label; name and date on personal & resident food/beverage items. any unlabeled food found in fridge on cleaning days will be thrown away. Perishable foods are to be thrown away 3 days after the date labeled.</p> <p>During an interview of Licensed Nurse 6 (LN 6) on [DATE].4 at 3:37 p.m. in unit 1, LN 6 stated that food brought to residents from outside would be checked to make sure it is safe for the resident (such as ensuring it didn't have allergens that the resident may react to). The food would be labelled with the resident name and date brought to facility before storing in the refrigerator. LN6 further stated the food would be tightly sealed to prevent cross contamination. Once in the refrigerator the food could be kept for 24 hours before being discarded.</p> <p>During an interview of Certified Nursing Assistant (CNA) 6 on [DATE] at 3:55 p.m., CNA 6 stated that food from outside would be labeled with the resident name and date brought in and stored in the resident refrigerator for up 3 days.</p> <p>During an observation on [DATE] at 4:11 p.m. of the resident's refrigerator/freezer located in the Hospitality Suite, expired and unlabeled foods were found. The refrigerator contained the following expired items: a box of 12 flavored Greek yogurts with a use-by date of [DATE]th, 2024, a jar of Kimchi best by date of [DATE], a carton of vanilla medication drink with a use-by date of [DATE], and an opened apple juice carton labeled [DATE].</p> <p>The refrigerator also contained a chocolate shake without any labeling, a package of bologna without a date, 2 unlabeled black tea drinks, 1 unlabeled can of sparkling, white tea; and one unlabeled canned soymilk.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The freezer contained an unlabeled, undated plastic container of frozen fruit, 3 unlabeled containers of ice cream, a bag of 4 sandwiches without a date, and half a sandwich in a brown bag with no date or name.</p> <p>During a concurrent observation and interview of the resident refrigerator on [DATE] at 2:40 p.m. with the Director of Nursing (DON) and the QA nurse, the DON stated Our expectation is that housekeeping is checking this fridge and throwing any expired items out. Anything that doesn't have a name or is past 72 hours, housekeeping will discard it. If sealed, we may use the manufacturer's use-by date. The DON further confirmed the expired foods and went on to state that, My expectation is that all items have a last name, date, and room number. Housekeeping should be cleaning it out. The nursing department knows to name and date items. The DON further confirmed that staff would not know when food was no longer safe to eat without the inclusion of dates.</p> <p>Due to inconsistent staff practices, the policy for outside food was requested again in an attempt to understand facility practices. Review of 2nd policy received titled Food For Resident From Outside Sources (Healthcare Menus Direct LLC. dated 2023) indicated that If opened, the food must be sealed, dated to the date opened and disposed by the best by date or . disposed of in 2 days after opening. Frozen items, such as ice cream will be disposed of in 30 days.</p> <p>This policy differed from the first policy which did not allow resident food to be kept longer than 2 hours at bedside. It also differed from the resident refrigerator signage which indicated that food could be kept for 3 days after opening. This confusion could lead to unsafe practices with staff uncertain as to correct procedures.</p> <p>50351</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834</p> <p>Based on observation, interview, and facility document review, the facility failed to provide 80 square feet of living space per resident in rooms 24, 33, 43, and 68.</p> <p>This failure had the potential to compromise the residents' care and privacy.</p> <p>Findings:</p> <p>Review of a facility request for the square footage room waiver dated 10/7/24, indicated the following multiple resident bedrooms measured less than 80 square feet (sq. ft.) per resident:</p> <p>room [ROOM NUMBER] measured 296 sq. ft., providing 74 sq. ft. per resident;</p> <p>room [ROOM NUMBER] measured 286 sq. ft., providing 71.5 sq. ft. per resident;</p> <p>room [ROOM NUMBER] measured 310 sq. ft., providing 77.5 sq. ft. per resident; and,</p> <p>room [ROOM NUMBER] measured 293 sq. ft., providing 73.25 sq. ft. per resident.</p> <p>During an interview on 10/15/24 at 9:08 a.m. with Resident 97, Resident 97 stated when asked about her room, They just moved me here. My things are adequately spaced.</p> <p>During an interview on 10/15/24 at 3:55 p.m. with Resident 118, Resident 118 stated room is huge and there was no issue with enough space. Resident 118 stated has enough room to manuever his wheelchair and to park it. Resident 118 stated the curtains separate him from his roommates and has privacy. Resident 118 stated, I signed a paper that I was aware that the room had four beds before they moved me here.</p> <p>During an interview on 10/17/24 at 3:53 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated a mechanical lift can fit inside the rooms if needed. CNA 4 stated, I have enough space to do my job. CNA 4 stated she has not heard any complaints from residents about space.</p> <p>During a concurrent observation and interview on 10/17/24 at 4:40 p.m. with Resident 16, observed Resident 16 in a large electric wheelchair sitting next to the bed. Resident 16 stated room currently is comfortable and has enough space to manage care with three residents in the room. Resident 16 stated he signed a waiver to be in the room.</p> <p>During a concurrent observation and interview on 10/17/24 at 4:44 p.m. with Resident 38, observed electric wheelchair at end of bed. Resident 38 stated he has enough room and is able to use his electric wheelchair in the room. Resident 38 stated he may have signed a waiver to be in the room, but did not recall.</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 10/17/24 at 4:46 p.m. with Resident 78, observed Resident 78 sitting in wheelchair in doorway. Resident 78 stated he has enough room to use his wheelchair in his room. Resident 78 stated he is okay with room.</p> <p>During an interview on 10/17/24 at 4:48 p.m. with Unit Supervisor (US), US stated she has not heard any complaints from residents about the size of the rooms. US stated there is enough room to provide care to residents.</p> <p>During an interview on 10/17/24 at 4:50 p.m. with CNA 5, CNA 5 stated rooms have enough space to provide care for residents with electric wheelchairs.</p> <p>The Department recommends a continuation of the room waiver for rooms 24, 33, 43, and 68.</p> <p>43247</p> <p>48445</p>