STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Rehab and Care Center	1630 N. Edison Street Stockton, CA 95204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of five sampled residents, (Resident 3) who was dependent on staff to carry out activities of daily living, (ADLs, tasks of everyday life including eating, dressing, bathing, showering, and using the bathroom) received services to maintain personal hygiene when Resident 3 was not provided with once weekly showers for two months.This failure had the potential to cause discomfort, skin impairment, infection, and a decline in emotional and psychological well-being.Findings:A review of Resident 3's clinical record titled, admission Record, indicated Resident 3 was admitted to the facility in 2018 with diagnoses which included Cerebral Infarction (a result of disrupted blood flow of the brain - also known as a stroke), Hemiplegia (unable to move a part of the body), and Hemiparesis (muscle weakness on one side of the body).A review of Resident 3's clinical record titled, Minimum Data Set, (MDS, a comprehensive care assessment tool) indicated that Resident 3 was dependent of the staff for completion of ADLs.During a phone interview with Resident 3's Responsible Party (RP, the person designated to direct the care of a loved one admitted into a nursing facility) on 7/3/25 at 10:43 a.m., the RP stated that she was concerned that the facility had not provided Resident 3 with showers but had only provided bed baths.During a concurrent interview and record of review on 7/7/25 at 11:33 a.m., with the Director of Staff Development (DSD), Resident 3's clinical record titled, Skin Check Forms, were reviewed. The DSD stated the Certified Nursing Assistants (CNAs) completed the skin check forms and placed them in the binder each day. The DSD stated the residents' skin checks, baths, and/or showers were completed at the same time unless the residents were bedridden. The DSD stated that residents like Resident 3 (who were bedridden) would have received bed baths daily and showers once a week. During a concurrent interview and record review on 7/8/25 at 4:10 p.m., with the Licensed Nurse (LN) 1, the document titled, July 2025 ADL-Bathing, (a task list documentation in the electronic medical record [EMR]) was reviewed. LN 1 stated that the residents' baths and showers were documented with body skin checks by the CNAs. LN 1 stated that residents in A beds were checked Monday, Wednesday, Friday, residents in B beds were checked Tuesday, Thursday, Saturday, and residents in C beds were checked on the days that the residents in the A beds were checked. LN 1 stated that the CNAs also documented baths and/or showers on the task lists electronically in the residents' medical records. LN 1 stated that Resident 3 went to the acute (area that treated new health concerns) care facility on 6/27/25 and returned to the facility from acute care on 7/3/25. LN 1 confirmed that Resident 3 received a shower on 7/8/25.During a concurrent interview and record review on 7/8/25 at 4:35 p.m., with the Medical Records (MR), Resident 3's clinical document titled, May 2025 and June 2025 ADL-Bathing (task list documentation) was reviewed. The MR stated that she was not able to print a report that indicated specifically whether Resident 3 received a bath or shower, as she did not have access to do so. MR stated that the Director of Nursing (DON) would be able to print a report that indicated whether Resident 3 received a shower in May or June 2025. During a concurrent interview and record review on 7/8/25 at 4:40 p.m. with the Minimum Data Set (MDS) Coordinator, Resident 3's clinical document titled, ADL-Bathing (located in the EMR that tracked shower dates) was reviewed. MDS stated the document did not indicate if Resident 3 had a bath or shower. The MDS confirmed that Resident 3's ADL-Bathing task list indicated that Resident 3 did not have a shower in May 2025 or in June 2025. During a concurrent phone interview and record review on 7/9/25 at 9:30 a.m., with the DON, Resident 3's EMR was reviewed. The DON stated that her expectation was that residents in A beds had skin checks Monday, Wednesday, Friday, residents in B beds had skin checks Tuesday, Thursday, Saturday, and residents in C beds had skin checks on the days that the residents in the A beds had skin checks and that the residents received bed baths or showers with the skin checks. The DON stated that her expectation was that residents who were bedridden received bed baths daily and received showers once a week. The DON stated that when the residents received bed baths, they were wet fully while in bed. The DON confirmed that Resident 3 did not receive a shower in May 2025 or June 2025. The DON stated that the risk of Resident 3 not receiving a shower was that a shower was more comfortable and refreshing than a bed bath. The DON acknowledged that the facility policy was not followed.A review of an undated facility policy and procedure (P&P) titled, Policy and Procedure on Bathing, indicated, .Policy .It shall be this facility's policy to provide bathing services to residents to promote cleanliness, good hygiene, and comfort .8. Formulate plans of care to meet the resident's bathing needs .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review the facility failed to maintain the confidentiality of two of three sampled residents (Resident 6 and Resident 7) when portions of Resident 6's and Resident 7's medical records were discovered in Resident 3's medical record.This failure had the potential for exposure of Resident 6's and Resident 7's private and confidential information to unauthorized individuals.Findings:A review of Resident 3's clinical record titled, admission Record, indicated Resident 3 was admitted to the facility in 2018 with diagnoses which included Cerebral Infarction (a result of disrupted blood flow of the brain, also known as a stroke), Hemiplegia (unable to moved parts of the body), and Hemiparesis (muscle weakness on one side of the body).A review of Resident 6's clinical record titled, admission Record, indicated that Resident 6 was admitted to the facility in 2014 with diagnoses which included Respiratory Failure (disease that can cause shortness of breath, anxiety, and confusion).A review of Resident 7's clinical record titled, admission Record, indicated that Resident 7 was admitted to the facility in 2019 with diagnoses which included Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar), and Hemiparesis. During a concurrent interview and record review on 7/7/25 at 4:10 p.m. with Medical Records (MR), Resident 3's medical records were reviewed. MR confirmed that intake and output forms for Resident 7 and a physician's order for a Licensed Nurse to pronounce the time of death and release of body to mortuary for Resident 6 were in Resident 3's medical record. The MR stated that the documents were mixed up and someone could have followed the order for the wrong resident. The MR confirmed that the facility policy was not followed.During a review of the faciliy's undated policy and procedure (P&P) titled, Health Policy and Procedure Manual Long Term Care Storage and Protection of Records, indicated, .The facility must maintain clinical records on each resident in accordance with acceptable professional standards and practices that are: 1. Complete 2. Accurately documented .It is the policy of this facility to store all medical records in such a manner so as to protect against .unauthorized use .Each patient is assigned a medical record number upon admission, and this number is retained for all subsequent readmissions .all admissions are filed under the .number .Do not allow records out in an area where they could be lost, misplaced .