

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |                            |                                                                    |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>555164</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/02/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARBOR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>900 NORTH CHURCH STREET</b><br><b>LODI, CA 95240</b>                         |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| F 000                                                           | <p><b>INITIAL COMMENTS</b></p> <p>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of entity reported incident #CA00447045.</p> <p>Representing the Department of Public Health:<br/>HFEN, 29750</p> <p>The inspection was limited to the specific entity reported incident investigated and does not reflect the findings of a full inspection of the facility.</p> <p>The Department was unable to substantiate a violation of regulations.</p> | F 000                                                                      |                                                                                                                          |                            |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

*Administrator*

*7-9-15*

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.