

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

Printed: 07/18/2026
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 11/21/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the 82 residents who received facility prepared meals when:1. An open bottle of vinegar was observed under the food steam table; and,2. An open box of salt was stored where the mouth of the box was taped but a visible gap remained between the tape and the box, leaving the contents partially exposed; and,3. A fish [NAME] (spatula) was found in the clean utensils box with a melted middle section; and,4. Canned goods were found in the dry storage room without expiration dates or a received by dates; and,5. Vendors and Staff were not wearing hairnet/beard-net inside the kitchen. These failures pose a risk for food contamination, increasing the chance for foodborne illness among the 82 residents consuming facility-prepared meals. Findings:1. During the initial kitchen tour on 11/18/25, beginning at 8:39 AM with the kitchen Supervisor/Manager (KS), an open bottle of vinegar was observed stored under the kitchen steam table. During a follow up interview with KS on 11/18/25 at 2:05 PM, the KS stated the cook had covered the bottle but did not notice that the cap had fallen off, acknowledging that this was an error. During an interview with the KS and the Registered Dietician (RD) on 11/19/25 at 11:00 AM, the KS stated that the open bottle of vinegar found under the kitchen steam table had been stored there along with other condiments (e.g., soy sauce and Worcestershire sauce) due to limited kitchen space. The KS stated she would look for an alternative storage area. The KS further stated that leaving a bottle of vinegar uncovered poses a risk of dust contamination. A review of the facility's policy titled, Labeling/Date Marking and Safe Storage of Refrigerated & Frozen Foods, dated 1/1/17, indicated that .foods held in refrigerated or other storage areas shall be covered. Liquids and food which are prepared and not served shall be tightly covered, stored appropriately. A review of FDA Food Code 2022, (1/18/23 Version), Chapter 3-302.11, indicated that .(A) Food shall be protected from cross contamination by.(4) .storing the food in packages, covered containers, or wrappings. Additionally, S3-305.11 indicated that .Food shall be protected from contamination by storing the food.(2) Where it is not exposed to splash, dust or other contamination. https://www.fda.gov/media/164194/download?attachment 2. During the initial kitchen tour on 11/18/25, beginning at 8:39 AM with the kitchen Supervisor/Manager (KS), an open box of salt was observed. The mouth of the box had been taped; however, a visible gap remained between the tape and the box, leaving the contents partially exposed to air. During a follow up interview with KS and RD on 11/19/25 at 11:00 AM, the KS stated that the partially open box of salt had been found under the steal kitchen worktable, which is sometimes used for food preparation depending on the recipe. The KS further stated that leaving it partially open can attract insects. A review of the facility's policy titled, Labeling/Date Marking and Safe Storage of Refrigerated & Frozen Foods, dated 1/1/17, indicated that .foods held in refrigerated or other storage areas shall be covered. Liquids and food which are prepared and not served shall be tightly covered, stored appropriately. A review of FDA Food Code 2022, (1/18/23 Version), Chapter 3-302.11, indicated that .(A) Food shall be protected from cross contamination by.(4) .storing the food in packages, covered containers, or wrappings. (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
--	-------	-----------

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 11/21/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, S3-305.11 indicated that .Food shall be protected from contamination by storing the food.(2) Where it is not exposed to splash, dust or other contamination. https://www.fda.gov/media/164194/download?attachment 3. During the initial kitchen tour on 11/18/25, beginning at 8:39 AM with the kitchen Supervisor/Manager (KS), a fish-[NAME] stored inside the utensils box was observed to be melted at the center. The KS immediately discarded the item and stated they had a replacement available.During a follow up interview with KS on 11/18/25 at 2:05 PM, she stated that the melted fish-[NAME] should have already been discarded because it was not safe for cooking.During an interview with the KS and RD on 11/19/25 at 11:00 AM, the KS stated, the plastic fragments could potentially contaminate food when using the damaged fish-[NAME]. She added that it could not be adequately cleaned and sanitized due to its condition and that she expects all food-contact surfaces to be smooth, intact and easily cleanable.A review of the facility's reference guide titled, Nutrition Ink/Nutricopia Cleaning and Sanitizing - Basics (2023) indicated that .when cleaning and sanitizing any food contact surface, it is extremely important that the surface be smooth, free of cracks or crevices.which may hide bacteria.A review of FDA Food Code 2022, (1/18/23 Version), Chapter 4-101.11 indicated .materials used in the construction of utensils and food-contact surfaces of equipment .may not allow migration of deleterious [harmful] substances or impart colors, odors, or tastes to food. and under normal use shall be.(A) Safe.(B) Durable, corrosion-resistant, and nonabsorbent.(D)Finished to have a smooth easily cleanable surface.(E) Resistant to chipping, crazing, scratching scoring, distortion and decomposition. Additionally, 4-501.11 indicated that .A utensil.can act as a source of contamination to the food it contacts if it is not maintained in good repair. https://www.fda.gov/media/164194/download?attachment 4. During the initial kitchen tour on 11/18/25, beginning at 9:23 AM with the Dietary Assistant Supervisor/Cook (DAS), canned goods were observed in the dry storage room without expiration dates or a received-by dates.During an interview with the KS on 11/18/25 at 2:05 PM, the KS stated that the DAS made an error, as upon delivery, he assumed that a printed marking on the top of the cans represented the expiration date. The KS stated that moving forward, they will use the facility's received-by date labels and/or ensure that expiration dates are clearly visible.During an interview with the RD on 11/21/25 at 9:02 AM, the RD stated that it was not within professional standards of practice to receive or store canned goods without a clear expiration date and/or received-by date, and that the incident was an oversight on the part of the DAS.Review of a reference guide provided by the facility titled, Nutrition Ink/Nutricopia Food Storage Chart - Dry Storage (2023) indicated that the recommended storage time for unopened canned food was 12 months.A review of the FDA Food Code 2022, (1/18/23 Version), Chapter 2-103.11(F) indicated .Employees are verifying that food delivered.are placed into appropriate storage locations such that they are maintained at the required temperatures, protected from contamination, unadulterated, and accurately presented. Additionally, Annex 3-127 indicates that .Manufacturer's use-by dates.is its recommendation for using the product while its quality is at its best. Although it is a guide for quality, it could be based on food safety reasons.if the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind. https://www.fda.gov/media/164194/download?attachment 5. During the kitchen tour on 11/18/25, at 9:56 AM with the Dietary Assistant Supervisor/Cook (DAS), a Delivery Trainee (DT) from the facility's food vendor/distributor was observed inside the kitchen without wearing a hairnet. The DT entered and exited the kitchen twice, and no staff instructed him to wear a hairnet. The DAS confirmed the DT was not wearing a hairnet but should have been.During an interview with the KS on 11/18/25 at 2:05 PM, the KS stated that the vendor's delivery personnel typically wear hats; however, the DT was new and did not wear a hairnet upon entering as expected. The KS stated that had she observed the DT entering the kitchen without a hairnet, she would have stopped him, and that this practice did not meet her expectations.During a concurrent observation and interview On 11/19/25 at 10:49 AM, the Director of Nursing from a sister company of the facility (DON) was observed exiting the kitchen without wearing a hairnet. When asked what he had been (continued on next page)		

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

Printed: 07/18/2026
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 11/21/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doing in the kitchen, he stated he took snacks (Jell-O) for a resident and was observed holding Jell-O cups and plastic spoons. The DON stated that no one instructed him to wear a hairnet upon entering the kitchen. During a concurrent observation and interview with DAS and the RD on 11/19/25 AT 10:53 AM, the DAS stated he would be preparing the pureed dish for the day. It was observed that his mustache was not covered by his beard-net. At 10:58 AM, after the DAS completed preparation of the pureed dish, the RD confirmed that the DAS's beard was covered but his mustache remained uncovered. During an interview with the KS and RD on 11/19/25 at 11:00 AM, the KS stated that the risk of not wearing a hairnet was that hair may fall into food and acknowledged that the facility failed to stop individuals from entering the kitchen without appropriate hair coverings. The RD stated that all hair, including facial hair, must be fully covered. A review of the facility's policy titled, Food Preparation and Service revised October 2017 indicated .23. Food and nutrition services staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that the hair does not contact food .		

