STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555164	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Rehabilitation & Nursing Center	900 North Church Street 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 - Few	Provide and implement an infection prevention and control program. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to follow their surveillance plan (oversight plan to prevent the spread of infection) for scabies (an infection that causes an itchy skin rash when mites [tiny insects] burrow under the skin) prevention and control for one of four sampled residents (Resident 1) when, the Infection Preventionist (IP) did not implement the required six-week contact identification list and failed to train and notify all key healthcare personnels on how to recognize and report signs and symptoms consistent with scabies infestation.These failures had the potential to result in continued transmission of scabies among staff and residents within the facility. Findings:During a review of Resident 1's clinical record titled, admission Record, the record indicated Resident 1 was admitted to the facility in 2020 with a diagnosis which included respiratory failure. A review of Resident 1's clinical record titled, Order Summary, dated 8/26/25 at 11:33 AM, indicated the medical provider ordered permethrin cream (medicine that kills mites) and Ivermectin tablets (medicine that kills tiny bugs or worms that live in or on the body) to be administered to Resident 1. A review of Resident 1's clinical record titled, Scabies Examination, dated 8/30/25, indicated, .scabies mites seen. During a concurrent phone interview and record review on 9/23/25 at 2:05 PM with the Infection Preventionist (IP), the facility's surveillance plan titled, PREVENTION AND CONTROL OF SCABIES IN CALIFORNIA HEALTHCARE SETTINGS, was reviewed. The IP stated the PREVENTION AND CONTROL OF SCABIES IN CALIFORNIA HEALTHCARE SETTINGS was intended to guide the facility's response to a scabies infestation. The IP stated she verbally notified the following individuals of Resident 1's scabies diagnosis; the staff during a huddle (a quick and informal meeting), Resident 1's responsible party (RP), and the RPs of Resident 1's three roommates. The IP also stated that she did not follow the submitted surveillance plan when instead of conducting contact identification for six weeks as outlined, she only did for six days (8/21/25 through 8/26/25). Additionally, the IP stated she did not assign a dedicated care team member to provide care for Resident 1 as specified in the plan. During a phone interview on 9/23/25 at 2:30 PM, with the Director of Staff Development (DSD), the DSD stated the facility had not provided a stand-up meeting to all of the staff regarding Resident 1's scabies diagnosis.During a phone interview on 9/23/25 at 2:40 PM, with the IP, the IP stated that the risk of the facility not following their submitted surveillance plan was that the scabies infection could have spread within the facility. During interview on 9/24/25 at 3:05 PM with the Janitor (J) 1, J 1 stated that he heard from other janitors and housekeeping staff that there was a case of scabies in the facility; however, he did not know which resident was affected and believed the affected resident was only under observation for scabies and the case had not been confirmed.During an interview on 9/24/25 at 3:14 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was not part of a huddle when scabies was discussed, and that the huddle was only conducted with the staff who cared for Resident 1 (on the north hallway). CNA 1 stated that all staff should have been informed of the scabies diagnosis because staff were sometimes required to work in other hallways of the facility and could have been exposed. CNA 1 stated that she learned of Resident 1's diagnosis after she was assigned to deliver meal trays to the north hallway and was advised by other staff to wear Personal Protective Equipment (PPE, gown, gloves, mask, booties) when going into Resident 1's room. CNA 1 also stated she had not attended an in-service about scabies. During an interview on 9/24/25 at 3:31 PM with CNA 2, CNA 2 stated that she normally worked at the north station and was unaware that Resident 1 had tested positive for scabies. CNA 2 stated she learned of it only when another CNA informed her while passing meal trays. CNA 2 denied attending a huddle or being notified by the IP regarding the Resident 1's positive scabies case and could not recall receiving any scabies in-services. CNA 2 stated that if anyone who cared for Resident 1 (who was positive for scabies) should have worn a gown, washed hands before and after care, and thrown the gown in the trash can located inside Resident 1's room.During an interview on 9/24/25 at 3:44 PM, with Housekeeper (H) 1, H 1 stated that her duties included cleaning inside the resident rooms. H 1 stated she became aware of Resident 1's diagnosis of scabies after she observed an isolation sign posted by the door (a sign that indicates what PPE was necessary to wear before entering the room) and after a nurse informed her of the scabies. H1 stated she did not attend a huddle or receive in-service training regarding scabies. During an interview on 9/24/25 AT 3:53 PM with CNA 3, CNA 3 stated she was unaware that any resident (Resident 1) at the facility had scabies in 8/25 and did not know of any staff huddles that were conducted. During an interview on 9/24/25 at 3:57 PM with Licensed Nurse (LN) 1, LN 1 stated he was not informed of any staff huddle or of a positive case of scabies in the building. LN 1 stated he recalled receiving a scabies in-service