

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: 555164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Arbor Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, and serve food in accordance with professional standards for food safety when: 1. There was no air gap or back flow prevention device installed for the food prep sink or the three compartment sink (a commercial kitchen essential with three basins for washing, rinsing, and sanitizing dishes), 2. Dietary staff (DS) 1 and DS 2 did not wear hygienic hair gear/hair net in the food preparation area, 3. Food items for residents were stored inside the utility room. These failures had the potential to affect the flavor and palatability of the food and to lead to food borne illness (nausea, vomiting, diarrhea) for the 123 residents receiving facility prepared food. Findings: 1. During a concurrent observation and interview on 1/6/26, at 8:11 a.m., with the Dietary Manager (DM), in the kitchen, there was no air gap back flow system in place at the three-way compartment sink. The DM stated the facility was aware there was no air gap and the facility was in the process of fixing it. The DM further stated one concern of not having an air gap was for sanitation purposes, if there was any pressure change in the system it could pull water the wrong direction and it would go back up into the line. During an interview on 1/6/26, at 12:05 p.m., with the Registered Dietitian (RD), the RD stated the air gap helped so the flooding/water did not backup into the sink, and it had the potential of reverse back flow. The RD further stated having an air gap would help with sanitation and cross contamination. 2. During an observation on 1/7/26, at 11:24 a.m., with the Dietary Staff (DS) 1, the DS 1 walked into the kitchen, went to the kitchen sink to wash her hands, near the kitchen stove, then she walked to the dishwashing area and began washing dishes without a hair net on. The DC was already cooking beef in the pot for the taco menu at lunch time. During a concurrent observation and interview on 1/7/26, at 11:28 a.m., with DS 1, DS 1 confirmed she did not have hairnet on when washing dishes. DS 1 stated she should have covered her hair when she is in the kitchen. The DS 1 further stated the hairnet was to keep her hair away from the food and for sanitation purposes. During an interview on 1/7/26, at 11:31 a.m., with the DM, the DM confirmed DS 1 did not have hairnet on while in the kitchen. The DM stated hair was to be covered while in the kitchen to prevent contamination. During an observation on 1/7/26, at 11:37 a.m., in the meal prep area, near the tray lines, DS 2 walked into the kitchen to the food prep area where tray lines were already being set up by the Dietary [NAME] (DC) without his hairnet on. (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/7/26, at 11:40 a.m., with DS 2, DS 2 confirmed he did not have a hairnet on when he walked into the kitchen and stated he had just started his shift for the day. DS 2 stated he was required to wear his hairnet when in the food prep or in the kitchen. DS 2 further stated the hairnet should be worn at the doorway, upon entering the kitchen to keep the hair from getting into the food. During an interview on 1/7/26, at 11:44 a.m., with the DM, the DM confirmed DS 2 did not wear a hairnet when in the kitchen/food prep area. The DM stated hairnets must be worn by all staff at all times when in the kitchen to prevent contamination. During an interview on 1/8/26, at 1:18 p.m., with the RD, the RD stated the facility's policy was to wear hairnets for cleanliness and to prevent any type of contamination. During an interview on 1/9/26, at 11:33 a.m., with the Director of Nursing (DON), the DON confirmed she witnessed DS 2 who walked into the kitchen without his hairnet on, that she was at the kitchen door. The DON stated the reason hairnets were worn because the facility did not want hair in the food and to prevent cross contamination and infection control. A review of facility policy and procedure (P&P) titled, Healthcare Menus Direct, LLC dated 2023, indicated, . the Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. Backflow prevention air gaps. if a connection exists between the system and the source of contamination water during times of negatives pressure, contaminated water be drawn into and foul the entire system. An airgap is the most reliable backflow prevention device. It is the physical separation of the portable and non-potable water supply systems by an air space. All steam tables, ice machines and bins, food preparation sinks, display cases, soda fountains, espresso machines, and other equipment that discharge liquid waste or condensate shall be drained through an air gap into an open floor sink. am tables. An air gap between the water supply inlet (drain pipe) and the flood level rim of the plumbing fixture (floor sink drained), equipment or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch A review of an undated facility provided document titled, Dress Code, indicated, . 6. Hats are acceptable if all hair is covered by a hat . 7. Hairnets must be worn if all hair cannot be covered by a hat . 8. All facial hair of nominal length must be covered . 3. During an interview on 1/8/26, at 3:10 PM with Certified Nurse Assistant (CNA) 5, inside South Utility room, CNA 5 stated that the bins inside the South utility room were for solid waste, trash, dirty diapers with urine and feces, soiled tissue papers, and paper towels. The janitor would eventually pick up these bins and take them to the dumpsters. CNA 5 stated that food items like applesauce, thickened liquids, pudding, and nutritional supplements intended for residents, even if sealed and with the refrigerator dedicated to residents' food were unacceptable to be stored and kept in the utility room, given their proximity to the dirty side. CNA 5 stated that the red line separating the clean and dirty areas cannot guarantee prevention of cross-contamination. During an interview on 1/8/26, at 3:21 PM, with licensed nurse (LN) 8, LN 8 stated that storing food items for residents and a refrigerator for resident food inside the utility room, in close proximity to bins for soiled trash and a refrigerator for biohazard materials with urine and stool samples, posed (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	great potential risks for cross contamination and health safety risks for residents. During an interview on 1/8/26, at 4:33 PM with Janitor (J) 1, J1 stated he felt uneasy about seeing food items stored in the combined utility room, considering there was only about four feet separating the clean area from the dirty area. J1 stated that this setup posed a high risk for contamination and the potential spread of diseases. During an interview on 1/9/26, at 9:19 AM, with Janitor (J) 2, J2 stated that storing food items inside the utility room was not safe and did not create a homelike