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 11/21/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective Infection Prevention and Control Program for a census of 82 residents when: 1. Resident 7's Contact Precautions (a set of measures used to prevent the spread of germs through direct or indirect physical contact) were discontinued without physician involvement, failing to apply Enhanced Barrier Precautions (EBP - Extra safety that healthcare workers take to prevent spreading infections) when indicated, 2. Facility staff did not perform hand hygiene during resident care; and, 3. Licensed Nurse (LN) 5 did not sanitize the medication tray and blood pressure cuff during medication administration in between resident use. These failures placed staff, visitors and other residents at increased risk for transmission of infection and other multidrug-resistant organisms (MDROs - bacteria that are resistant to many antibiotics). Findings: 1. A review of Resident 7's admission RECORD, indicated that Resident 7 was admitted to the facility in 2025 with diagnoses including metabolic encephalopathy (brain is not working properly because of a problem somewhere else in the body), osteomyelitis (infection in the bone), methicillin resistant staphylococcus aureus infection, and acute kidney failure (kidneys suddenly stop working correctly, causing waste to build up in the blood) among others. A review of Resident 7's Brief Interview for Mental Status (BIMS, an assessment tool), dated 10/30/25, revealed a score of 15 out of 15 total points, indicating Resident 7 had normal memory, thinking, and understanding abilities. A review of Resident 7's hospital Discharge summary, dated 10/15/25, indicated, . Skilled Nursing Facility [SNF] Transfer Orders. Isolation Type: Contact [to come into physical connection with something or someone] due to MRSA. Medication Orders for SNF: . Linezolid [antibiotic] 600 mg oral tablet. 1 Tab [tablet] , ORAL, Q12H [every 12 hours], X 28 Days [medicine is to be taken for 28 days]. A review of the facility's Order Details, for Resident 7 dated 10/16/25, indicated the resident was placed on . CONTACT PRECAUTION SECONDARY TO DX [Diagnosis]: MRSA POSITIVE TO BILATERAL [both side of the body] BKA [below the knee amputation] WOUND. Start date: 10/16/25. End date: 11/13/25 [Duration: 28 days]. A review of Resident 7's Care plan Report, dated 10/16/25, indicated, . Focus - Contact Isolation Required: Resident requires Contact Isolation precaution r/t [related to] MRSA in BL [bilateral] BKA. Goal - Contact isolation precaution will be followed during high contact activities through next review date. Intervention/Tasks - Place Contact Isolation notifications/signage near resident room/doorway to alert staff and visitors of precautions. During a concurrent observation and interview on 11/20/25, at 8:48 AM, with Resident 7 in her room, no isolation signage was posted at her door. Resident 7 stated that she had been in a private hospital room because she had MRSA on her right leg wound and she was placed on contact isolation when she first came to the facility. She stated the isolation was removed after she finished her antibiotic treatment. During a concurrent interview and record review on 11/20/25, at 9 AM, the IP stated that Resident 7 had been on contact precaution from 10/15/25 to 11/13/25 due MRSA of the right lower limb wound and that he removed the isolation signage on 11/13/25 because she had completed her course of Linezolid (antibiotic) according to the physician's signed admission order. A review of the Infectious Disease doctor's note titled, Infectious Disease - consult dated 11/6/25, indicated Resident 7 was evaluated via audio-video visit and that she, . presents as referral for newly diagnosed osteomyelitis and nonhealing lower extremity wound on R [right] stump [remaining part of the limb after an amputation (cutting off a body part)] s/p [after] BKA. Pt has remained on linezolid for almost 6 weeks in the setting of osteomyelitis. Plan: 1. Obtain repeat MRI with and w/o [without] contrast of lower extremity, ESR and CRP [blood tests]; 2. Return in 4 weeks. During a phone interview on 11/21/25 at 10:53 AM, with the facility's Medical Doctor (Physician), the Physician stated she did not receive any documentation or text messages from the facility regarding discontinuation of contact isolation for Resident 7. She stated she did not recall anyone from the facility asking her to discontinue isolation. The Physician further stated that (continued on next page)		

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 11/21/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given the resident's case, it would have been better for staff to ask her to reassess the resident and consider whether EBP should have been implemented. During an interview on 11/21/25, at 11:54 AM, with the IP, the IP stated he believed Resident 7 did not require reassessment prior to discontinuation of isolation because the requires reassessment box on the contact isolation document titled, Order Details dated 10/16/25 was not checked. He stated he removed isolation after the resident finished her antibiotic treatment and did not believe he needed to notify the physician because the admission order already listed 11/13/25 as the isolation stop date. The IP stated Resident 7 did not receive MRSA re-testing after finishing antibiotics and therefore the facility had no way of knowing whether the resident still had an active MRSA infection or colonization (the person carries the bacteria, but they are not sick).The IP also acknowledged he did not document contacting the local health department for guidance after the resident completed antibiotics and stated he did not call the facility physician because doctors are hard to talk to, but admitted he should have contacted her for guidance.During a follow-up interview on 11/21/25, at 2:09 PM, with IP, the IP stated he was responsible for updating the isolation care plan. He further stated that he felt like he updated the care plan but apparently did not. A review of the facility's policy titled, Isolation - Categories of Transmission-Based Precautions, revised on September 2022, indicated .Contact precautions are used for residents infected or colonized with MDRO's.when a resident has wounds.the decision on whether contact precautions are necessary are evaluated on a case by case basis.Review of the facility's policy titled, Multidrug-Resistant Organism revised in August 2019 indicated .Identify persons with experience in infection control and the epidemiology of MDRO, either in house or through outside consultation, for assessment of the local MDRO problem and for the design, implementation, and evaluation of appropriate control measures. Implement contact precaution routinely for all residents colonized or infected with a target MDRO.Review of the facility's policy titled, Enhanced Barrier Precautions dated August 2022 indicated .Enhanced barrier precautions (EBP's) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDROs) to residents.EBP's are indicated.for residents infected or colonized with.MRSA.EBP's are indicated.for residents with wound.Review of facility's policy titled, Care Plans, Comprehensive Person-Centered revised on March 2022 indicated, .Care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Infection Control, Section III. Precautions to prevent Transmission of Infectious Agents, subsection III.D discontinuation of Transmission Based Precautions. dated 11/22/23 indicated .Transmission-Based Precautions remain in effect for limited periods of time.colonization with.MRSA.can persist for many months, especially in the presence of severe underlying disease. It may be prudent to assume that MDRO carriers are colonized permanently and manage them accordingly. https://www.cdc.gov/infection-control/hcp/isolation-precautions/precautions.htmlReview of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated June 2021 indicated .Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: wounds.regardless of MDRO colonization status. https://www.cdc.gov/infection-control/media/pdfs/enhancedbarrierprecautions-508.pdf?CDC_AAref_Val=https://www.cdc.gov/infection-control/media/pdfs/enhancedbarrierprecautions-508.pdfReview of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Long-term Care Facilities (LTCF's): Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes dated 6/18/24 indicated .As part of Standard Precautions, which apply to the care of all residents, the use of PPE [personal protective equipment] is based on the 'anticipated exposure' to blood, body fluids, secretions, or excretions.Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been (continued on next page)		

