

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Lodi Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for one of one sampled resident (Resident 1), when staff did not perform hand hygiene and change their gloves during a nephrostomy tube (a tube that drains urine directly from the kidney) dressing change for Resident 1 who was on Enhanced Barrier Precautions (EBP, an infection control strategy used in nursing homes that requires use of gowns and gloves during high-contact care activities to reduce the transmission of germs and bacteria). This failure increased the risk for infection to Resident 1 and had the potential to spread infection and cause health problems for the residents in the facility. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including artificial openings of urinary tract status (surgically created route to divert urine out of the body when the normal pathway is blocked, diseased, or bypass). A review of Resident 1's TREATMENT ADMINISTRATION RECORD, dated for the months of June and July 2026, indicated, .Nephrostomy Tube Right Flank - Cleanse site with NS [normal saline- a mix of salt and sterile water], pat dry, apply split gauze dressing daily and PRN [as needed] if soiled or dislodged. A review of Resident 1's undated Care Plan, indicated that Resident 1 was at high risk for developing complications including UTI (urinary tract infection) due to the presence of a nephrostomy tube. The care plan interventions included to implement EBP and to observe good hand-washing technique. During a concurrent observation and interview on 7/2/26, at 11:54 AM, with Licensed Nurse (LN) 1, LN 1 entered Resident 1's room to change Resident 1's nephrostomy tube dressing. LN 1 was observed donning gloves without performing hand hygiene and then proceeded to touch the light fixture and curtains inside Resident's room. LN 1 wiped the edges of the dressing with adhesive remover and then removed Resident 1's soiled nephrostomy dressing. LN 1 proceeded with cleaning the nephrostomy tube site. LN 1 then placed a new dressing on the nephrostomy tube site without doing hand hygiene and changing gloves. LN 1 confirmed that she did not change her gloves during the dressing change and used only one set of gloves during the entire wound treatment. During an interview on 7/2/26, at 2 PM, with the Infection Preventionist (IP), the IP stated when providing treatments, the staff needed to follow infection control practices. The IP further stated that if a resident was on EBP with high contact activities, the staff need to perform hand hygiene, then don (put on) gown and gloves. The IP stated the nurse have changed their gloves after the soiled dressing was removed. The IP further stated that after cleansing the wound, nurses need to change their gloves again, before placing the new dressing. The IP explained that if nurses did not perform hand hygiene and changed their gloves, then the resident would be at risk for infection, and it would take the wound longer to heal. During an interview, on 7/2/26, at 2:51 PM, with the Director of Nursing (DON), the DON stated that when providing treatments, the nurses needed to follow the doctor's order regarding the frequency for changing the dressings and cleansing the site, follow up with an assessment, and documenting the treatment provided. The DON further stated that the nurse should have changed their gloves when providing a new dressing change to Resident 1' nephrostomy tube. A review of the facility's policy and procedure titled, Wound Care, revised 2010, indicated, .Steps in the Procedure. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves.		

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