environment. J2 further stated that food storage should be handled in the same way as it would be at home. J2 stated that the bins with soiled trash sometimes emitted an odor resembling urine or stool inside the utility room, making it seem unsanitary to use the room for food storage. During a concurrent observation and interview on 1/9/26, at 11:28 AM, with the Infection Preventionist (IP), in the South Utility room. The IP stated the facility had three utility rooms, one each for the South station, North station, and East/Terrace stations. The IP confirmed that the South utility room had both clean and dirty areas. In the dirty area (right side of the room), found a sink for hand washing, a dirty nebulizer for Central Supply personnel to clean and disinfect, green-colored wedges from a discharged resident, two bins for soiled trash, and a refrigerator labeled biohazard (something that can make people sick because it contains germs or harmful biological material) dedicated to sample specimens. On the clean side (left hand side of the room), there were three pieces of laboratory equipment (one near the food items supplied by the kitchen) used by phlebotomists (a healthcare worker who draws blood from patients) when handling blood specimens, seven IV (intravenous &dash; given directly into a vein) poles, five nebulizers (a machine that turns liquid medicine into a mist so you can breathe it into your lungs), briefs for residents' use, a toilet seat, suction machines (a device that removes mucus, saliva, or fluids to help a person breathe safely) , and a refrigerator labeled Resident Food Only. During a subsequent concurrent observation and interview on 1/9/26, at 11:37 AM, it was observed that food items (pudding, applesauce, thickened liquids and nutritional supplements) were kept in the East/Terrace combined utility room. The IP described the East/Terrace combined utility room. On the clean side (right side of the room), there was a refrigerator labeled Resident Food Only, briefs for residents, under pads, a toilet seat raiser, small and large plastic bags, two sinks, two boxes of isolation gowns, and three IV poles. The dirty side (left side of the room) contained two wedges from discharged residents, four plastic bags with residents' belongings labeled with their names and room numbers, and a dirty suction machine. During an observation and interview on 1/9/26, at 11:45 AM, observed food items, including pudding, applesauce, thickened liquids, and nutritional supplements, kept in the North combined utility room. The IP described the North combined utility room. The IP stated that on the clean side (left side of the room), stored IT (Information Technology) equipment with black and blue wires, washcloths or wet wipes for residents, plastic cups, suction machines, a nebulizer, and cabinet storage containing gait belts, blue-colored plastic bags, and a toilet seat raiser. On the dirty side (right side of the room), there were two rolls of paper towels, a sink for handwashing, one dirty suction machine, residents' personal belongings inside a blue-yellow bag, and three bins for soiled waste trash. The IP further stated that although the facility followed infection control practices, storing food items in combined utility rooms posed a potential risk for cross-contamination. During an interview on 1/9/26, at 12:18 PM, with the Director of Nursing (DON), the DON confirmed (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that food items for residents were stored in the combined utility rooms. The DON stated she did not think it was a problem to keep residents' food items in the combined utility room along equipment like GT (gastrostomy tube & a feeding tube placed directly into the stomach) pumps, nebulizers, fall mats, suction machines, IV poles, centrifuge machines (a machine that spins samples like blood very fast to separate their parts) used by phlebotomists, and a refrigerator for specimen samples such as urine, sputum, wound specimens, and feces. The DON confirmed that sinks used for hand washing were considered a drain. During a concurrent interview and record review on 1/9/26, at 2:06 PM with the Registered Dietitian (RD), presented to RD the facility policy for storage of food and supplies. RD acknowledged the presence of centrifuge machines near the food items stored in the South utility room, and the RD stated, I cannot dispute that about the equipment's proximity to the food items. Review of a facility policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, indicated, . POLICY: Food and supplies will be stored properly and in a safe manner. The storeroom should be well-lighted, well-ventilated, cool, dry, and clean at all times. Storage areas should be free from exposed pipes, drains, and mechanical equipment. Review of Food and Drug Administration (FDA) Food Code 2022 titled, Preventing contamination from the premises under the section, Food Storage, Prohibited Areas, indicated, . FOOD shall be protected from contamination by storing the FOOD . in a clean, dry location . Where it is not exposed to splash, dust, or other contamination . Food may not be stored . in garbage rooms . or Under other sources of contamination.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide the COVID-19 vaccine, for four out of five sampled residents (for immunization review) when Resident 58, Resident 36, Resident 29 and Resident 86's electronic health record (EHR) did not contain documented evidence that the COVID-19 vaccine was administered after obtaining consent. This deficient practice placed Resident 58, Resident 36, Resident 29 and Resident 86 at risk to be infected with COVID-19 virus that could lead to severe illness, hospitalization, and/or death. Findings: A review of Resident 58's admission RECORD, indicated Resident 58 was admitted early October 2025. A review of Resident 36's admission RECORD, indicated Resident 36 was admitted early December 2025. A review of Resident 29's admission RECORD, indicated Resident 29 was admitted on [DATE]. A review of Resident 86's admission RECORD, indicated Resident 86 was admitted on [DATE]. During a concurrent interview, and record review on 1/8/26, at 10:27 AM, with the Infection Preventionist (IP), Resident 58, Resident 36, Resident 29 and Resident 86's EHR were reviewed. The IP confirmed that Resident 58 signed a consent upon admission to receive COVID-19 vaccine. The IP stated that she had not provided COVID-19 vaccine to Resident 58. The IP confirmed there was no information on Resident 36's vaccine status for COVID-19. The IP further confirmed that the consent was not uploaded on the EHR for Resident 36. The IP stated she had not provided the COVID-19 vaccine to Resident 36. The IP stated the COVID-19 vaccine should have been given upon admission or shortly after admission. The IP confirmed that the COVID-19 immunization consent was signed by Resident 29. The IP stated that the facility did not have