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 11/21/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition. Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities. wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. Enhanced Barrier Precautions are intended to be used for residents colonized or infected with novel. MDROs or MDROs targeted by CDC. Residents colonized with a novel or targeted MDRO are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because MDRO colonization is typically prolonged and follow-up testing to determine clearance may yield false negatives. In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html2a. During an observation on 11/18/25, at 9:20 a.m., Housekeeper (HK) 1 came out of room [ROOM NUMBER], with trash in her hands and placed it in the housekeeping trash outside of the room. HK 1 did not change her gloves or sanitized her hands, touched the door with her dirty gloves, and went back into room [ROOM NUMBER].During a joint interview on 11/18/25, at 09:22 a.m., with HK 1 and Licensed Nurse (LN) 1, HK 1 stated she should have changed her gloves after leaving the room and when going back in, for risks of cross contamination and to prevent the spread of infection.2b. During an observation on 11/20/25, at 9:44 a.m., Certified Nursing Assistant (CNA) 4 came out of a resident room, with gloved hands and holding a clear trash bag containing a dirty urinal with brownish urine content in it. CNA 4 walked down the hallway with the trash in one hand, then placed the trash in a large grey trash bucket in the hallway, removed her one glove, walked to nursing station 2, and then touched a binder at the table without hand hygiene.During an interview on 11/18/25, at 9:48 a.m., CNA 4 stated the best practice was to have tied the bag to contain the trash. CNA 4 stated it was more sanitary to tie the trash bag to prevent cross contamination, and that she should have performed hand hygiene prior to going to the nursing station.2c. During a concurrent observation and interview on 11/19/25, at 11:28 a.m., with LN 4, LN 4 went into Resident 82's room two times, came back out to the medication cart and did not hand sanitize prior to prepping and administering Resident 82's medication. LN 4 stated she should have hand sanitized prior to giving Resident 82's medication and prior to entering resident's room for cross contamination and infection prevention.During an interview on 11/18/25, at 9:24 a.m., with the Infection Preventionist (IP), the IP stated it was the facility policy for no gloves in the hallway, to prevent the spread of infection, so that staff were not contaminating other surfaces and patients.3. During a medication observation on 11/20/25, at 8:27 a.m., with LN 5, LN 5 came out of room [ROOM NUMBER], that had a sign posted outside of the door indicating Enhanced Barrier Protection (EBP), meaning resident is on isolation precaution for an MDRO. LN 5 placed the soil med tray on top of the medication cart, removed her gown and gloves, and did not sanitize her hands or sanitized the med tray before prepping and administering medications for Residents 37. LN 5 took the blood pressure machine into Resident 37's room, checked Resident 37's blood pressure and then placed the used blood pressure machine on top of the medication cart.During a subsequent observation on 11/20/25, at 8:44 a.m., LN 5 did not sanitize the medication cart surface prior to placing the med cups with medications, on top of the med cart for Resident 37.During an interview on 11/20/25, at 8:52 a.m., with LN 5, LN 5 confirmed she had come out of room [ROOM NUMBER] which was on EBP and did not sanitize the medication tray prior to administering medications to Resident 37. LN 5 stated she should have sanitized the medication cart after she had placed the used med tray and soiled blood pressure machine on top of the medication cart and prior to starting medication pass for Resident 37 to prevent cross contamination, spreading germs & bacteria.During an interview (continued on next page)		

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 11/21/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/20/25, at 10:01 a.m., with the Director of Nursing (DON), the DON stated staff were expected to disinfect in between residents for infection control. The DON further stated staff did not know what the patient had for example, Urinary Tract Infection (UTI), and other bacteria, and if they were not cleaning equipment in between residents, they could risk cross contamination. During an interview on 11/20/25, at 10:26 a.m., with the IP, the IP stated the expectation was for all staff to sanitize in between resident care, and when entering and leaving the resident's room. The IP further stated nursing staff should clean residents' equipment in between residents, to stop the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene Policy Statement, dated 2019, the P&P indicated, .The facility considers hand hygiene the primary means to prevent the spread of infection .1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors.7. Use an alcohol-based rub containing at least 62% alcohol; or; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations.b. before and after direct contact with residents.c. Before preparing or handling medication. j. After contact with blood or bodily fluids.l. After contacts with objects (e.g., medical equipment) l the immediate vicinity of the resident; after.9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .During a review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 2022, the P&P indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.c. Non-critical items are those that come in contact with intact skin but not mucous membranes.(1). Non- critical resident-care items include bedpans, blood pressure cuffs, crutches and computers.5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) .		

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 11/21/2025
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of 1 out of 22 sampled residents (Resident 57) when Resident 57's call light (device used to contact staff for assistance) was not within her reach. This deficient practice placed Resident 57 at increased risk for unmet care needs, delayed staff response, and potential for accidents or injury. Findings: A review of Resident 57's admission RECORD, indicated Resident 57 was admitted to the facility with a diagnosis of, but not limited to cerebral infarction (condition that occurs when the blood flow to the brain is blocked), epilepsy (brain condition characterized by seizures), and muscle weakness. During a concurrent observation and interview on 11/18/25, at 2:49 PM, with Resident 57, in Resident 57's room, Resident 57's call light was observed lying on the right lower leg area. Resident 57 attempted to reach her call light but was unable to extend her left arm enough to access it. Resident 57 nodded and stated Yes when asked how important her call light to be within her reach. During a concurrent observation and interview on 11/18/25, at 2:53 PM, with Licensed Nurse (LN) 6 in Resident 57's room, LN 6 confirmed Resident 57 was unable to reach her call light. LN 6 stated Resident 57's call light should always be within reach. LN 6 stated Resident 57 could not get help with potential to compromise her safety if the call light not within reach. During a review of Resident 57's clinical record titled, Care Plan Report, dated 5/6/25, the record indicated, .Focus: Resident is at risk for fall related to unsteady gait .Interventions. Resident's call light is within reach. use it for assistance .During an interview on 11/21/25, at 9:22 AM, with Certified Nurse Assistant (CNA) 7, CNA 7 stated Resident 57 preferred her call light positioned between her chest and stomach area together with Resident 57's phone charger. CNA 7 further stated Resident 57 cannot call for assistance if her call light was not within reach. During an interview on 11/21/25, at 1:50 PM, with the Director of Nursing (DON), the DON stated it was her expectation that the call light should be placed within Resident 57's reach at all times. Resident 57 was at increased risk for unmet needs if her call light was kept not within her reach. Review of a facility policy and procedure titled, Answering the Call Light, revised 9/22, indicated, .The purpose of this procedure is to ensure timely responses to the resident's request and needs. Ensure that the call light is accessible to the resident when in bed.		

