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	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from abuse (physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment resulting in physical harm, pain, mental suffering, or deprivation by a care custodian of goods and services necessary to avoid harm) for 2 of 3 sampled residents (Resident 2 and Resident 3) when:Resident 1 made open hand contact to Resident 2's face and chest area on 8/27/25 at 8 PM, and the physician was not notified timely to evaluate and manage Resident 1's aggressive behavior; and,Certified Nursing Assistant (CNA) 1 left Resident 1 unmonitored in the hallway after the first incident, which resulted in a physical altercation with Resident 1 and Resident 3 on 3/27/26 at 8:50 PM following the 8 PM incident, during which Resident 1 hit Resident 3 on the back of the head and upper back, resulting in pain to Resident 3's head; and, The facility continued to place Resident 1 and Resident 3 at risk for further resident-to-resident altercations by failing to monitor Resident 1 while Resident 1 ambulated in the hallway and by allowing Resident 1 and Resident 3 to share a bathroom between their rooms, creating ongoing opportunity for unsupervised interaction.These failures resulted in Resident 3 experiencing physical harm and caused fear for Resident 3 and had the potential to cause Resident 2 to harm and experience fear. These failures also placed Resident 3 at risk for further resident to resident altercations, serious injury, and psychosocial distress, and placed other residents at risk for abuse.Findings:1. Review of Resident 2's admission RECORD indicated Resident 2 was admitted with diagnoses including but not limited to dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizophrenia (disruptions in thought processes, perceptions, and emotional responsiveness, causing individuals to interpret reality abnormally), and need for assistance with personal care.Review of Resident 1's admission RECORD indicated Resident 1 was admitted with diagnoses including but not limited to Alzheimer's disease (memory loss and confusion), dementia, mild neurocognitive disorder (mild problems with thinking), major depressive disorder in full remission (history of depression, currently improved), and unsteadiness of feet.Review of Resident 1's Minimum Data Set Assessment (MDS- a required standardized assessment for all nursing home residents), dated 1/4/26, in the section titled Section C- Cognitive Patterns.Brief Interview for Mental Status [BIMS-to check a resident's thinking and memory], indicated that Resident 1 scored a 9 (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe) on the BIMS assessment which indicated Resident 1 had moderately impaired cognition (a slight decline in thinking and memory). Review of Resident 1's behavior care plan, initiated 3/29/26, in the section titled Focus indicated .[Resident 1] noted with aggressive/physical behaviors toward peers, potential to escalate quickly. In the section titled Interventions, indicated .Assign CNA [Certified Nursing Assistant] monitoring during ambulation or activities in proximity to other residents; ensure line-of-sight [continuous, direct visual observation] supervision at all times.During a concurrent observation and interview on 4/20/26 at 2:10 PM with Resident 1 by the door of Resident 1's room, located in the middle of the hallway away from the nurse's station, Resident 1 was in her bathroom in her room. Resident 1 then exited the bathroom and (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walked in the hallway to the dining room. Resident 1 stated she had no conflict with other residents.During an observation on 4/20/26 at 2:15 PM, in the hallway by the door of Resident 3's room located next to Resident 1's room, Resident 1 walked in the hallway without staff present to monitor her.During an observation on 4/20/26 at 2:20 PM no staff members were present in the hallway. At 2:25 PM, the closed nurse's station door, located at the beginning of the hallway next to the entrance of the unit within a secure room, the door was opened and revealed three staff members inside, including CNA 1.During a concurrent observation and interview on 4/20/26 at 2:26 PM with CNA 1, CNA 1 was in the nurse's station and exited the nurse's station to speak with the surveyor. CNA 1 stated she was aware Resident 1 had a history of resident-to-resident altercations and required monitoring to prevent further altercations. CNA 1 stated no staff were present in the hallway to monitor Resident 1. CNA 1 stated that if Resident 1 ambulated in the hallway and exhibited aggression, there would be no staff available to intervene immediately. CNA 1 further stated she did not know Resident 1's whereabouts, which placed Resident 1 at risk for another episode of resident-to-resident altercations due to lack of monitoring. CNA 1 stated that Resident 2 was not interviewable (unable to answer questions).During a concurrent interview and record review on 4/20/26 at 2:34 PM with Licensed Nurse (LN) 1, Resident 1's SBAR (Situation, Background, Assessment, Recommendation- a structured communication tool used to clearly share important resident information with other healthcare staff), dated 3/27/26 at 8 PM, was reviewed. Resident 1's SBAR indicated that on 3/27/26 at 8 PM, .Per CNA, at approximately 2000 [8 PM], CNA was assisting.