a COVID-19 vaccine yet, and last week or the week before, she ran out of COVID-19 vaccine and the pharmacy was out of stock of COVID-19 vaccine. The IP confirmed that Resident 86 consented to receive COVID-19 vaccine which he signed upon admission. The IP stated that Resident 86 was sent out to the hospital but the COVID-19 vaccine should have been given to Resident 86 prior to his hospitalization. The IP further stated that Resident 86 was on antibiotics due to osteomyelitis (bone infection) and that was the reason she did not provide Resident 86 the COVID-19 vaccine. The IP stated that she should have communicated with the doctor first before deciding not to give the COVID-19 vaccine. The IP stated that she ordered COVID-19 vaccine a few weeks ago and they have not received the COVID-19 vaccine yet. A review of the facility's policy and procedure (P&P) titled, Immunizations - Residents, dated 9/2017, revised 8/2025, indicated, .It is the policy of this facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine (s) and obtaining consent. Purpose To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza, pneumococcal disease, or COVID-19 by ensuring that each resident is informed about the benefits and risks of immunizations; and has the opportunity to receive the influenza, pneumococcal, or COVID-19 vaccine (s), unless medically contraindicated, declined or already immunized. Residents will be screened at that time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines, to receive the influenza, pneumococcal, and/or COVID-19 vaccine(s). Each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated, or the resident has already been immunized.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure safe medication management for 1 out of 44 sampled residents (Resident 52) when Resident 52's two inhalers were allowed to remain at Resident 52's bedside for self use without a determination made by the interdisciplinary team if self-administration of medications was safe and appropriate for Resident 52. This deficient practice placed Resident 52 at risk for unsupervised medication administration, incorrect dosing, misuse, adverse medication effects, and lack of monitoring for effectiveness and side effects. Findings: A review of Resident 52's admission RECORD, indicated Resident 52 was admitted to the facility with diagnoses including acute respiratory failure (when not enough oxygen passes from the lungs to the blood), chronic obstructive pulmonary disease (COPD - a lung condition that makes it hard to breathe because airflow into and out of the lungs get blocked), difficulty in walking, nicotine dependence, and anxiety disorder (when normal, occasional worry, turns into intense, persistent, and excessive fear about everyday things, making it hard to control and interfering with daily life). A review of Resident 52's, Order Details, dated 8/21/25, indicated that the Medical Doctor (MD) had prescribed Breyna Inhalation Aerosol (medicine that helps people with COPD breathe easier) 2 puffs inhale orally two times a day for shortness of breath (SOB). A review of Resident 52's, Order Details, dated 9/13/25, indicated that the MD had prescribed Albuterol Inhalation Aerosol (medicine that helps people with COPD breathe easier) 2 puffs by mouth every four hours as needed for SOB. During a concurrent observation and interview on 1/6/26, at 2:46 PM, with Resident 52, in Resident 52's room, a red and a blue inhaler were seen on Resident 52's bedside table. Resident 52 stated she used the red inhaler two times in the morning and two times at night, and the blue inhaler every two to four hours as needed. Resident 52 further stated that she had brought the inhalers from home. Resident 52 stated that the nurses also had their own supply, but no nurses checked on her while she used the inhalers by herself. Resident 52 stated that no one had completed an assessment regarding her ability to use the inhalers on her own. During a concurrent observation, interview, and record review on 1/6/26, at 4:48 PM, with the Assistant Director of Nursing (ADON), in Resident 52's room, the ADON confirmed that Resident 52 had two inhalers on the bedside table. The ADON stated that Resident 52 preferred to self-administer the inhalers, and Resident 52 needed a doctor's order and a self-administration of medication assessment and a care plan. Upon reviewing Resident 52's Electronic Health Record (EHR), the ADON confirmed that an assessment for self-administration of medication was not completed for Resident 52. The ADON further confirmed there was no care plan that reflected the use of the two inhalers found on Resident 52's bedside table. The ADON stated that by not performing a self-administration of medication assessment and not creating a care plan for Resident 52, Resident 52's safety was at greater risk. The ADON further stated that staff did not know if Resident 52 was safe to use the inhalers, which could lead to improper use or an overdose. The ADON stated that she expected nurses to complete the self-administration of medication assessment and care plan before allowing Resident 52 to use the inhalers on her own. During an interview on 1/7/26, at 8:31 AM, with licensed nurse (LN) 11, LN 11 stated that Resident 52 had kept the inhalers at the bedside since the day Resident 52 was admitted to the facility. LN 11 stated that staff needed to watch how Resident 52 used the inhalers to avoid using too much or too little medicine. During an interview on 1/9/26, at 9:50 AM, with the Director of Nursing (DON), the DON stated that if Resident 52 wanted to use her inhalers by herself, licensed nurses needed to complete a self-administration of medication assessment to make sure Resident 52 could use her inhalers safely. The DON further stated it was also important to make a care plan for Resident 52's ability to use the inhalers by herself. Review of a facility policy and procedure titled, Self-Administration of Medications, revised 6/5/24, indicated, . Facility should comply with facility policy, applicable law and the State Operations Manual with respect to resident self-administration of medications . the manner of storage shall prevent access by other residents . facility staff shall (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record in the patient health record the bedside medications used . facility in conjunction with the interdisciplinary care team [a group of people from different professional backgrounds who work closely together, sharing knowledge and making joint decisions to achieve a common goal], should assess and determine . whether self-administration of medications is safe and clinically appropriate . facility should document in the resident's care plan whether the resident or facility staff is responsible for the storage of the resident's medications . facility should document the self-administration and self-storage of medications in the resident's care plan.		