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 11/21/2025
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain a safe and home-like environment for 1 out of 22 sampled residents (Resident 108) when Resident 108's privacy curtain was found not properly secured and functioning. This deficient practice had the potential to compromise Resident 108's privacy and dignity during care. Findings: During a concurrent observation and interview on 11/18/25, at 11:06 AM, in Resident 108's room, Resident 108 was observed lying in bed with her window curtain hanging down because three hooks were loose. Resident 108 stated the window curtain needed to be fixed and that she already told the staff about it. During an interview on 11/18/25, at 11:11 AM, in Resident 108's room, with Licensed Nurse (LN) 4, LN 4 confirmed that the window curtain needed to be repaired. During an interview on 11/19/25, at 8:28 AM, in Resident 108's room, Resident 108 stated she told the staff that her curtain needed to be fixed, but no one had come to repair it. Resident 108 stated it would be much better if someone fixed it, and that the curtain doesn't look good the way it is now. During an interview on 11/19/25, at 8:35 AM, in Resident 108's room, with LN 1, LN 1 confirmed that the curtain was not working and had not been repaired. LN 1 stated she expected someone to have already come to fix it. LN 1 further stated the broken curtain was a safety and privacy issue, and that the curtain could fall on Resident 108. During an interview on 11/21/25, at 8:52 AM, with Certified Nurse Assistant (CNA) 8, CNA 8 stated that Resident 108's window curtain was very important, especially when providing peri-care and changing Resident 108's brief, because it protected Resident 108's privacy, comfort and dignity. During an interview on 11/21/25, at 1:50 PM, with the Director of Nursing (DON), the DON stated she expected staff to report Resident 108's curtain problem in the maintenance logbook. The DON stated it was important to keep Resident 108's window curtain working and functional to protect Resident 108's privacy during care. The DON further stated that not fixing the curtain put Resident 108 at risk of not having her privacy and dignity respected. Review of a facility policy and procedure titled, Homelike Environment, revised 2/21, indicated, .Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment.2. The facility staff and management maximize the characteristics of the facility that reflect a personalized, homelike setting.a. clean, sanitary and orderly environment.		

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 11/21/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy and completeness of the Minimum Data Set (MDS - tool that measures health status in nursing home residents) assessment for 1 out of 22 sampled residents (Resident 59) when Resident 59's physician ordered antidepressant medication was not captured during MDS assessment. This deficient practice had the potential to result in Resident 59's inaccurate clinical assessments and care planning. Findings: A review of Resident 59's admission RECORD, indicated Resident 59 was admitted to the facility with a diagnosis of, but not limited to major depressive disorder (mood disorder characterized by persistent feelings of sadness and loss of interest that interfere with daily life), and anxiety disorder (mental health condition characterized by persistent and excessive worry, fear, or panic that is difficult to control and interferes with daily life). During a concurrent interview and record review on 11/19/25, at 10:50 AM, with the MDS Nurse, the MDS Nurse confirmed that Resident 59 was prescribed Prozac (fluoxetine - an antidepressant medication) by the physician on 3/13/23 for depression. The MDS Nurse stated the record review showed Resident 59 had an active physician order for Prozac oral capsule 20mg (milligrams), give 1 capsule by mouth in the morning for depression manifested by worried facial expression during the MDS assessment reference period dated 9/18/25. The MDS Nurse further stated that part of the process was to check the Medication Administration Record (MAR - used to record all medications given to a patient) and make sure it was administered to Resident 59. After reviewing the MAR, the MDS Nurse confirmed that the antidepressant medication was administered during September 2025 as ordered throughout the assessment timeframe. The MDS Nurse stated record review of the completed MDS Section N (Medications) revealed that Resident 59's antidepressant medication was not coded, despite being administered during the look-back period. The MDS Nurse further stated that the antidepressant medication for Resident 59 should have been captured in the MDS assessment. The MDS Nurse confirmed that failing to capture the antidepressant medication in the MDS assessment led to an inaccurate assessment and this error could impact care planning, quality measures, and facility reporting. During an interview on 11/21/25, at 1:50 PM, with the Director of Nursing (DON), the DON stated that MDS Nurses must assess Resident 59 accurately in the MDS. The DON stated the importance of capturing psychotropic (affects the mind, emotions, and behavior) medications, like antidepressants, in Section N of the MDS assessment, especially during quarterly evaluations. The DON stated that accurate assessment and coding were important for care planning, quality measures, and facility reporting. Review of a facility policy and procedure titled, Resident Assessments, revised 3/22, indicated, .3. A comprehensive assessment includes a. completion of the Minimum Data Set (MDS); b. completion of the care area assessment (CAA) process, and c. development of the comprehensive care plan. 8. All persons who have completed MDS resident assessment form must sign the document attesting to the accuracy of such information. 9. The results of the assessment are used to develop, review, and revise the resident's comprehensive care plan.		

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 11/21/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to implement a care plan intervention for 2 out of 22 sampled residents when:1. A care plan intervention of providing food to resident during and after the dialysis session was not implemented for Resident 106; and2. Weights were not checked monthly for Resident 3 and Resident 10 and the MD (medical doctor) and RP (responsible party) were not notified. These failures has the potential to place Resident 106 at risk for weight loss, Resident 3, and Resident 10 at risk for undetected weight loss, and for not receiving effective and person-centered care.Findings: 1. A review of Resident 106's admission RECORD indicated Resident 106 was admitted to the facility with diagnoses of, but not limited to, End stage renal disease (ESRD-the final stage (Stage 5) of chronic kidney disease), acute kidney failure (sudden kidney failure), dependence on renal dialysis (a medical treatment taking 3-4 hours, usually 3 times per week, that filters waste, toxins, and extra fluid from your blood when your kidneys fail). During a concurrent observation and interview on 11/18/25, at 11:57 AM, with Resident 106, a sandwich in a resealable plastic bag was observed on Resident 106's bedside table. Resident 106 stated that she had requested packed snacks from the staff for her dialysis session today because she might get hungry again and they did not provide her food the last time she went for dialysis. During an interview on 11/20/25, at 2:12 PM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated when a resident goes to dialysis, staff prepare packed food for the resident to take with them. During an interview on 11/20/25, at 2:26 PM, CNA 3 stated that a resident needed to request snacks if they wanted them prior to leaving the facility. During an interview on 11/20/25, at 2:58 PM, with the Director of Staff Development (DSD), the DSD stated it was part of their protocol to have packed snacks for the residents when they go for a dialysis session. The DSD stated it was the kitchen staff's responsibility to pack the snacks for the residents on their dialysis days, and the CNAs were supposed to get the packed food from the kitchen. During an interview on 11/21/25, at 9:02 AM, with the Kitchen Supervisor (KS), the KS stated if the resident prefers to eat his or her food outside, they will provide the packed lunch. KS stated in their diet system, they have a list of residents on dialysis and their schedule. KS stated the standard was to give the residents on dialysis a sack lunch before they leave the facility for their dialysis session. KS stated that the kitchen staff prepares the sack lunch, and the CNAs will pick up the packed food for the residents that were going to dialysis. During an interview on 11/21/25, at 9:32 AM, with Resident 106, Resident 106 stated she left for a dialysis appointment yesterday and she did not get the packed snacks. Resident 106 stated she did not asked the staff for the packed snacks and the staff did not provide it either. During a concurrent interview and record review on 11/21/25, at 2:22 PM with the Director of Nursing (DON), the DON stated the residents on dialysis were supposed to have a sack lunch before leaving for dialysis, the CNAs and nurses were the ones responsible to get the sack lunch from the kitchen. The DON stated if the resident had no food, the resident would get hungry, and it could lead to weight loss. The DON confirmed that there was an order and a care plan to provide a sack lunch to Resident (continued on next page)		