[Resident 2].who was in the wheelchair, back to her room. While slightly passing [Resident 1's room], CNAs talking with [Resident 2], [Resident 1] exited her room and stated that CNA's needed to be quiet because her roommate was asleep. Per CNAs, [Resident 2] responded to [Resident 1] but CNA's were unable to clearly understand the exact statement made by.[Resident 2]. [Resident 1] appeared to perceived [sic] the response as disrespectful and made brief open hand contact with [Resident 2's] left side of her face. CNA immediately separated [sic] residents in an attempt to de-escalate and create distance. While the CNA was intervening, [Resident 1] reached over the CNA and made another another [sic] quick open handed contact with [Resident 2] somewhere around the chest area. Residents were separated right away and safety ensured. The contacts were brief and limited in duration due to immediate staff response. CNA was able to redirect her to room [Resident 1's room number] and provide snack. When Nurse went to Station 3 and met with [Resident 1] she was in her room eating snack. [Resident 1] was calm and non stress behavior and nurse spoke to [Resident 1] and ask did she remember about incident stated this is my house. LN 1 stated staff were expected to prevent repeated altercations by closely monitoring Resident 1.During a concurrent interview and record review on 4/20/26 at 3:40 PM with the Assistant Director of Nursing (ADON), Resident 1's Care Plan was reviewed. Resident 1's Care Plan, initiated 2/28/24, in the section titled Focus indicated, .Resident [Resident 1] is making statements that this is her house. The ADON acknowledged that Resident 1's belief that the unit was her house could trigger aggression when other residents were perceived as invading her personal space. Resident 1's Care Plan, initiated 3/29/26, in the section titled Focus indicated .[Resident 1] noted with aggressive/physical behaviors toward peers, potential to escalate quickly. In the section titled Interventions, indicated .Assign CNA [Certified Nursing Assistant] monitoring during ambulation or activities in proximity to other residents; ensure line-of-sight supervision at all times.Separate residents proactively when near identified triggers or other residents. The ADON acknowledged that without monitoring of Resident 1, staff could not promptly de-escalate or intervene if Resident 1 exhibited aggression toward other residents. The ADON stated CNAs were expected to provide line-of-sight monitoring of Resident 1 due to unpredictable aggressive behaviors.During a concurrent interview and record review on 4/23/26 at 3:34 PM with the Director of Nursing (DON), Resident 1's SBAR dated 3/27/26 at 8 PM was reviewed. Resident 1's SBAR indicated Resident 1 had a resident-to-resident altercation with Resident 2 at 8 PM and the physician was notified on 3/28/26 at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation Survey Report v2 Apr [April] 26 dated 4/1/26 through 4/21/26 was reviewed. The ADON confirmed that Resident 3 was provided with set up or clean up assistance during toilet use and did not require supervision for the entire toileting process. The ADON acknowledged Resident 1 had confusion, unpredictable aggressive behaviors, and belief that the unit was her house, combined with sharing a bathroom with Resident 3, placed Resident 1 and Resident 3 at risk for further resident-to-resident altercations and serious injury.During an interview on 4/23/26 at 10:24 AM with the Director of Nursing (DON), the DON stated staff were expected to always protect residents and that repeat altercations involving the same resident should not occur. The DON acknowledged that Resident 1's belief that the unit was her house triggered aggression and contributed to the two altercations on 3/27/26, and that allowing Resident 1 and Resident 3 to share a bathroom placed both residents at risk for further altercations and serious injury given Resident 1's unpredictable behaviors and confusion.Review of facility's policy and procedure (P&P), titled Behavioral Assessment, Intervention, and Monitoring, revised 2/25, the P&P indicated .Behavior can be a way for an individual in distress to communicate unmet needs.Behavioral interventions refers to individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress.The nursing staff identify, .inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition.Safety strategies are implemented immediately, if necessary, to protect the resident and others from harm.Review of facility's P&P titled Resident Rights, revised 12/16, the P&P indicated .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be free from abuse.Review of facility's P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/21, the P&P indicated .Residents have the right to be from abuse, neglect, misappropriation of resident property and exploitation.The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment.Protect residents from abuse.by anyone including, but not necessarily limited to.other residents.