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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 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 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure podiatry care (Podiatrists (foot care specialists) deal with medical problems related to the feet - in the skin or toenails) was provided to 1 out of 44 sampled residents (Resident 1) when Resident 1 had long, thickened, hard, chipped, toe nails that were sensitive to touch and a request for podiatry service on 12/28/25 was not followed up on by facility staff. This failure had the potential for Resident 1 to sustain injury, impaired skin integrity, and/or acquire an infection. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was originally admitted to the facility with diagnoses including Alzheimer's disease (a chronic gradual /worsening of memory, attention, and reasoning), dementia (a progressive decline in mental functions, marked by memory loss, reasoning, judgement, abstract thought, learning, task execution, and use of language), age related osteoporosis (loss of bone mass that occurs throughout the skeleton leading to weak bones), chronic kidney disease (renal disease-a disease where damaged kidneys cannot filter waste and fluid from the blood), restlessness and agitation. During an observation on 1/6/26, at 9:37 a.m., in Resident 1's room, Resident 1 was observed lying in bed with her left foot dangling out of bed. Resident 1's foot was observed to have long, thickened, hard, yellowish toenails. During an interview on 1/7/26, at 10:52 a.m., with the ADON, the ADON confirmed she was notified about Resident 1's podiatry consultation request. The ADON stated it was everyone's responsibility to set up podiatry appointments for residents, including nursing staff. During a concurrent interview and record review on 1/9/26, at 10:30 a.m., with Minimum Data Set Coordinator (MDS, an assessment tool), Resident 1's nursing progress note, dated 12/28/25, was reviewed. The MDS confirmed Licensed Nurse (LN) 2 documented he had requested a podiatry consultation for Resident 1 because Resident 1's Responsible Party (RP) requested one on 12/28/25. The MDS stated she did not know whether the consultation was ever done. The MDS stated the wound care nurse was responsible for the weekly nail or podiatry care assessment. During an interview on 1/9/26, at 10:51 a.m., with LN 2, LN 2 confirmed he requested a podiatry consultation for Resident 1 as Resident 1's RP was requesting one. LN 2 stated he notified the Assistant Nursing Director (ADON) and documented it in Resident 1's progress notes. LN 2 further stated he had checked Resident 1's toenails and agreed there was a need for a podiatry consultation. LN 2 explained Resident 1's nails were overgrown and when staff attempted to touch her nails, they were sensitive and Resident 1 would draw back her feet or yell. LN 2 stated he attempted to touch Resident 1's toes today (1/9/26) and they were still sensitive to touch. During an interview on 1/9/26, at 1:14 p.m., with the Social Services Director (SSD), the SSD stated she did not follow through with the podiatry care request for Resident 1. The SSD stated podiatry care was important for residents because it was for their comfort and wellbeing, and their rights as a resident living in the facility. During an interview on 1/9/26, at 11:33 a.m., with the Director of Nursing (DON), the DON stated podiatry should have been consulted if the resident needed nail care. The DON further stated if the resident were diabetic (the inability to control sugar levels in the body leading to poor healing) the facility would set up a podiatry visit for the resident, and if they were non-diabetic then staff could trim their nails. The DON further stated the appropriate course was for staff to notify social services there was a need for podiatry and then social services would carry out the referral. The DON further stated the importance of providing nail care for Resident 1 was to prevent Resident 1's toenails from growing into the skin, it could cause skin injury, and it would not be comfortable to have an unattended long thickened, hard nail. The DON stated the expectation for skin assessment was facility nursing staff should conduct a weekly head-to-toe assessment. The DON stated nursing staff should follow this practice to look for any changes in the resident's skin. A review of facility's policy and procedures (P&P) titled, Nail Care, dated 8/1/25, indicated, the purpose of this procedure is to provide guidelines for provision of care to resident's nails for good grooming and health. 1. Assessment of resident's nails will be conducted on admission and readmission to determine the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's nail condition, needs, and preferences for nailcare, if possible. a. Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.). c. Obtain history and preferences regarding podiatrist. 2. Identify conditions that increases risk for foot or nail problems. 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Principles of nail care. a. Nails should be kept smooth to avoid skin injury. c. If residents have a toe infection.renal failure.toenail trimming should be performed by a physician or practitioner. 5. Procedures. 5. Document completion of task, any complications, or if resident refuses.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received the care and services necessary to attain and maintain the highest practicable physical, mental, and psychosocial well-being, including preventing avoidable decline for 1 of 44 sampled residents (Resident 14) when Resident 14's Physician-ordered Range of Motion (ROM) exercises were not consistently provided as ordered. This deficient practice placed Resident 14 at risk for decline in mobility, development of contractures, muscle stiffness, decreased functional ability, and diminished quality of life. Findings: A review of Resident 14's, admission RECORD, indicated Resident 14 was admitted to the facility with diagnoses including hemiplegia (very little or no movement on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - a part of the brain gets damaged because it did not receive enough blood and oxygen). During a review of Resident 14's clinical record titled, Care Plan Report, Resident 14's care plan, initiated on 10/7/25, in the section titled Focus, indicated, . [Resident 14] has limited physical mobility r/t [related to] Disease process, Stroke, Weakness AEB [as evidenced by] limited BUE [both upper extremities]/ BLE [both lower extremities] ROM [range of motion]. During a review of Resident 14's Electronic Health Record (EHR) titled, Care Plan Report, Resident 14's care plan, initiated on 11/3/25, in the section titled, Intervention/Tasks, indicated, . [Resident 14] . RNA [Restorative Nursing Assistance: helping residents maintain or improve their physical abilities so they don't lose strength or independence] Programs: Gentle PROM [Passive Range of Motion - moving person's joints for them when they cannot move on their own] to RUE [right upper extremity] then apply R [right] WHFO [wrist, hand, forearm orthosis - a brace or splint that supports the wrist, hand, and forearm] for 4 hours, or as tolerated 6x/wk [6 times a week] and PROME [passive range of motion exercises - exercises where someone else gently moves your arms or legs for you] on B [both] [NAME] [lower extremities] all planes with end range stretching towards knee extension [straightening the knee] x 30 secs [seconds] hold x 7 reps [repetitions] 3x/wk. A review of Resident 14's, Documentation Survey Report, for November 2025, in the section titled, Intervention/Task, indicated, RNA Program PROM on RUE all planes 10 reps x 2 sets then apply R WHFO for 4 hours or as tolerated 6x/wk NA (Not Applicable) was documented on the following dates: 11/3/25, 11/4/25, and 11/5/25 and on RNA Program: PROME on BLE all planes with end range stretching towards knee extension x 30 secs hold x 7 reps 3x/wk NA was documented on 11/4/25. During a concurrent observation and interview on 1/6/26, at 9:25 AM with Resident 14, in Resident 14's room, Resident 14 was observed having difficulty opening his right hand. Resident 14 stated that both left and right arm muscles felt tight and had trouble opening his right hand. Resident 14 further stated that staff sometimes missed performing the restorative exercises. Resident 14 stated that since he was not in rehabilitation therapy but in a restorative program, it was very important for him not to miss the exercises. During a concurrent interview and record review on 1/8/26, at 8:21 AM, with the Restorative Nursing Assistant (RNA - helps residents practice everyday skills like moving safely after therapy ends or alongside nursing care so they don't decline), Resident 14 EHR was reviewed. The RNA confirmed that Resident 14 had RNA orders for upper extremities, specifically Resident 14's right hand six times per week from Monday to Saturday and for lower extremities three times per week implemented every Monday, Wednesday, and Friday. The RNA stated that the RNA programs for Resident 14 were crucial to prevent muscle stiffness and joint contractures. The RNA reviewed facility documentation for Resident 14 from date 12/11/25 to 1/7/26 and confirmed that RNA documentation in the section titled, Task RNA Program: Gentle PROM to RUE then apply R WHFO for 4 hours or as tolerated 6x/week, indicated NA on the following dates 1/1/26, 1/2/26, 1/3/26, and 1/5/26 and for RNA Program: PROME on BLE all planes with end range stretching towards knee extension x 30 secs hold (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	x 7 reps 3x/wk, indicated NA on 1/2/26 and 1/5/26. The RNA stated that 'NA' meant the tasks were not done as ordered by the doctor. The RNA further stated that if Resident 14's RNA programs were not followed, it could lead to increased muscle stiffness, loss of remaining functional ability, and worsening of contractures. During an interview on 1/8/26, at 2:05 PM, with the Director of Staff Development (DSD), the DSD stated that RNAs were expected to implement and perform all RNA programs as ordered by the doctor. The DSD further stated that not following the RNA program could cause Resident 14's condition to potentially decline functionally. The DSD stated they will assign extra staff, especially during the week of monthly weighing of residents, to ensure the RNA programs ordered by the doctor were implemented. During an interview on 1/9/26, at 10 AM, with the Director of Nursing (DON), the DON stated that RNAs were expected to follow the doctor's orders and carry out all RNA instructions unless the residents refused. The DON further stated that the RNA program was important to keep the residents' functional mobility and maintain their range of motion as much as possible. Review of a facility policy and procedure titled, Restorative Nursing Programs, dated 8/1/25, indicated, . It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. assisting residents with range of motion exercises, performing passive range of motion for residents who lack the active range of motion ability. Restorative Nurse is responsible . for ensuring that all elements of each resident's program are implemented . Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form or other facility designated form .		