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 11/21/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	106 on dialysis days. The DON confirmed that the care plan and order was not followed. The DON stated that the importance of the care plan was to reflect the plan of care for the resident and to use it as a guide on how to provide care for the resident. A review of Resident 106's Order Details dated 11/14/25, indicated, .DIALYSIS: Provide sack lunch to resident per their schedule . A review of Resident 106's Care Plan Report, dated 11/19/25, indicated, .[Resident 106] needs dialysis r/t [related to] ESRD, kidney disease, renal failure . Care Plan interventions includes, .Provide brown bagged food for patient while out for Dialysis . A review of the facility's undated policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, the P&P indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.2. Education and training of staff includes, specifically: a. the nature and clinical management of ESRD (including infection prevention and nutritional needs).4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. how the care plan will be developed and implemented.5.The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. 2a. A review of Resident 10's admission RECORD indicated Resident 10 was admitted to the facility with diagnoses of Moderate Protein-Calorie Malnutrition (not eating enough), Dysphagia (difficulty swallowing), and Adult failure to Thrive (overall physical and mental decline in older adults). A review of Resident 10's Care Plan Report dated 11/21/25, indicated, Resident 10 was non-compliant with care/treatment: Weights. Care plan interventions included,. Notify physician of difficulties.Notify responsible party of refusal and or non-compliance . A review of the facility provided documents titled, Monthly Weights, dated 10/1/25 and 11/1/25, indicated, RX3 (refused three times) written in front of Resident 10's name. A review of the facility provided record, titled Weights and Vitals Summary dated 11/21/2025, indicated last time Resident 10's weight was checked was on 06/01/2024. 2b. A review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility with diagnoses of schizophrenia (a chronic brain disorder causing distorted thinking, disorganized speech/behavior, and reduced emotional expression), the need for assistance with personal care, and dysphagia. A review of the facility provided record, titled Weights and Vitals Summary dated 11/21/2025, indicated the last time the Resident 3's weight was checked was on 09/02/2025. A review of facility provided documents titled, Monthly Weights, dated 10/1/25 and 11/1/25, indicated, RX3 written in front of Resident 3's name. A review of Resident 3's record titled, Care Plan Report dated 08/30/2024, indicated, .Resident is non-compliant with care m/b[manifested by]. refusing weights. Care plan interventions included, .Notify resident representative. (continued on next page)		

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

Printed: 07/18/2026
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 11/21/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 3's record titled, Care Plan Report dated 08/30/2024, indicated, .Resident is at nutritional risk r/t [related to] intermittent weight measurement refusals. Care plan interventions included, .Notify MD of significant wt [weight] changes. During an interview with Restorative Nurses Assistant (RNA) on 11/20/25, at 12:03 p.m., the RNA stated that she checked the weights of residents of the facility at the beginning of each month. The RNA stated Resident 10 and Resident 3 refused to get their weights checked. RNA further stated, she tries 3 times to check the weight, and if the resident still refuses, she puts RX3 on the sheet and hands it to the charge nurse. During a concurrent interview and record review with Licensed Nurse (LN) 6, on 11/20/25, at 12:20 p.m., the LN stated, if there was a weight refusal by the resident, we would notify the family and the doctor. LN 6 further stated, by checking both the residents' medical records, that there was no documentation that the residents' families or the doctors were notified. LN 6 also stated that notification should have been done and documented, as this puts residents at risk for unknown weight loss or gain and it was important to weigh and notify the family and doctor to provide appropriate care. During a concurrent interview and record review on 11/21/25, at 11:10 a.m., with the Director of Nursing (DON), the DON stated missed weights and notifications put the resident at risk of missed care, and facility staff would not know if the resident was gaining or losing weight which can result in malnutrition/dehydration.		

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 11/21/2025
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 7) comprehensive care plan was revised when Resident 7 was taken off of contact isolation precautions (infection control measures such as hand washing and wearing gloves, gowns, and masks used in healthcare when caring for a resident to prevent the spread of germs), but her comprehensive care plan was not updated to reflect the change. This failure placed Resident 7 at risk for staff providing care based on inaccurate information, inconsistent implementation of interventions, miscommunication across shifts and disciplines, and potential errors during emergency care, due to the care plan not reflecting the resident's current condition. Findings: A review of Resident 7's admission RECORD, indicated, Resident 7 was admitted to the facility with diagnoses including Osteomyelitis (infection in the bone) and Methicillin Resistant Staphylococcus Aureus Infection (MRSA-a contagious type of bacteria that can cause infections and is hard to treat with usual antibiotics). A review of Resident 7's Brief Interview for Mental Status (BIMS, an assessment tool), dated 10/30/25, revealed a score of 15 out of 15 total points, indicating Resident 7 had normal memory, thinking, and understanding abilities. A review of Resident 7's Order Details dated 10/16/25 indicated, . CONTACT PRECAUTION [SECONDARY TO DX [Diagnosis]: MRSA POSITIVE TO BILATERAL [both side of the body] BKA [below the knee amputation] WOUND. Start date: 10/16/25. End date: 11/13/25 [Duration: 28 days]. A review of Resident 7's Care plan Report dated 10/16/25, indicated, . Focus - Contact Isolation Required: Resident requires Contact Isolation precaution r/t [related to] MRSA in BL [bilateral]] BKA. Goal - Contact isolation precaution will be followed during high contact activities through next review date. Intervention/Tasks - Place Contact Isolation notifications/signage near resident room/doorway to alert staff and visitors of precautions. During a concurrent observation and interview with Resident 7 inside her room on 11/20/25 at 8:48 AM, no isolation signage was noted by her door. Resident 7 stated the staff took away her isolation status because she finished her antibiotics. During a concurrent interview and record review on 11/20/25 at 9:00 AM with the Infection Preventionist (IP), the IP stated that Resident 7 was placed on contact isolation precaution from 10/15/25 through 11/13/25 for MRSA on her right lower limb wound and that the isolation precaution was removed after completing the antibiotic course per facility policy. During a follow-up interview with the IP on 11/21/25 at 2:09 PM, the IP stated he was responsible for updating the isolation care plan. He further stated that he felt like he updated the care plan but apparently did not. A review of facility's policy titled, Care Plans, Comprehensive Person-Centered revised on March 2022 indicated, . Care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.		

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 11/21/2025
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to follow professional standards of practice for the use of an indwelling urinary catheter (a thin, flexible tube left inside the bladder for continuous urine drainage into a bag, held in place by a small, water-filled balloon at the tip, allowing for long-term or short-term use) for 1 of 7 residents with an urinary catheter (Resident 1) when Resident 1's urinary bag was positioned improperly. This failure had the potential to cause Resident 1 to have complications related to the use of an indwelling urinary catheter. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses including retention of urine and obstructive and reflux uropathy (a blockage in the body that makes it difficult or impossible to urinate). During a concurrent observation and interview on 11/18/25, at 10:25 a.m., with Licensed Nurse (LN) 2 and Licensed Nurse Consultant (LNC), LN 2 confirmed Resident 1's urinary catheter was placed on the upper bedside rail above the resident's bladder level. LN 2 stated Resident 1's urinary catheter should have been placed at the lower part of the bed to prevent urine backflow into his bladder, preventing a urinary infection (UTI). During an interview with on 11/18/25, at 10:57 a.m., with the Infection Preventionist (IP), the IP stated residents' catheters needed to be placed below the level of their bladder to prevent urine backflow, so that tubing had no kinks, it flowed naturally with gravity, and that fluid was not stagnant in the catheter tubing. The IP further stated by not doing so, there were higher chances of bacteria growth and potential infection. Review of the facility policy and procedure titled, Catheter Care, Urinary, with a revised date on August 2022, indicated, .Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder .		

