STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stockton Nursing Center	4545 Shelley Court Stockton, CA 95207

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43496 Based on observation, interview, and record review, the facility failed to maintain a sanitary and comfortable facility interior for two of two sampled bathrooms when, two jack and [NAME] bathrooms (a bathroom shared between two bedrooms, with doors entering from each room) that were intended for use for eleven residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11) were noted in disrepair with large areas of peeling paint behind the toilet, an open gap behind the toilet, missing baseboards, and a chipped trim counter located at the front of the sink. These failures did not provide a homelike environment for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11 with the potential to result in injury and/or negative psychosocial outcomes. Findings: During a concurrent observation and interview on 1/6/25, at 3:29 PM, the Maintenance Director (MD) confirmed the shared bathroom, for Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11 was missing all the baseboards and the wood trim in front of the sink counter was damaged with a chipped laminate covering exposing the bare wood. The MD stated the baseboards needed to be installed and the trim in front of the sink counter needed to be repaired. The MD stated if a piece of the trim in front of the sink continued to break off a resident could cut their foot on the broken pieces. The MD confirmed the shared bathroom, for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6, had a wall that was peeling away from behind the toilet. The MD stated the wall to the bottom left of the toilet was damaged, peeling, and needed to be repaired. The MD confirmed there was an open gap behind the toilet that measured approximately 1/4 to 1/2 of an inch. The MD stated he was not aware of the condition of the bathrooms, and he would have repaired them prior had staff made him aware. The MD stated the condition of the bathrooms in their current state were ugly and did not provide a home like environment for the residents. During an interview on 1/6/25 at 3:42 PM, Licensed Nurse (LN) 1 stated staff complained about the condition of the bathrooms all the time, but nothing was ever done. LN 1 stated the resident bathrooms were not great, nor were the walls in the bathroom well maintained. LN 1 stated the bathroom walls in the current condition could contain bacteria and could affect a resident's well-being. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/24, at 4:01 PM the Assistant Director of Nursing (ADON) stated any staff could put in a maintenance request for repairs to the facility. The ADON stated the current condition of the two identified resident bathrooms was a safety hazard. The ADON explained, with the resident bathrooms in their current condition it did not provide for a homelike environment for the residents. The ADON stated the purpose of creating a home like environment for the residents was so the residents would feel welcomed and comfortable in their home (the facility). During an interview on 1/6/24 at 4:19 PM, the Administrator (ADM) confirmed the current condition of the two resident bathrooms identified was not acceptable and needed to be repaired. The ADM stated the condition of the resident bathrooms was a safety issues and did not provide a home like environment for the residents. Review of a facility Policy and Procedure (P&P) titled Homelike Environment, dated 2/21, indicated, . Resident are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean, sanitary and orderly environment . Review of a facility P&P titled Maintenance Services, dated 12/09, indicated, .Maintenance service shall be provided to all areas of the building .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner .Functions of maintenance personnel include, but are not limited to .Maintaining the building in good repair and free from hazards .Establishing priorities in providing repair service .Providing routinely scheduled maintenance service to all areas . 51681 Based on observation, interview, and record review, the facility failed to maintain a sanitary and comfortable facility interior for two of two sampled bathrooms when, two jack and [NAME] bathrooms (a bathroom shared between two bedrooms, with doors entering from each room) that were intended for use for eleven residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11) were noted in disrepair with large areas of peeling paint behind the toilet, an open gap behind the toilet, missing baseboards, and a chipped trim counter located at the front of the sink. These failures did not provide a homelike environment for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11 with the potential to result in injury and/or negative psychosocial outcomes. Findings: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/6/25, at 3:29 PM, the Maintenance Director (MD) confirmed the shared bathroom, for Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11 was missing all the baseboards and the wood trim in front of the sink counter was damaged with a chipped laminate covering exposing the bare wood. The MD stated the baseboards needed to be installed and the trim in front of the sink counter needed to be repaired. The MD stated if a piece of the trim in front of the sink continued to break off a resident could cut their foot on the broken pieces. The MD confirmed the shared bathroom, for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6, had a wall that was peeling away from behind the toilet. The MD stated the wall to the bottom left of the toilet was damaged, peeling, and needed to be repaired. The MD confirmed there was an open gap behind the toilet that measured approximately 1/4 to 1/2 of an inch. The MD stated he was not aware of the condition of the bathrooms, and he would have repaired them prior had staff made him aware. The MD stated the condition of the bathrooms in their current state were ugly and did not provide a home like environment for the residents. During an interview on 1/6/25 at 3:42 PM, Licensed Nurse (LN) 1 stated staff complained about the condition of the bathrooms all the time, but nothing was ever done. LN 1 stated the resident bathrooms were not great, nor were the walls in the bathroom well maintained. LN 1 stated the bathroom walls in the current condition could contain bacteria and could affect a resident's well-being. During an interview on 1/6/24, at 4:01 PM the Assistant Director of Nursing (ADON) stated any staff could put in a maintenance request for repairs to the facility. The ADON stated the current condition of the two identified resident bathrooms was a safety hazard. The ADON explained, with the resident bathrooms in their current condition it did not provide for a homelike environment for the residents. The ADON stated the purpose of creating a home like environment for the residents was so the residents would feel welcomed and comfortable in their home (the facility). During an interview on 1/6/24 at 4:19 PM, the Administrator (ADM) confirmed the current condition of the two resident bathrooms identified was not acceptable and needed to be repaired. The ADM stated the condition of the resident bathrooms was a safety issues and did not provide a home like environment for the residents. Review of a facility Policy and Procedure (P&P) titled Homelike Environment, dated 2/21, indicated, . Resident are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean, sanitary and orderly environment . Review of a facility P&P titled Maintenance Services, dated 12/09, indicated, .Maintenance service shall be provided to all areas of the building .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner .Functions of maintenance personnel include, but are not limited to .Maintaining the building in good repair and free from hazards .Establishing priorities in providing repair service .Providing routinely scheduled maintenance service to all areas .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43496 Based on observation, interview, and record review, the facility failed to implement and revise a person-centered care plan for one of two sampled residents (Resident 1) when, Resident 1's fall care plan interventions of a bedrail, call light within reach, and the bed in the low position was not implemented. This failure had the potential to be a safety risk which could result in Resident 1 falling, negatively impacting Resident 1's health and wellbeing. Findings: Review of Resident 1's actual fall care plan, initiated on 5/13/24, in the section Focus indicated, .hx [history] of fall(s) w/ [with] recent major injury .poor memory, bouts of confusion, poor safety awareness, impulsive, attempts to get up and out of bed/chair without staff assistance . During a concurrent observation and interview on 1/6/25, at 3:01 PM, Licensed Nurse (LN) 1 confirmed Resident 1 was in bed and Resident 1's bed was not in the lowest position. LN 1 confirmed Resident 1's call light was draped in the bottom drawer in the nightstand located to the left of Resident 1's bed. LN 1 stated Resident 1 would not be able to reach the call light to use it if needed. LN 1 confirmed Resident 1's bed did not have any side rails in place. During an interview on 1/6/25, at 3:42 PM, LN 1 stated, the risk to residents when care plan interventions were not implemented could result in resident falls and residents could hurt themselves. LN 1 stated the purpose of a care plan was to make sure safety precautions were in place. During a concurrent interview and record review on 1/6/24 at 4:01 PM, Resident 1's fall care plans were reviewed with the Assistant Director of Nursing (ADON). The ADON confirmed Resident 1's fall care plan, initiated on 12/20/24, included interventions of .Bed in lowest position .Place call light within reach at all times . The ADON confirmed Resident 1's fall care plan, initiated 5/13/24, included interventions of .Implement measures to prevent falls: keep bed in low position with side rails up when client is in bed keep needed items within easy reach . The ADON stated care plan interventions should be carried out and were necessary for the safety of the residents. The ADON checked Resident 1's medical record and noted that the facility conducted a bed rail assessment on 11/16/24 which indicated that Resident 1 did not need bed rails. The ADON acknowledged that Resident 1's care plan should have been updated/corrected to remove the intervention of the bed rails. Review of a facility policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated 4/09, indicated, .When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly .Goals and objectives are entered on the resident's care plan so that all discipline have access to such information and are able to report whether or not the desired outcomes are being achieved .Goals and objectives are reviewed and/or revised: . at least quarterly . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility P&P titled CARE PLAN COMPREHENSIVE, dated 8/25/21, indicated, .must develop and implement a comprehensive person-centered care plan for each resident .to meet a resident's medical, physical, and mental and psychosocial needs .Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change . Review of a facility P&P titled Answering the Call Light, dated 10/24/24, indicated, .Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor . 51681 Based on observation, interview, and record review, the facility failed to implement and revise a person-centered care plan for one of two sampled residents (Resident 1) when, Resident 1's fall care plan interventions of a bedrail, call light within reach, and the bed in the low position was not implemented. This failure had the potential to be a safety risk which could result in Resident 1 falling, negatively impacting Resident 1's health and wellbeing. Findings: Review of Resident 1's actual fall care plan, initiated on 5/13/24, in the section Focus indicated, .hx [history] of fall(s) w/ [with] recent major injury .poor memory, bouts of confusion, poor safety awareness, impulsive, attempts to get up and out of bed/chair without staff assistance . During a concurrent observation and interview on 1/6/25, at 3:01 PM, Licensed Nurse (LN) 1 confirmed Resident 1 was in bed and Resident 1's bed was not in the lowest position. LN 1 confirmed Resident 1's call light was draped in the bottom drawer in the nightstand located to the left of Resident 1's bed. LN 1 stated Resident 1 would not be able to reach the call light to use it if needed. LN 1 confirmed Resident 1's bed did not have any side rails in place. During an interview on 1/6/25, at 3:42 PM, LN 1 stated, the risk to residents when care plan interventions were not implemented could result in resident falls and residents could hurt themselves. LN 1 stated the purpose of a care plan was to make sure safety precautions were in place. During a concurrent interview and record review on 1/6/24 at 4:01 PM, Resident 1's fall care plans were reviewed with the Assistant Director of Nursing (ADON). The ADON confirmed Resident 1's fall care plan, initiated on 12/20/24, included interventions of .Bed in lowest position .Place call light within reach at all times . The ADON confirmed Resident 1's fall care plan, initiated 5/13/24, included interventions of .Implement measures to prevent falls: keep bed in low position with side rails up when client is in bed keep needed items within easy reach . The ADON stated care plan interventions should be carried out and were necessary for the safety of the residents. The ADON checked Resident 1's medical record and noted that the facility conducted a bed rail assessment on 11/16/24 which indicated that Resident 1 did not need bed rails. The ADON acknowledged that Resident 1's care plan should have been updated/corrected to remove the intervention of the bed rails. (continued on next page)

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