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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 pharmaceutical services with a census of 128 when: Medications were left at Resident 97's bedside, and; Narcotic (strictly regulated substances due to their high potential for abuse, addiction, or illegal use) sheets were not signed immediately after medication administration. These failures had the potential to negatively affect the health and well-being of Resident 97, the efficacy of the medications being administered, and had the increased risk of drug diversion. 1. A review of Resident 97's admission Record indicated that Resident 97 was admitted to the facility in 2025 with diagnoses which included Type II Diabetes Mellitus and Heart Failure (a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs). During a concurrent observation and interview with Resident 97 in her room on 1/6/26 at 9:02 a.m., Resident 97 sat in her wheelchair at her bedside where a cup of medications on the bedside table was observed. When asked about the cup of medications at the bedside, Resident 97 quickly put the medications into her mouth and drank water. Resident 97 answered, Yes, when asked if the Licensed Nurse (LN) left the medications at the bedside for her to take. During an interview on 1/6/26 at 9:11 a.m. with LN 1 at the medication cart, LN 1 stated that he gave medications to Resident 97 to take earlier in the morning. LN 1 stated that Resident 97 was in the process of taking the medications when he left the room. LN 1 stated that Resident 97 put the medications in her mouth, so he left the room. LN 1 stated that the risk of leaving the medications at Resident 97's bedside was that Resident 97 could give the medications to another resident, or double dosing (taking the same medication twice). During an interview with the facility Director of Nursing (DON) on 1/8/26 at 11:08 a.m., the DON stated that her expectation was that licensed staff administered medications to residents per the physician orders, adhered to the five rights for medication administration, and that staff did not leave medications at the residents' bedside unless there was a physician order to do so. The DON stated that the risk of leaving medications at the residents' bedside was that a wandering resident could take someone else's medications, or the resident forgets to take the medications. The DON acknowledged that the facility policy was not followed. 2. During a concurrent medication cart observation, interview, and record review on 1/7/26, at 2:09 p.m. with LN 4 at the South Station, the medication cart #2 was inspected and the controlled drug (strictly regulated substances due to their high potential for abuse, addiction, or illegal use) binder was reviewed. There were 7 controlled drug count sheets (a tool used to track the inventory, administration, and disposal of controlled substances to ensure strict accountability and prevent theft or misuse) reviewed involving 3 sampled residents (Resident 27, Resident 120, Resident 15) and 3 unsampled residents (Resident 38, Resident 45, Resident 61). All 7 controlled count sheets reviewed did not match the number of pills documented on the count sheets with the number of pills that were available in the bubble packs (a medication management system where individual doses are pre-sorted into sealed, clear compartments). LN 4 stated she did not have the time to document on the count sheets immediately after removing the pills from the bubble packs and after administering the pills to the residents. The controlled count sheets reviewed were as follows: Resident 27's count sheet titled, Controlled Drug Record, dated 12/5/25, indicated, .CLONAZEPAM (used to treat anxiety or seizures) 2MG (milligram, unit of measurement) TABLET, TAKE 1 TABLET (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BY MOUTH TWICE A DAY FOR ANXIETY. The pills remaining as documented was 9 and the pills available in the bubble pack was 8. Resident 120's count sheet titled, Controlled Drug Record, dated 12/9/25, indicated, .OXYCODONE IMMEDIATE (a strong pain medication) 10MG TABLET, GIVE 1 TABLET BY MOUTH TWO TIMES A DAY FOR PAIN . The pills remaining as documented was 9 and the pills available in the bubble pack was 8. Resident 15's count sheet titled, Controlled Drug Record, dated 12/23/25, indicated, .OXYCODONE IMMEDIATE 5MG TABLET, GIVE 1 TABLET BY MOUTH EVERY 6 HOURS FOR MODERATE TO SEVERE PAIN. The pills remaining as documented was 6 and the pills available in the bubble pack was 5. Resident 38's count sheets titled, Controlled Drug Record, dated 12/25/25 and 1/1/26, indicated, .MORPHINE SULFATE ER F/C (a strong pain medication) 60MG TABLET, GIVE 1 TABLET BY MOUTH EVERY 12 HOURS FOR PAIN (4-10). The pills remaining as documented was 5 and the pills available in the bubble pack was 4. And .OXYCODONE.10-325MG TABLET, GIVE 1 TABLET BY MOUTH EVERY 4 HOURS AS NEEDED FOR MODERATE TO SEVERE PAIN . The pills remaining as documented was 20 and the pills available in the bubble pack was 19. Resident 45's count sheet titled, Controlled Drug Record, dated 1/4/26, indicated, .HYDROCODONE (a strong pain medication).5MG-325MG TABLET, GIVE 2 TABLET [sic] BY MOUTH EVERY 6 HOURS AS NEEDED FOR SEVERE PAIN . The pills remaining as documented was 24 and the pills available in the bubble pack was 22. Resident 61's count sheet titled, controlled Drug record, dated 11/27/25, indicated, .LORAZEPAM (used to treat anxiety) 1MG TABLET, GIVE 1 TABLET BY MOUTH EVERY 12 HOURS FOR ANXIETY . The pills remaining as documented was 8 and the pills available in the bubble pack was 7. During an interview on 1/7/25, at 2:09 p.m. LN 4 confirmed that she did not sign off the controlled medications at the time the pills were popped out from the bubble pack and at the time the pills were given to the residents. LN 4 also stated she should have documented immediately on the count sheets at the time the pills were removed and administered, and it would be best practice to document immediately. LN 4 further stated there could be a high risk for medication errors when controlled count sheets were not signed off in a timely manner. During an interview on 1/7/26, at 2:54 p.m. with the Assistant Director of Nursing (ADON), the ADON stated it was not the facility practice to sign the controlled count sheets at a later time. The ADON explained it was best practice to sign off the controlled drugs in a timely manner to prevent the risk for medication errors. During an interview on 1/8/26, at 2:55 p.m. with the DON in the presence of the Clinical Nurse Consultant (CNC), the DON stated she expected the nurses to sign out the controlled drugs in the count sheets immediately after popping out the pills. She explained controlled drugs not accounted for could lead to further investigation due to possible drug diversion. During a record review of the facility's policy and procedure (P&P), titled, General Dose Preparation and Medication Administration, revised date 11/15/24, the P&P indicated, .Document the administration of controlled substances in accordance with applicable law. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's undated policy and procedure (P&P), titled, Medication Administration, the P&P indicated, .If medication is a controlled substance, sign narcotic book.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for one of five sampled residents (Resident 109) during medication administration by failing to follow a physician order when, Resident 109's insulin (medication used to manage blood sugar levels in people with diabetes, a chronic condition where the body does not produce or use insulin properly leading to high blood sugar levels) order indicated to administer the medication on an empty stomach and Resident 109's insulin was administered during the breakfast meal on 1/8/26. This failure had the potential for Resident 109 to experience blood sugar fluctuations of hypoglycemia (when blood sugars are too low) and hyperglycemia (when blood sugars are too high) and increased the risk for unsafe medication administration. Findings: During a review of Resident 109's admission RECORD, indicated Resident 109 was admitted to the facility with diagnoses including diabetes. During a medication administration observation on 1/8/26, at 7:59 a.m. with Licensed Nurse (LN) 6 at the hallway in front of Resident 109's room, LN 6 was preparing her equipment to take Resident 109's fasting blood sugar (FBS) level. Resident 109 was seated by the doorway with her breakfast meal tray on top of the bedside table and in front of her. After LN 6 took her FBG, she had asked LN 6 to remove the plate cover. LN 6 walked back to her medication cart to administer resident 109's insulin. LN 6 read the order from the eMAR (electronic Medication Administration Record) and looked for the medication in the cart. LN 6 had indicated to Resident 109 that she did not see her insulin in the cart, and she was going to look for it in the refrigerator that was in the medication room. LN 6 then locked her cart and took the cart with her to the nurses' station without administering the insulin to Resident 109. In the meantime, Resident 109 had started eating her breakfast. In her meal tray, she had sausage patty, hard boiled eggs, banana, and hot cereal. Resident 109 had eaten her sausage patty and LN 6 had not been back to administer her insulin. Resident 109 had indicated that she ate her sausage patty. During a record review of Resident 109's Medication Administration Record, (MAR-a record that guides the nurses for medication administration) dated 11/10/25, indicated, .Insulin Lispro Injection solution 100 UNIT/ML (UNIT-strength of insulin in ML-milliliter, unit of measurement) (Insulin Lispro) Inject as per sliding scale. subcutaneously before meals for DM [diabetes mellitus]. During an interview on 1/8/26, at 8:29 a.m. with LN 6, LN 6 explained that she did not find Resident 109's Insulin Lispro and there was none from the emergency kit, but Novolog (insulin aspart) injection 100 units/ml was available. LN 6 stated she had to call the physician to get an order to give Novolog insulin instead. By this time, LN 6 administered the insulin to Resident 109. During a record review of Resident 109's Medication Administration Record (MAR), dated 1/8/26, indicated, .Novolog Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale. subcutaneously before meals. for DM. During an interview on 1/8/26 at 11:32 a.m. with LN 6, LN 6 confirmed she administered Resident 109's insulin after Resident 109 had eaten some of her breakfast meal and stated it should have been given at least 15 minutes before meals. LN 6 explained she should have followed the physician order to administer before meals because it could have a potential risk for Resident 109's blood sugar level to spike once food was digested and her blood sugar level to drop later causing hypoglycemia. During a record review of Resident 109's Diabetes Care Plan, dated 1/27/23, indicated, .Diabetes medication as ordered by doctor. During a record review of Resident 109's Order summary Report, dated 1/8/26, indicated, .Novolog Injection Solution (Insulin Aspart) Inject as per sliding scale. subcutaneously before meals. for DM. During an interview on 1/8/26, at 2:46 p.m. with the Director of Nursing (DON), the DON stated she expected the physician order should be followed in order to keep the blood sugar at a stable level and prevent the potential spike in blood sugar if given too late and the insulin medication could bring the blood sugar level down too fast. During a record review of the facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 11/15/24, the P&P indicated, .Verify each time a medication is administered that it is the correct medication, at the correct dose, at (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Arbor Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the correct route, at the correct rate, at the correct time, for the correct resident.Administer medications within timeframes specified by facility policy or manufacturer's information.During a record review of the facility's undated P&P titled, Medication Administration, indicated, .Medications are administered by licensed nurses.as ordered by the physician.Medications requiring administration on an empty stomach.Insulin.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage for a census of 128 when prescribed medications found in the pharmaceutical waste container (where unused and/or discontinued prescribed medications were held for ultimate safe disposal) in the South Station medication room were not disposed of properly where pills, medication bottles, and inhalers (used to deliver medication directly to the lungs) were still recognizable and retrievable by hand. This failure had the potential for misuse of prescribed medications due to unsafe disposal practices. During a medication storage observation and interview on 1/7/26, at 2:41p.m. with Licensed Nurse (LN) 7, the medication room at South Station was inspected. A pharmaceutical waste container inside the cabinet contained discarded prescribed pills, inhalers, and medication bottles that were still recognizable and retrievable by hand. LN 7 could not explain when asked what the process was of discarding prescribed pills into a pharmaceutical waste container. During an interview on 1/7/26, at 2:54 p.m. with the Assistant Director of Nursing (ADON), the ADON confirmed the discarded prescribed pills found in the pharmaceutical waste containers were still recognizable and retrievable by hand. The ADON explained the discarded pills should have been mixed with a drug buster (drug disposal product used to safely and effectively dispose of unwanted or expired medications) such as used coffee grounds, cat litter, or covered with fluid to prevent the risk of drug misuse and/or drug diversion. During an interview on 1/8/26, at 2:55 p.m. with the Director of Nursing (DON) in the presence of the Clinical Nurse Consultant (CNC), the DON stated she expected the discarded prescribed medications in the pharmaceutical waste containers should have been unrecognizable and unretrievable by hand. The DON also stated the discarded medications should have been mixed with drug buster, cat litter, or used coffee grounds to prevent the risk for misuse and potentially be pulled out from the waste container and be used by unauthorized individuals. During a record review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 8/1/25, the P&P indicated, .Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. During a record review of the facility's P&P titled, Destruction of Unused Drugs, dated 8/1/25, the P&P indicated, .All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with current and applicable state and federal requirements.		

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an appointment was scheduled within 1 to 2 weeks after a hospitalization for 1 out of 44 sampled residents (Resident 161), when Resident 161's cardiology appointment was not scheduled as ordered. This failure resulted in Resident 161 missing a physician's appointment and a potential risk for causing a delay in care and treatment. Findings: A review of Resident 161's admission RECORD, indicated Resident 161 had diagnoses including disorder of circulatory system (impaired blood supply in certain areas of the body), embolism and thrombosis of arteries of the lower extremities (a blood clot forming or traveling to block blood flow in leg arteries), cardiomyopathies (a disease that weakens or changes the heart muscle, making it harder for the heart to pump blood effectively to the body), acute on chronic combined systolic congestive and diastolic congestive heart failure (a severe, sudden worsening of a long-term heart problem where the heart struggles with both its pumping and relaxing/filling functions, leading to fluid backup in the lungs and body), hypertensive heart disease with heart failure (long-term high blood pressure has damaged the heart, forcing it to work harder, thicken, and eventually weaken, making it unable to pump blood effectively). A review of Resident 161's [Hospital] Discharge summary, dated [DATE], indicated, Resident 161 had a follow-up appointment with cardiology within 1 to 2 weeks. Further review of the record indicated, .Call for outpatient follow up appointment with cardiology for further management of cardiomyopathy and heart failure. During an interview on 1/6/26, at 10:48 AM, with Resident 161, Resident 161 stated she was supposed to have an appointment with a cardiologist (heart doctor) but it was not scheduled yet. Resident 161 further stated she was admitted to the facility because she had a blood clot in her heart. During an interview on 1/6/26, at 8:28 AM, with the Social Service Director (SSD), the SSD stated that when a new admission came in, the case manager would schedule the appointments for the residents depending on their insurance. The SSD further stated that the MDS Manager (Minimum Data Set - A comprehensive, standardized assessment of a resident's health status, functional capabilities, and needs) scheduled the appointments for Medicare residents, made the referrals and sometimes the nurses and the ADON would help with the scheduling. The SSD stated that the Social Services department arranged the transportation and she would oversee the transportation schedule for the residents' appointments. During a concurrent interview and record review on 1/8/26, at 8:52 AM, with the MDS Manager (MDS), Resident 161's electronic health record (EHR) was reviewed. The MDS stated that she and the case manager were responsible for scheduling the appointments for the residents. The MDS confirmed that Resident 161's hospital discharge records indicated there was an order for a consultation with cardiology within 1 to 2 weeks. The MDS further confirmed that the cardiology appointment was not in the active order list of Resident 161's EHR. The MDS stated that the risk of missing the appointment especially if it was a cardiology appointment, could potentially worsen Resident 161's condition. The MDS further stated that the cardiology appointment was important because Resident 161 was admitted for cardiac issues. During a concurrent interview and record review on 1/8/26, at 9:04 AM, with the Case Manager (CM), Resident 161's EHR was reviewed. The CM stated that when the nurses would admit the residents, they placed the order from the hospital discharge summary. The CM further stated that if the admission nurse missed placing the appointment order in the EHR, she would double check the uploaded documents in the resident's EHR. The CM stated that when they completed the meet and greet with the newly admitted resident, she would often ask the resident or the RP (responsible party) if they were aware of any scheduled appointments. The CM confirmed that the cardiology appointment should have been ordered upon admission or shortly after Resident 161 was admitted to the facility. The CM stated missing a cardiology appointment could lead to a health risk and it could complicate Resident 161's health condition. During a concurrent interview and record review on 1/9/26, at 10:55 AM, with the Director Of Nursing (DON), Resident 161's hospital discharge summary was reviewed. (continued on next page)		

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated that the nurses that were admitting the resident were responsible to place the order in the EHR. The DON further stated that the doctor would then review the orders. The DON confirmed that the appointment should have been discussed with the doctor and documented that discussion with the doctor. The DON stated that the appointment should have been discussed with Resident 161. The DON further stated that the nurse who admitted Resident 161 did not see the appointment and failed to input the order in the EHR. A review of the facility's policy and procedure (P&P) titled, Resident Appointments, revised December 2008, indicated, .The facility will assist residents with scheduling, transportation, and coordination of medically necessary and requested appointments. Appointments will be documented in the resident record, and appropriate clinical information will be communicated to the provider as needed.		