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 11/21/2025
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to provide appropriate care for one of one resident (Resident # 6) requiring tube feeding (method of providing nutrients via a tube directly into the stomach or intestine when a person is unable to eat by mouth) when Resident 6's head of bed was not at the prescribed elevated angle. This failure had the potential for Resident 6 to have complications related to tube feedings such as aspiration (when food goes into the lungs instead of the stomach), pneumonia (infection of the lungs), and possible hospitalization. Findings: During a review of Resident 6's clinical record titled, admission Record, the record indicated Resident 6 was admitted to the facility in 5/25 with diagnoses which included dysphagia (difficulty swallowing foods or liquids) and the presence of a gastrostomy (a tube that is surgically inserted into the resident's stomach to allow access for food, fluids, and medications). During an observation in Resident 6's room on 11/18/25 at 10:20 a.m., Resident 6's head of the bed was noted to be almost flat while the tube feeding was being administered. During a concurrent observation and interview on 11/18/25 at 10:35 a.m., with the Certified Nursing Assistant (CNA), in Resident 6's room, CNA1 confirmed Resident 6's head of bed was down too low and it should have been placed at a higher angle. During an interview with the Director of Nursing (DON) on 11/18/25 at 10:42 a.m., the DON acknowledged Resident 6's head of bed was too low. The DON stated she expected the head of bed to be between 30 and 45 degrees while Resident 6 received tube feedings. The DON further stated the risks involved by not having the head of bed at correct height put the Resident 6 at risk of aspiration, which could lead to pneumonia, and possible hospitalization. Review of Resident 6's care plan dated 05/20/25, indicated, . Keep HOB 30-40 degrees during feedings. Review of Resident 6's physician orders, dated 07/08/2025, indicated, . Elevate HOB 30-45 degrees when feeding is on. Review of the facility policy titled, Enteral Tube Feeding via Continuous Pump, revised 11/18, indicated, .4. Position the head of the bed at 30 - 45 (semi-Fowler's position) for feeding, unless medically contraindicated.		

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 11/21/2025
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure 1 of 18 sampled residents (Resident 106) who required hemodialysis (HD/dialysis, a medical procedure that helps remove waste and excess fluid from the blood when the kidneys are unable to perform this function), received services consistent with professional standards of practice when Resident 106 was not provided meals during and after dialysis sessions. This failure has the potential to cause complications including weight loss for residents on dialysis. Findings: A review of Resident 106's admission RECORD, indicated Resident 106 was admitted to the facility with a diagnosis of, but not limited to, end stage renal disease (when the kidneys are permanently damaged and can no longer filter waste, fluids, and electrolytes from the blood effectively), acute kidney failure (the sudden and rapid loss of the kidneys' ability to filter waste from the blood, balance fluids, and regulate electrolytes), and dependence on renal dialysis (medical treatment that acts like artificial kidneys). During a concurrent observation and interview on 11/18/25, at 11:57 AM, with Resident 106, Resident 106 stated she went for a dialysis session last Saturday and when she got back to the facility, she did not have a meal tray left for her. Resident 106 stated she told her family member that she was hungry, and her family member bought her food from outside. A sandwich in a resealable plastic bag was observed on Resident 106's bedside table, Resident 106 stated that she had requested packed snacks from the staff to take to her dialysis session today because she might get hungry again and they did not provide her food the last time she went for dialysis. During an interview on 11/20/25, at 2:12 PM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated when a resident went to dialysis, they have a packed food for the resident. CNA 2 stated that they could get the meal tray early from the kitchen so that the resident could eat before going to the dialysis. CNA 2 stated that if a resident returned from dialysis after meal times, they should ask if the resident wanted to eat but the staff could not heat the food in the microwave. CNA 2 stated that residents could request new food, and the kitchen staff would prepare it for them. During an interview on 11/20/25, at 2:26 PM, CNA 3 stated that when residents return from their dialysis sessions, it was her responsibility to take their vital signs, weigh them, and ensure the kitchen staff has a meal ready for them and if mealtime had already passed, the kitchen staff will keep their meal. CNA 3 stated that CNAs usually request an early meal tray from the kitchen staff before the resident leaves for an appointment or dialysis. CNA 3 stated that the resident would have to request for snacks if they want prior to leaving the facility. CNA 3 stated that Resident 106 came from the dialysis around 9 PM or 10 PM last Saturday and the kitchen was already closed. CNA 3 stated that if it was late, sandwiches were the only available food and when the resident returned from dialysis at that time, she only wanted coffee. During an interview on 11/20/25, at 2:58 PM, with the Director of Staff Development (DSD), the DSD stated that the CNAs were supposed to ask the kitchen staff for the meal tray early if the residents were leaving for a dialysis session before the scheduled mealtimes. The DSD stated that the staff were supposed to leave the food in the cart to stay warm during meal pass if the resident has not returned yet from the dialysis. The DSD also stated that when the resident comes back after the meal tray had been passed, the resident should be offered with food. The DSD stated sometimes the resident does not want to eat if the food was not warm enough and the staff were not allowed to reheat the food. The DSD stated that the staff could go to the kitchen and there could be an extra food, or the kitchen staff can make a new plate for the resident. The DSD stated it is part of their protocol to have a packed snacks for the residents when they go for a dialysis session. The DSD stated it is the kitchen staff's responsibility to pack the snacks for the residents on dialysis, and the CNAs were supposed to get the food snacks from the kitchen. During an interview on 11/21/25, at 9:02 AM, with Kitchen Supervisor (KS), KS stated if the resident was leaving before mealtime and the resident prefers to eat early, the nursing staff will provide a pink slip to the kitchen staff which was a request for an early tray, and when the tray is ready, the kitchen staff will page that the tray is ready for pickup. KS (continued on next page)		

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 11/21/2025
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if the nursing staff did not provide the pink slip, they do not provide an early tray. KS stated if the resident prefers to eat his or her food outside, they will provide the packed lunch. KS stated in their diet system, they have a list of residents on dialysis and their schedule. KS stated the standard was to give the residents on dialysis sack lunch before they leave the facility for their dialysis session. KS stated kitchen closes at 8PM but they have a cart for nourishments, that has names of resident with evening snacks. KS stated not all residents has evening snacks, it is per request or per order. KS stated that they have extra snacks in the nourishment cart without names and the nurses has a key to the kitchen, and they can come anytime. KS stated she expects her staff to save the meal tray for 2 hours for the residents on dialysis if the resident was still out of the facility during mealtimes, but beyond 2 hours, they need to offer sandwiches and discard the meal tray. KS stated that she expects the kitchen staff to provide snacks with resident name and room number and once the CNAs go to the nourishment cart, they will see the resident's name. KS stated that the kitchen staff prepares the sack lunch, and the CNAs will pick up the packed food for the residents that were going to dialysis. KS stated it was the kitchen staff's responsibility to prepare the snacks, and it was the CNA's responsibility to pick up the snacks for the residents. During an interview on 11/21/25, at 9:32 AM, with Resident 106, Resident 106 stated she left for dialysis appointment yesterday and she did not get the packed snacks. Resident 106 stated she did not asked the staff for the packed snacks and the staff did not provide it as well. During an interview on 11/21/25, at 10:36 AM, with the Director of Staff Development (DSD), the DSD stated if the resident would come back before 8 PM, she expected the CNAs to get food from kitchen which was open until 8 PM and ask the kitchen staff if they have a hot meal or snacks like a sandwich for the resident. The DSD stated the kitchen staff could still cook for the resident when the resident comes back from the dialysis. The DSD stated the resident needed to eat, and the facility did not want the resident to lose weight. The DSD stated if the resident arrived at the facility after 8 PM, and the meal tray was not available anymore, they would have extra snacks without labelled names from the kitchen, and she expected the CNAs to grab a snack for the resident. During a concurrent interview and record review on 11/21/25, at 2:22 PM with the Director of Nursing (DON), the DON stated the residents on dialysis were supposed to have sack lunch before leaving for dialysis, the CNAs and nurses were the ones responsible to get the sack lunch from the kitchen. The DON stated Resident 106 should have food when she came back after her dialysis. Resident 106's medical record was reviewed with the DON, the document out on pass indicated that Resident 106 came back to the facility at around 8:30 PM, the DON stated the kitchen was already closed. The DON stated the staff could not keep the food for more than 2 hours, but they have nourishments available. The DON stated she expected the staff to offer the snacks when the meal tray was not available anymore. The DON stated if the resident had no food, the resident would get hungry, and it can lead to weight loss. A review of Resident 106's Order Details dated 11/14/25, indicated, DIALYSIS: Provide sack lunch to resident per their schedule. A review of Resident 106's Care Plan Report, dated 11/19/25, indicated, Resident 106 needs dialysis r/t [related to] ESRD, kidney disease, renal failure. Care Plan interventions includes, .Provide brown bagged food for patient [resident] while out for Dialysis. A review of the facility's undated policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, the P&P indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Education and training of staff includes, specifically: a. the nature and clinical management of ESRD (including infection prevention and nutritional needs).		

