

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Lodi Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete the comprehensive admission assessment (a thorough health history and physical evaluation conducted when a resident enters a healthcare facility) for one of three sampled residents, (Resident 1) when Resident 1 was admitted to the facility on [DATE] and the admission comprehensive assessment was not completed within the required 14 calendar days after admission. This failure had the potential to delay the identification of Resident 1's care needs, completion of Care Area Assessments (CAAs - assessments used to identify care needs and guide care planning), and the development of an appropriate comprehensive care plan (an individualized plan of care that identifies problems, goals, and interventions). Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (otherwise known as a stroke, when blood flow had been interrupted or reduced to the brain), type 2 diabetes mellitus (inability to control blood sugar), hypertension (high blood pressure), gastrostomy (feeding tube), dysphagia (difficulty swallowing), aphasia (difficulty speaking or understanding language), difficulty in walking, protein-calorie malnutrition (poor nutrition), atrial fibrillation (irregular heartbeat), gastrointestinal hemorrhage (bleeding in the stomach or intestines), muscle weakness, and retention of urine (difficulty emptying the bladder). During a concurrent interview and record review on 7/7/26 at 1:29 PM with the Minimum Data Set Coordinator, (MDSC 1 - nursing staff responsible for resident assessments) Resident 1's Minimum Data Set (MDS - a standardized resident assessment used to identify care needs and develop the resident's care plan) tracking screen (part of the resident's electronic health record used to track required resident assessments and due dates) was reviewed. The MDS tracking screen indicated Resident 1's entry date (date admitted to the facility) was 6/12/26. The admission assessment, dated 6/18/26, remained under the status of, In Progress, indicating it had not been completed. The MDS tracking screen also indicated the Assessment Reference Date (ARD - the date used to establish the assessment timeframe) was 12 days overdue with a required completion date of 6/25/26. MDSC 1 confirmed Resident 1's admission comprehensive assessment had not been completed by the required completion date of 6/25/26. MDSC 1 stated that when the admission comprehensive assessment was not completed, it delayed the identification of the resident's care needs and the implementation of appropriate interventions because the CAAs and comprehensive care plan were not completed, which could have affected resident's safety. During an interview on 7/7/26 at 2:27 PM with the Assistant Director of Nursing (ADON), the ADON stated that resident assessments were expected to be completed timely because they helped identify the resident's care needs and develop appropriate interventions in the resident's care plan. Review of the facility's policy and procedure (P&P) titled, (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Completion and Submission Timeframes, revised in 7/2017, the P&P indicated .facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.Timeframes for completion and submission of assessments is based on the current requirements.Review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised in 3/2022, the P&P indicated .The comprehensive, person-centered are plan is developed within seven (7) days of completions of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) received care to prevent worsening of an existing pressure injury (localized areas of skin and tissue damage caused by sustained pressure) on the right foot and/or prevent the development of new pressure injuries when Resident 3 was not turned in bed at least every two hours to relieve pressure on the body. This failure placed Resident 3 at risk for worsening of the existing pressure injury on the right foot and the development of additional pressure injuries. Findings: During a review of Resident 3's admission Record, the record indicated Resident 3 was admitted to the facility with diagnoses including palliative care (care focused on comfort), dementia (progressive decline in memory and thinking), cerebral infarction (stroke), traumatic hemorrhage of the right cerebrum (bleeding in the right side of the brain), type 2 diabetes mellitus (high blood sugar), pituitary-dependent [NAME] disease (a hormonal disorder caused by excess cortisol production), atherosclerosis of the native arteries of the right leg (reduced blood flow to the leg), reduced mobility (limited ability to move), major depressive disorder, cognitive communication deficit (difficulty understanding or expressing information), morbid obesity, and generalized muscle weakness. Review of Resident 3's Brief Interview for Mental Status, (BIMS - to assess a resident's thinking and memory) dated 6/16/26, indicated Resident 3's BIMS score was 6, which reflected severe cognitive impairment (13-15 = Intact, 8-12 = Moderate Impairment, 0-7 = Severe Impairment). Review of Resident 3's SKIN ASSESSMENT (PRESSURE INJURY) ., dated 7/6/26, indicated Resident 3 had a pressure injury to the right lateral foot. Review of Resident 3's Care Plan, initiated on 4/28/26, in the section titled, Focus, indicated . [Resident 3] has pressure ulcer [pressure injury] or potential for pressure ulcer development r/t Immobility, Incontinence, DM [Diabetes Mellitus], Depression R [right] lateral foot. In the section titled, Interventions, indicated, . [Resident 3] needs to turn/reposition at least every 2 hours, more often as needed or requested. During a concurrent observation and interview on 7/7/26 at 11:53 AM with Resident 4 in Resident 4's room, where Resident 4 shared a room with Resident 3, Resident 3 was observed sleeping in Bed A while Resident 4 was in Bed B. Resident 3 was lying flat on her back. Resident 4 stated the last time staff had repositioned Resident 3 in bed was at 9 AM that same day. During a concurrent observation and interview on 7/7/26 at 1:58 PM with Resident 4 in Resident 4's room, Resident 3 remained asleep in the same position as observed at 11:53 AM, lying flat on her back. Resident 4 stated staff had not repositioned Resident 3 since the first observation and further stated that Resident 3 required assistance with bed repositioning. During a concurrent observation and interview on 7/7/26 at 2:05 PM with Certified Nursing Assistant (CNA) 2 in Resident 4's room, Resident 3 remained asleep in the same position, lying flat on her back. CNA 2 stated the last time Resident 3 had been repositioned was at 11:30 AM when she assisted the hospice nurse because Resident 3 required a two-person assist for repositioning. CNA 2 confirmed Resident 3 had remained in the same position for more than two hours. CNA 2 acknowledged that repositioning Resident 3 in bed helped prevent the development and worsening of pressure injuries. During an interview on 7/7/26 at 2:13 PM with the Assistant Director of Nursing (ADON), the ADON stated that if a resident's care plan required repositioning every two hours to prevent pressure injuries, nursing staff were expected to reposition the resident at least every two hours to help prevent the development of pressure injuries and further skin breakdown. Review of the facility's policy and procedure titled, Prevention of Pressure Injuries, revised in 4/2020, indicated . Reposition all residents with or at risk of pressure injuries on an individualized schedule. Choose a frequency for repositioning based on the resident's risk factors.		