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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 ensure infection control measures were used to prevent the spread of germs for a census of 128 when the oxygen nasal cannula (a flexible plastic tube connected to an oxygen source with two prongs that fit in the nostrils used to provide extra oxygen through the nose) was not placed in an antimicrobial bag (a bag that reduces the growth of germs on the nasal cannula) as ordered for Resident 134. This failure had the potential to result in the spread of germs and the need for additional medical interventions (medications and/or treatments). Findings: A review of Resident 134's admission Record indicated that Resident 134 was admitted to the facility in 2019 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, a long-term disease that cause airflow blockage, breathing related problems, shortness of breath and cough). During an observation and concurrent interview with Resident 134 in her room on 1/8/26 at 9:12 a.m., Resident 134 pointed to her walker and stated that she asked facility staff for a plastic bag to protect her nasal cannula attached to the oxygen tank on Monday 1/5/26, and they still have not brought it to her. Resident 134 stated that she felt that it was unsanitary (not clean) to have the nasal cannula drag on the floor when she walked, so she put the nasal cannula in the compartment under the seat of her walker. The nasal cannula was observed coiling under the seat of Resident 134's walker and was not in a protective bag. A review of Resident 134's Physician Order Summary Report on 1/8/26 at 10:00 a.m. indicated, .Oxygen at 3_LPM (liters per minute, unit of measure) via_nasal cannula_ continuous every shift. Order Status.Active. Order Date.08/05/2025. A review of Resident 134's Physician Order Summary Report on 1/8/26 at 10:00 a.m. indicated, .Change Oxygen tubing as needed for when visibly soiled (dirty). Please place tubing in antimicrobial bag. Order Status.Active. Order Date.04/10/2025. Start Date.04/10/2025. A review of Resident 134's Physician Order Summary Report on 1/8/26 at 10:00 a.m. indicated, .Change Oxygen tubing every night shift starting on the 10th and ending on the 11th every month Please place tubing in antimicrobial bag. Order Status.Active. Order Date.04/10/2025. A review of Resident 134's Care Plan Report on 1/8/26 at 10:00 a.m. indicated, .Focus.Has Oxygen Therapy r/t (related to) COPD.Goal.Will have no s/sx (signs/symptoms) of poor oxygen absorption through the renew date.Date Initiated.09/25/2025.Target Date.01/31/2026.Interventions/Tasks.Oxygen per MD (physician) orders.A review of Resident 134's Medication Administration Record (MAR, a document listing medications and monitoring parameters) January 2026 on 1/8/26 at 10:00 a.m. indicated no documented oxygen tubing changes. During an observation and interview with the facility Director of Nursing (DON) on 1/8/26 at 11:08 a.m., the DON stated that her expectation was that oxygen tubing, nasal cannulas, masks for breathing treatments and CPAP (Continuous Positive Airway Pressure, a machine that uses mild air pressure to keep breathing airways open during sleep) masks needed to be stored in black bags or clear plastic bags off the floor when not in use. The DON stated that the black bags were antimicrobial and were good for thirty days. The DON stated that the nasal cannulas should be in a bag when placed in the resident walker seat compartment. The DON acknowledged that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Oxygen Administration, dated 8/1/2025, the P&P indicated, .Policy.Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.Policy Explanation and Compliance Guidelines.1. Oxygen is administered under orders of a physician.5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include.b. Change oxygen tubing and mask/cannula monthly and as needed if it becomes soiled or contaminated (in contact with germs). Documentation of this is made on the MAR.d. Keep delivery devices covered in.bag when not in use.		

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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 follow their policy and procedure for the pneumococcal (a serious bacterial infection that can cause respiratory illness) immunization for two out of five sampled residents (for immunization review) when: 1. Resident 31's pneumonia vaccine was not documented; and, 2. Resident 86's pneumococcal vaccine was not given after being admitted to the facility. These failures had the potential for Resident 31 and Resident 86 to be at risk to be infected with the pneumococcal virus that could lead to severe illness, hospitalization, and/or death. Findings: a. A review of Resident 31's admission RECORD, indicated Resident 31 was admitted on [DATE]. b. A review of Resident 86's admission RECORD, indicated Resident 86 was admitted on [DATE]. During a concurrent interview and record review on 1/8/26, at 10:27 AM, with the Infection Preventionist (IP), Resident 31 and Resident 86's electronic health record (EHR) were reviewed. The IP stated Resident 31 received pneumonia vaccine on 7/21/2020. The IP confirmed that pneumonia vaccine information was not documented on the electronic health record for Resident 31. The IP stated that the pneumonia vaccine information of Resident 31 should have been documented at the EHR. Resident 86's immunization record was reviewed with the IP, the record indicated Resident 86 consented to receive a pneumonia vaccine which he signed upon admission on [DATE]. The IP further stated that Resident 86 went to the hospital on 1/5/26 but the pneumonia vaccine should have been given to Resident 86 before he went to the hospital. The IP stated that Resident 86 was on antibiotics due to osteomyelitis (bone infection) and that was the reason she did not provide Resident 86 the pneumonia vaccine. The IP further stated that she should have communicated with the doctor first before deciding not to give the pneumonia vaccine to Resident 86. During an interview on 1/9/26, at 10:55 AM, with the Director Of Nursing (DON), the DON stated that the immunization information and consent were obtained during admission for new residents. The DON further stated that the IP would follow up on the next business day if the consents were signed or needed to be signed. The DON stated that a reasonable time to complete a resident's immunization record was within 7-10 days upon admission. A review of the facility's policy and procedure (P&P) titled, Immunizations - Residents, dated 9/2017, revised 8/2025, indicated, .It is the policy of this facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine (s) and obtaining consent. Purpose To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza, pneumococcal disease, or COVID-19 by ensuring that each resident is informed about the benefits and risks of immunizations; and has the opportunity to receive the influenza, pneumococcal, or COVID-19 vaccine (s), unless medically contraindicated, declined or already immunized. Residents will be screened at that time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines, to receive the influenza, pneumococcal, and/or COVID-19 vaccine(s). Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized.		