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 11/21/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe medication management for 1 out of 22 sampled residents (Resident 21) when Resident 21's saline nasal spray was allowed to remain at Resident 21's overbed table without a physician's order for self-administration and without completion of a self-administration assessment. This deficient practice had the potential to result in Resident 21's unsupervised medication use, improper administration, and safety risks. Findings: During a review of Resident 21's admission RECORD, indicated Resident 21 was admitted to the facility with a diagnosis of, but not limited to chronic respiratory failure (long-term condition where the lungs cannot get enough oxygen into the blood), obstructive sleep apnea (a sleep condition where the airway becomes repeatedly blocked during sleep, causing breathing to repeatedly stop and start), abnormalities of gait and mobility, and need for assistance with personal care. During a concurrent observation and interview on 11/18/25, at 2:30 PM, with Resident 21, in Resident 21's room, it was noted that a bottle of saline nasal spray was present on Resident 21's overbed table. The nasal spray bottle was accessible to Resident 21 and was not secured. Resident 21 stated, I use it when my nose gets dry. Resident 21 stated that she used it every day, approximately 3 to 4 times a day or whenever needed. During a concurrent interview and record review on 11/18/25, at 2:55 PM, with Licensed Nurse (LN) 6, LN 6 stated Resident 21's current physician order revealed Deep Sea Nasal Spray Nasal Solution (Saline) 2 sprays in each nostril every 2 hours as needed for nasal dry membrane (tissue lining the inside of the nose). This order was dated 9/2/25. LN 6 indicated that nasal spray was last administered on 10/7/25, according to the Medication Administration Record (MAR - used to record all medications given to a patient) for October 1-31, 2025. LN 6 stated that she was unaware of Resident 21's daily use of the nasal spray. LN 6 reviewed Resident 21's clinical record and found no complete self-administration assessment, and no physician's order for self-administration of the saline nasal spray indicating it was safe for Resident 21 to self-administer the nasal spray. LN 6 stated that Resident 21 was at risk of potential self-harm and overuse of the nasal spray due to the lack of assessment, physician's order, and supervision. During an interview on 11/21/25, at 1:50 PM, with the Director of Nursing (DON), the DON stated it was her expectation that licensed nurses should assess if a resident wants to self-administer physician-prescribed medication. The Interdisciplinary Team (IDT) will conduct the assessment, notify the physician if the resident can safely self-administer the medication, and obtain the necessary order. The DON stated the importance of care planning to ensure it reflects the resident's ability to self-administer medication, and to communicate this update with other team members. Review of a facility policy and procedure titled, Self-Administration of Medications, revised 2/21, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. 6. For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken. 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 12. Nursing staff reviews the self-administered medication record for each nursing shift, and transfers pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered.		

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 11/21/2025
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 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 ensure two of eight sampled residents (Resident 69, Resident 34) medication administration record (MAR) maintained accurate documentation when:1. Licensed Nurse (LN) 4 administered Resident 69's Tylenol and did not document administration in Resident 69's Medication Administration Record (MAR); and2. LN 5 administered Resident 34's Docusate (medication used to relieve occasional constipation, usually helps produce a bowel movement in 12 to 72 hours), but was documented as not given on the MAR.This failure had the potential for residents at risk for medication errors, by getting a double dose of the same medication, risk for injury, and possible hospitalization. Findings:1. During a review of Resident 69's admission RECORD, indicated Resident 69 had a diagnosis of diastolic congestive heart failure (a serious condition in which the heart does not pump blood as effectively as it should), chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial collapse of the upper airway causing oxygen desaturation or sleep arousal), essential hypertension (high blood pressure when the pressure in the blood vessels is too high), and acute kidney failure (a sudden or reversible reduction in kidney function).During an observation on 11/19/25 at 12:17 p.m., with LN 4, LN 4 administered Tylenol 650 mg by mouth to Resident 69 for pain.During a concurrent interview and record review on 11/20/25, at 2 p.m., of Resident 69's MAR with LN 4, LN 4 confirmed she administered Tylenol 650 mg for pain and did not document on Resident 69's MAR. LN 4 stated it was important to document any medication administration, especially the Tylenol administration to prevent medication errors. LN 4 stated if the next shift comes after her, they could give another dose of Tylenol to Resident 69, and this would not be good for the resident.During a concurrent interview and record review on 11/21/25, at 1:24 p.m., with the Director of Nursing (DON), the DON stated LN 4 told her she gave the drug and did not document in the MAR, but she had corrected the MAR yesterday on 11/20/25. The DON further stated the reason all medication administrations must be documented at the time they are administered is to prevent medication errors and resident safety.During a concurrent interview and record review on 11/20/25, at 3:14 p.m., of Resident 69's MAR with the Assistant Director of Nursing (ADON), the ADON confirmed there was no documentation of Acetaminophen 650 mg administration in Resident's 69's MAR, dated 11/19/2025. The ADON stated if it's not documented it was not done, another nurse can come after LN 4 and give the same drug, the resident is at risk of getting multiple doses and could exceed the daily max dose for Tylenol administration. 2. During a review of Resident 34's admission RECORD, indicated Resident 34 had a diagnosis of atherosclerotic heart disease of coronary artery (type of heart disease involving the reduction of blood flow to the cardiac muscles due to build up of plaque in the arteries of the heart), hypotension (low blood pressure is a condition in which the force of the blood pushing against the artery wall is too low), vascular disorder of intestine (the narrowing of the arteries that supply blood to the intestine, spleen, and liver, this narrowing in turn causes hardening of the arteries due to build up of plaque) and muscle weakness, dysphagia (difficulty swallowing).During an observation on 11/20/25, at 9:24 a.m., with Licensed Nurse (LN) 5, LN 5 administered all of Resident 34's daily medications scheduled at 8 a.m., including her Docusate Sodium 250 mg.During a record review of Resident 34's MAR, dated November 2025, the MAR indicated docusate 250 mg was documented as not given at 0800 on 11/20/25.During a concurrent interview and record review on 11/21/25, at 1:26 p.m., with LN 5 and the DON, LN 5 stated she did give the docusate sodium to Resident 34, yet documented not given in Resident 34's MAR. The DON confirmed the medication was given and documented as not given in Resident 34's MAR. The DON stated the reason all medication administrations should be documented at the time they were administered is to prevent medication error and resident safety.During a review of facility's policy and (continued on next page)		

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

Printed: 07/18/2026
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 11/21/2025
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure (P&P), titled, Administering Medication, dated 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medication are administered within one (1) hour of their prescribed time, unless otherwise specified (for example before and after meal order). times are determined.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route)of administration before giving the medication .11. The following information is checked/verified for each resident prior to administering medications.a. Allergies to medications; and.b. Vital signs, if necessary.22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.23. As required or indicated for a medication was administering the medication records in the resident's medical record.a. the date and time the medication was administered; the dosage.g. the signature and title of the person administering the drug .		

