STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Creek Post Acute	321 West Turner Road Lodi, CA 95240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview, and record review, the facility failed to ensure medical records were complete and accurately documented for one of three sampled residents (Resident 1) when scheduled showers were not documented accurately in Resident 1's electronic medical record (EMR).This failure had the potential for the records not to fully reflect Resident 1's scheduled showers being provided that could impact his health, hygiene and dignity.Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2022 with diagnoses that included type 2 diabetes (a condition when the blood sugar is too high), hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness or inability to move one side of the body) affecting the right dominant side and generalized muscle weakness. Review of the facility's shower schedule indicated Resident 1's showers were designated for Sunday and Wednesday during the PM (evening) shift. Review of Resident 1's EMR titled, BATHING, for the timeframe from 1/1/26 to 1/30/26, indicated Response not required was documented for all shifts except for the following:- 1/17/26 at 13:59 [1:59 p.m.] - Resident not available- 1/18/26 at 16:00 [4 p.m.] - bed bath - 1/29/26 at 13:9 [1:59 p.m.] - bed bath During an interview on 1/28/26, at 4:29 p.m., with Resident 1, Resident 1 stated he refused showers and preferred bed baths. Resident 1 further stated he got a bed bath every Wednesday. During an interview on 1/30/26, at 11:10 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated a CNA would fill out the shower sheet (a documentation tool used to record a resident's bathing routine, skin condition, and overall well-being during a shower or bed bath) and get it signed by a Licensed Nurse (LN) after a shower was given to a resident. CNA 1 further stated if a resident refused the scheduled shower, she would notify the LN and would offer two to three more times throughout the shift. CNA 1 stated she would then document in the resident's chart of the resident's shower refusal. During an interview on 1/30/26, at 12:22 p.m., with CNA 2, CNA 2 stated all residents received showers twice in a week. CNA 2 further stated Resident 1 was scheduled for PM shift showers but was always given a bed bath during the morning shift. CNA 2 stated she would chart in Resident 1's chart that she gave him a bed bath. CNA 2 further stated the CNA staff would be the one to chart for showers and bed baths provided to the residents. CNA 2 stated the CNA staff would also document in the resident's chart if a resident refused the showers. During an interview on 1/30/26, at 3:41 p.m., with CNA 3, CNA 3 stated Resident 1 was known to have refused showers and preferred bed baths. CNA 3 stated the CNA staff would document in the resident's chart when a shower or bed bath was done. During an interview on 1/30/26, at 10:51 AM, with Licensed Nurse (LN) 1, LN 1 stated the residents got a minimum of two showers per week. LN 1 further stated during showers the CNA would check on the resident's skin to see if there was any redness, bruising or any skin issue. LN 1 stated the CNA would document in the resident's chart if a shower was given. LN 1 further stated the risk of not getting the showers as scheduled would be the risk of infection, skin integrity could be compromised, and skin frictions (the physical force generated when the outer layer of the skin (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rubs or slides against another surface) could happen. During a concurrent interview and record review on 1/30/26, at 11:54 a.m., with LN 2, the facility's shower schedule was reviewed. LN 2 confirmed Resident 1 was scheduled for his showers every Sunday and Wednesday on the PM schedule. LN 2 stated the risk of not getting scheduled showers would be the potential for skin breakdown, possible pressure ulcers (localized injuries to the skin and underlying tissue, usually over a bony prominence, resulting from prolonged pressure, friction, or shear) and other skin issues. During a concurrent interview and record review on 1/30/26, at 12:43 p.m., with LN 3, Resident 1's EMR was reviewed. LN 3 stated Resident 1 had a known history of refusing showers. LN 3 further stated it was expected for the CNA staff to notify the LN or the treatment nurse if a resident refused the scheduled shower and to offer alternatives. LN 3 reviewed Resident 1's bathing task report from 1/1/26 to 1/30/26 and stated the CNA staff documented response not required instead of documenting refused. LN 3 verified two documented bed baths were done on 1/29/26 during the AM (morning) shift and 1/18/26 during the PM shift. LN 3 stated the expectation from CNA staff was to document refusal and not to document response not required. LN 2 further stated the CNA staff should have charted correctly in Resident 1's chart.During a concurrent interview and record review on 1/30/26, at 1:01 p.m., with the Director of Staff Development (DSD), Resident 1's bathing report for the month of January was reviewed. The DSD confirmed Resident 1 had two documented bed baths on 1/18/26 and 1/29/26 for the month. The DSD further confirmed Resident 1's EMR should have at least eight total showers documented for the month if he was getting them done twice a week. The DSD stated if the resident was not scheduled for a shower then the CNA should have documented did not occur or not applicable. The DSD further stated a resident's shower chart documentation was important for the CNA to complete. The DSD confirmed Resident 1's shower charting for the month of January was not consistent. The DSD stated it was very important to document in a resident's chart accurately because if it was not documented then it did not happen. During a concurrent interview and record review on 1/30/26, at 3:57 p.m., with the Director of Nursing (DON), Resident 1's bathing report for the month of January was reviewed. The DON stated this did not meet her expectations and staff were expected to have documented appropriate responses with the correct coding. The DON further stated it was important to have documented accurately to know what was going on with the resident. The DON stated the risk of not documenting accurately could be the risk of missing something or for the potential of worsening of an issue that was not being tracked. Review of an undated facility policy titled, Bath, Shower/Tub, indicated, .Purpose.The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.Documentation .1. The date and time the shower/tub bath was performed.5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.