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	01/09/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility did not provide adequate supervision to protect one of forty-four sampled residents (Resident 112) from alleged physical abuse when a Licensed Nurse (LN) witnessed one unsampled resident (Resident 25) hit Resident 112 on the face on 12/12/25. This failure could potentially result in physical injury and emotional distress that could negatively affect Resident 112's physical and psychosocial well-being.Findings:On 12/12/25, the Department received a facility reported incident regarding an alleged resident to resident altercation. This reported incident was investigated during the facility's unannounced annual recertification survey on 1/6/26.During a record review of Resident 25's admission RECORD, indicated, Resident 25 was admitted to the facility with diagnoses including schizophrenia and depression.During a record review of Resident 25's Order Summary Report, dated 12/17/25, indicated Resident 25 was discharged to another facility on 12/24/25. Resident 25 was not in the facility during the duration of their annual recertification survey.During a record review of Resident 112's admission RECORD, indicated, Resident 112 was admitted to the facility with diagnoses including depressive disorder.During a record review of Resident 112's Minimum Data Set, (an assessment tool) dated 11/4/25, indicated Resident 112's BIMS (Brief Interview for Mental Status) score was 14 out of 15 suggesting an intact mental functioning.During a concurrent observation and interview on 1/7/26, at 10:52 a.m. with Resident 112, Resident 112 was in the dining room playing table cards. When asked how he was doing, he responded in Spanish and motioned his hands indicating someone had hit him. When asked if the person who had hit him was still in the building and he motioned his hands that the other resident was no longer in the facility.During an interview on 1/7/26, at 10:52 a.m. with Resident 112, in the presence of Licensed Nurse (LN) 3 who interpreted Resident 112's responses from Spanish to English language, Resident 112 explained that he was minding his own business and was sitting out in the hallway when Resident 25 came out of nowhere and hit him on both sides of his head and he did not have the time to react. Resident 112 stated the other resident was his previous roommate. Resident 112 stated the other resident was no longer in the facility and had not seen him and went somewhere else. Resident 112 also explained that the nurse saw what happened and the nurse intervened and separated them.During an interview on 1/8/26, at 2:31 p.m. with Resident 112 in the presence of LN 3 who interpreted for Resident 112, Resident 112 stated he felt that what had happened to him was a physical abuse because the other resident had hit him out of nowhere and hitting was an abuse.During an interview on 1/8/26, at 4:23 p.m. with the Social Service Director (SSD), the SSD explained LN 5 had witnessed Resident 25 hit Resident 112 on the right cheek and sustained a scratch and some redness. The SSD stated this incident happened quickly and it was a spur of the moment. The SSD stated Resident 25 had a verbal outburst calling out staff devils and talking about snakes. The SSD also stated Resident 25 had visual hallucinations such as seeing snakes. The SSD added at times Resident 25 stood up and lunged at staff. The SSD stated Resident 25's family had reported he had cycles of (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episodes every few years.During an interview on 1/9/26, at 7:40 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 25 had behaviors of shouting at staff at times. CNA 1 also stated she had seen Resident 25 and Resident 112 exchanging words and at times could be verbally aggressive with each other.During an interview on 1/9/26, at 7:55 a.m. with CNA 2, CNA 2 explained that about two weeks prior to this incident she overheard Resident 25 saying things about faith, talking about God, and saying that he was being taken away from the place where he wanted to stay. CNA 2 also explained that she noticed Resident 25 did not want to go back to his room because Resident 112 had guns and he was a bad person. CNA 2 stated she also noticed Resident 25 who was previously quiet was now very talkative and talked a lot. CNA 2 also stated she observed Resident 25 getting mad and becoming aggressive. CNA 2 further explained before the incident happened that day Resident 25 went out to the patio and she followed him to calm him down and to encourage him to go back inside the building. CNA 2 stated Resident 25 entered the building and Resident 112 was sitting in front of the North Nurses Station while CNA 2 was in the North Nurses Station when she heard a commotion and saw Resident 25 walking with a walker approaching Resident 112 and hit him.During an interview on 1/9/26, at 9:34 a.m. with LN 5, LN 5 stated she witnessed Resident 25 hit Resident 112 on the face. LN 5 explained the morning of the incident Resident 25 and Resident 112 were sitting next to each other in the hallway near the North Nurses Station when suddenly, she heard yelling from Resident 25 and stood up from his chair and walked towards Resident 112. LN 5 further explained as she was going to assist and stop the altercation, Resident 25 was already standing and had hit Resident 112 twice on the face before she could intervene.During a record review of Resident 25's Care Plan Report, dated 8/14/25, indicated, .auditory hallucinations AEB [as evidenced by] hearing voices telling pt. [patient] Be careful [and] visual hallucinations AEB seeing snakes and the devil.During a record review of Resident 25's Care plan Report, dated 10/2/25, indicated, .Potential for mood problem.Observe for signs and symptoms of.racing thoughts.increased irritability.flight of ideas.agitation or hyperactivity.During an interview on 1/9/26, at 10:45 p.m. with the Administrator (ADM), the ADM stated that Resident 25 was transferred to another facility due to hallucinations. The ADM stated Resident 25 had a psychiatric diagnosis. The ADM also stated that things happen in an instance and do not guarantee nothing is going to happen. The ADM added that staff could not anticipate every resident's move every day.During a record review, Resident 25's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 7/18/25, indicated Resident 25 was positive for Serious Mental Illness (SMI) and a Level 2 Mental Health Evaluation was required.During a record review, Resident 25's Level 2 PASSR INDIVIDUALIZED DETERMINATION REPORT, dated 7/22/25, indicated a list of services and supports that supplement the facility's care to address mental health needs. During an interview on 1/9/26, at 12:29 p.m. with the Director of Nursing (DON), the DON stated Resident 25 was transferred to another facility due to escalated behavior and needed to be evaluated. The DON also stated that she was aware of Resident 25's diagnosis on admission. The DON stated that the goal for every resident staying in the building was their safety and any altercations would make the residents feel unsafe, fearful, or scared.During a record review of the facility's policy and procedure (P&P) titled, Abuse: Prevention of and Prohibition Against, revised date 8/25, indicated, .It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment.The Facility will act to protect and prevent abuse and neglect from occurring within the Facility by.identifying, correcting, and intervening in situations in which abuse.is more likely to occur.identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict.