STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Nursing & Rehabilitation	1334 S. Ham Lane Lodi, CA 95242

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN: a notice that informs residents of changes to their Medicare Part A coverage for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay) to one of one sampled resident (Resident 2) reviewed for Medicare benefit notification after skilled services ended.This failure had the potential for Resident 2 not to be able to make informed decisions about his care and finances, being unaware of his right to appeal and placed him at risk for unexpected medical bills.During a concurrent interview and record review on 8/6/25, at 2:48 PM, the Admissions Coordinator (AC) stated Resident 2's Medicare Part A skilled services coverage ended on 7/23/25. The AC stated Resident 2 continued to stay in the facility after his skilled care ended. The AC confirmed that Resident 2's Medicare eligibility benefits document indicated that Resident 2 had 46 Medicare days remaining. The AC stated the SNF ABN notice should have been issued to Resident 2 when his skilled services coverage ended on 7/23/25 and he continued to remain at the facility. The AC further stated that without the SNF ABN, the resident might not know his rights.During a concurrent interview and record review on 8/6/25, at 12:40 PM, the Social Services Director (SSD) confirmed that Resident 2 was discharged from Medicare Part A services on 7/23/25, but Resident 2 remained in the facility as a long term care resident. The SSD further confirmed there was no indication in Resident 2's medical record that the SNF ABN was provided to Resident 2.During a concurrent interview and record review on 8/6/25, at 1:13 PM, the Director of Nursing (DON) stated Resident 2 was scheduled for discharge on [DATE], but remained in the facility and transitioned to long term care. The DON stated further Resident 2's last Medicare-covered day was 7/23/25. The DON stated the SNF ABN notice should be given to residents three days before the last covered day, so the residents knew their rights and had a chance to appeal. The DON confirmed that the SNF ABN notice was not provided to Resident 2. The DON stated that not providing the SNF ABN could lead to unexpected billing for the residents.Review of an undated facility policy titled, Advance Beneficiary Notices, indicated, .The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides: (a.) An item or service that is usually paid for by Medicare .or (b.) Custodial Care .For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Nursing & Rehabilitation	1334 S. Ham Lane Lodi, CA 95242

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	09/08/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure an accident-free environment when necessary rehabilitation care instructions for nursing staff were not updated in the care plan for one of three sampled residents (Resident 1) when Resident 1 was placed in a regular wheelchair instead of a recliner wheelchair with a non-slip mat.This failure resulted in Resident 1 falling out of the wheelchair and hitting his head on the floor on 7/27/25. Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses including hemiplegia (paralysis or weakness to one side of the body) and hemiparesis (one- sided muscle weakness) following cerebral infarction (also known as stroke, when blood flow to the brain is interrupted, leading to brain tissue damage) affecting right dominant side, difficulty in walking, and paraplegia (inability to voluntarily move the lower parts of the body).A review of Resident 1's Brief Interview for Mental Status (BIMS - a standardized assessment to quickly evaluate a resident's cognitive function by asking a series of questions related to attention, orientation, and memory recall, resulting in a total score ranging from 0-15) dated 6/16/25, indicated Resident 1 had a BIMS Score of 10 which indicated moderate impairment.A review of Resident 1's medical record titled, Morse Fall Risk Screen, (is a rapid and simple method of assessing a patient's likelihood of falling, score of 0-24 low risk, 25-44 moderate risk, and 45 and higher as high risk) dated 6/16/25, indicated Resident 1 had a score of 56 which categorized Resident 1 as a high risk for falling.A review of Resident 1's Minimum Data Set (MDS - an assessment tool) Section GG (a standardized assessment in long-term care that measures a patient's ability to perform self-care and mobility activities, such as eating, bathing, and walking.) dated 6/19/25, indicated Resident 1 was, .Dependent- Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).A review of Resident 1's Nurses Notes, dated 7/27/25, at 6:49 PM, indicated, .Resident under Palliative Care Services [provides symptom relief, comfort and support to people living with serious or chronic illnesses.] under [name of hospice provider].Resident have [sic] a baseline of refusing ADLs [activities of daily living] care, but despite refusals, nursing staff still continues to offer resident to get up in wheelchair as tolerated. Resident has AROM [active range of motion] of right and left upper extremities and is contracted of right and left lower extremities.Due to patient's multiple attempts to get out of wheelchair unassisted, 2 CNAs [certified nursing assistants] assisted patient back to room [Resident 1's room] to prepare for transfer back to bed.Resident repeatedly attempted to push himself onto the floor still while being assisted to room.Resident had 1 CNA supervising him while the other CNA got the Hoyer lift [a mechanical, portable hoist used to safely transfer people with limited mobility].patient forcefully pushed himself forward past the CNA and projected forward onto the floor. [Resident 1] was in doorway of room.[Resident 1's forehead hit the floor which resulted in a minor lac [laceration or cut], scant bleeding was noted.During a phone interview on 8/5/25, at 2:03 PM, with Resident 1's responsibly party (RP), the RP stated she received a call from the facility on 7/27/25 and was informed that Resident 1 fell out of his wheelchair. The RP explained Resident 1 could not walk, was not able to move himself and he would fall forward. The RP stated Resident 1 required max assistance.During a joint interview on 8/6/25, at 1:52 PM, with the MDS Coordinator (MDSC) 1 and MDSC 2, both MDSC 1 and MDSC 2 stated Resident 1 needed a Hoyer lift to be transferred from bed to wheelchair and was dependent. MDSC 1 and MDSC 2 explained dependent meant that staff had to perform 100% of the activity. MDSC 1 and MDSC 2 stated Resident 1's sitting balance in therapy was poor and he required maximum assistance to maintain balance.During an interview on 8/7/25, at 3:03 PM, with the Medical Doctor (MD), the MD stated it was difficult to judge a resident's physical mobility because physical therapy recommended the ambulation status of the resident. The MD further stated he agreed with physical therapy if they recommended max assistance was needed for Resident 1's ability to be seated in a wheelchair.During a joint concurrent interview and record review on 9/8/25, at 9:28 AM, with the DOR and the Physical Therapist (PT), Resident 1's medical record was reviewed and indicated he was totally dependent with a 2 person assist for transfers. The PT stated she communicated with the nursing staff that Resident 1 could be transferred to a wheelchair and could tolerate sitting in a reclined position with a Dycem (a flexible, reusable, non-adhesive polymer material that can be cut to size and used on surfaces to secure people in chairs or wheelchairs, providing grip and stability by preventing sliding an slipping) on top of the wheelchair. The PT further stated Resident 1 had poor trunk control and it was not safe for him to be positioned in a 90-degree (a unit of measurement of