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 11/21/2025
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer the pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccine to two out of five sampled residents (Resident 7 and Resident 105) and the influenza (or the flu, is a contagious viral infection of the respiratory system that can range from mild to severe, causing symptoms like fever, cough, sore throat, muscle aches, and fatigue) vaccine and covid-19 (an infectious respiratory disease caused by the SARS-CoV-2 virus) vaccine to one out of five sampled residents (Resident 105) when:1. Resident 7 was not given the pneumococcal vaccine after consenting to receive it.2. Resident 105 was not given the influenza, pneumococcal and covid-19 vaccines after consenting to receive them. These failures had the potential for Resident 7 and Resident 105 to go unvaccinated with the risk for serious health related illness and/or death. Findings:1. A review of Resident 7's admission Record indicated, she was admitted to the facility with diagnoses which included Acute Respiratory Failure (a severe, life-threatening condition where the lungs suddenly cannot exchange enough oxygen and carbon dioxide, leading to dangerously low oxygen and/or high carbon dioxide in the blood, compromising vital organs), Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and Chronic Pulmonary Edema (a slow, gradual buildup of excess fluid in the lungs' air sacs causing persistent shortness of breath). During a concurrent interview and record review on 11/19/25, at 2:45 p.m., with the Infection Preventionist (IP), the IP confirmed Resident 7 did not receive the pneumococcal vaccine. The IP also confirmed Resident 7 consented to receiving the pneumococcal vaccine, but somehow, he missed it, and the resident did not receive the vaccine. A review of Resident 7's consent form for the Pneumococcal vaccine dated 10/15/25, indicated, Resident 7 consented to receive the Pneumococcal Vaccine.2. A review of Resident 105's admission Record indicated he was admitted to the facility with diagnoses which included pleural effusion (the buildup of excess fluid around the lungs) and atelectasis (a partial or complete collapse of the lung). During a concurrent interview and record review on 11/19/25, at 2:45 p.m., with the Infection Preventionist (IP), the IP confirmed Resident 105 did not receive the influenza, pneumococcal, and covid-19 vaccines. The IP also confirmed Resident 105 consented to receiving the influenza, pneumococcal and covid-19 vaccines, but the resident did not receive the vaccines. The IP also stated that he was responsible for administering the vaccines but could not administer them timely because of being busy and was going to administer it this week. A review of Resident 105's undated consent forms for Pneumococcal, influenza and covid-19 vaccines, indicated, Resident 105 consented to receive the Pneumococcal, influenza and covid -19 vaccines. The IP stated that these consent forms were received upon admission on [DATE]. During an interview with Director of Nursing (DON) on 11/21/25 at 11:10 a.m., the DON stated she expected the residents to get all their vaccinations within 5 days of admission, if they consent. The DON stated that this was flu season, and residents should be offered and given the influenza vaccine along with other vaccines. The DON also stated that if the residents do not get their vaccines in time, they are at risk of getting too sick or hospitalized, which can even lead to death. Per the DON vaccinations are very important as they prevent residents from getting too sick. A review of the facility's policy titled, Influenza Vaccine, revision date March 2022, indicated, .All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.2. Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of the employee's job assignment or the residents admission to the facility.11. Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. A review of the facility's policy titled, Pneumococcal Vaccine, revision date October 2023, indicated, . All residents are offered (continued on next page)		

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 11/21/2025
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission .4. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol.7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.A review of the facility's policy titled, Coronavirus Disease (Covid-19) - Vaccination of Residents, revision date May 2023, indicated, . Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated.4. The COVID-19 vaccine may be offered and provide the directly by the LTC facility.b. Vaccines are administered in accordance with CDC, ACIP, FDA and manufacturer guidelines.Review of the Centers for Disease Control and Prevention (CDC) webpage titled Pneumococcal Vaccination: What Everyone Should Know, dated 1/20/23, indicated, .Pneumococcal disease is common in young children, but older adults are at greatest risk of serious illness and death .CDC recommends pneumococcal vaccination for all children younger than 5 years old and all adults 65 years or older .Some pneumococcal infections are invasive. Invasive disease means that germs invade parts of the body, such as blood, that are normally free from germs. Invasive disease is usually very serious and can sometimes result in death. Vaccines that help protect against pneumococcal disease work well but cannot prevent all cases .(https://www.cdc.gov/vaccines/vpd/pneumo/public/index.html)		

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

Printed: 07/18/2026
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 11/21/2025
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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, eleven rooms (rooms 2, 3, 4, 8, 41, 43, 44, 45, 46, 47 and 48) in the facility did not meet the required 80 square feet per resident. This failure placed the residents in rooms 2, 3, 4, 8, 41, 43, 44, 45, 46, 47 and 48 at potential risk to impede their care and highest possible level of functioning due to smaller than required square footage. Findings: During an observation with the Maintenance Supervisor (MS rooms 2, 3, 4, 8, 41, 43, 44, 45, 46, 47 and 48), the following measurements were obtained for rooms 2, 3, 4, 8, 41, 43, 44, 45, 46, 47 and 48. Room Occupancy Required/Actual Square Foot/Resident 2 2 Residents 159/129 142.443 2 Residents 159/133 146.854 2 Residents 159/130 142.648 3 Residents 203/140 191.3641 3 Residents 188/171 223.2543 3 Residents 189/170 223.1344 2 Residents 146/143 144.9945 3 Residents 194/171 230.3846 2 Residents 150/146 152.0847 3 Residents 194/171 230.3848 2 Residents 146/145 147.01 During an interview on 11/20/25, at 12:43 PM, with Resident 109 and Resident 110 on room [ROOM NUMBER], they both stated that they had enough space even when staff was providing care. Resident 109 stated they did not do their physical therapy inside the room, they did it in the rehabilitation gym, they had enough space needed. During an interview on 11/20/25, at 12:58 PM, with Resident 21 and Resident 21's family member (FM) 1, Resident 21 stated she do not think she has enough space. Resident 21 stated she believed the room was meant for two residents and that the third bed was an addition. FM 1 stated the room was tight and when the staff needed to use the Hoyer lift (a type of patient lift that uses a mechanical system to safely transfer individuals who have difficulty moving on their own) for the resident or the roommate, he had to go to the bathroom to give them space. During an interview on 11/20/25, at 1:04 PM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated when she used the Hoyer lift in room [ROOM NUMBER] for residents on 8-A and 8-C, she needed to organize the chair, the table to make room/space for the Hoyer lift. CNA 2 stated that extra space was needed when using the Hoyer lift, as it requires two people to assist the resident. During an interview on 11/20/25, at 3:08 PM, with Housekeeper (HK) 2, the HK 2 stated it was okay for her to work on smaller rooms even if it had 3 residents in the room, she could still do her job to clean properly. Based on the findings during the Recertification survey, the Department recommends continuation of the room size waiver for rooms 2, 3, 4, 8, 41, 43, 44, 45, 46, 47 and 48.		