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	02/13/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 49823 Based on interview, and record review, the facility failed to protect the rights of two residents (Resident 5 and Resident 6) to be free from unreasonable confinement when Certified Nursing Assistant (CNA 7) tied the room door with a garbage bag to prevent Resident 5 from leaving the room shared with his roommate (Resident 6). This failure had the potential to negatively impact Resident 5's and Resident 6's sense of dignity and well-being. Findings: A review of Resident 5's Admission Record, indicated Resident 5 was admitted to the facility in 2024 with diagnoses which included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (a nervous disorder characterized by a state of excessive easiness and apprehension that interferes with daily living), and a history of falling. A review of Resident 5's electronic medical record (EMR) indicated that Resident 5's Responsible Party (RP, family member) and physician were notified of the incident on 2/5/25. A review of Resident 6's Admission Record, indicated that Resident 6 was admitted to the facility in 2021 with diagnoses which included congestive 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), and chronic kidney disease (progressive damage and loss of function of the kidneys). A review of Resident 6's EMR indicated that Resident 6's RP and physician were notified of the incident on 2/5/25. During an interview on 2/12/25, at 2 p.m., with CNA 1, CNA 1 stated that she heard about the incident. CNA 1 further stated that she had not heard of that happening at the facility before. CNA 1 stated that the CNA's role was to assist residents with meals and care needs. CNA 1 further stated that if she saw the incident she would have reported it right away because she was a mandated reporter (a person who is legally required to report suspected abuse or neglect of children, elders, or dependent adults). (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25, at 2:05 p.m., with Licensed Nurse (LN) 2, LN 2 stated that she heard about the incident during an in-service at the facility. LN 2 further stated that tying the residents' door closed so that they could not exit the room was a form of abuse. During a phone interview on 2/13/25, at 3:42 p.m., with LN 4, LN 4 stated she was the charge nurse on duty on the day of the incident. LN 4 confirmed that CNA 7 tied Resident 5's room door shut with a garbage bag, and that Resident 6 was also in the room. LN 4 further stated CNA 7 tied the room door shut because Resident 5 was trying to leave the room. LN 4 stated CNA 7 just tied the room door shut one time. LN 4 further stated she did not know how long the room door was tied because she was busy charting. LN 4 stated CNA 7 had said that she watched Resident 5 until Resident 5 went to sleep, then she untied the door, but she forgot to remove the garbage bag from the door. LN 4 stated she was aware that it was unacceptable to tie a resident's room door shut. During a phone interview on 2/13/25, at 4:15 p.m., with CNA 7, CNA 7 confirmed that she tied the door to Resident 5's room shut with a garbage bag. CNA 7 further confirmed that Resident 6 was also in the room when the door was tied shut. CNA 7 stated she tied the doors with the garbage bag to keep Resident 5 from leaving the room and going outside because he was agitated. CNA 7 stated she only tied the resident's room door shut one time, just that night, to keep the resident safe. CNA 7 stated she had informed the charge nurse that she tied the resident's room door shut. CNA 7 further stated she was aware that tying a resident's room door shut was unacceptable. During an interview on 2/13/25, at 11:30 a.m., with the Social Services Director (SSD), the SSD stated one of the facility CNAs took a photo of Resident 5 and Resident 6's room door that was tied shut with a garbage bag on 2/5/25 and sent the photo and a text message to the Assistant Director of Nursing (ADON). The SSD further stated the ADON was in a meeting with the SSD, Administrator (ADM), and the Director of Nursing (DON) when she received the text message. The SSD stated the ADON showed the photo and text message to the ADM, DON, and SSD. During an interview on 2/13/25, at 12:21 p.m., with the DON, the DON confirmed that she saw the photo and text message sent by a CNA showing Resident 5 and Resident 6's room door tied shut with a garbage bag. The DON further confirmed that Resident 5 and Resident 6 were in the room that had the door tied shut with the garbage bag. The DON stated that an investigation concluded that one of the CNAs on duty acknowledged that she tied the Resident 5 and Resident 6's room door shut with a garbage bag after another CNA identified her as the one who tied the door shut. The DON further stated the Licensed Nurse (LN) on duty stated that she was aware that the CNA tied the residents' room door shut. The DON stated that tying the residents' room door shut was unacceptable. During an interview on 2/13/25, at 2:45 p.m., with the ADM, the ADM stated that she became aware of the incident on 2/5/25 when the ADON showed her a text message from one of the CNAs with a photo of the resident room door tied with a garbage bag. The ADM further stated that this was the only instance of a resident room being tied shut that she was aware of. The ADM stated that she did not know how long the room door was tied shut. The ADM further stated that the incident occurred on the night shift which began on 2/4/2025 at 10:30 p.m. and ended on 2/5/2025 at 7 a.m. The ADM explained that this was involuntary seclusion and this was not an acceptable practice. The ADM stated the incident affected Resident 5's and Resident 6's sense of dignity. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility policy and procedure (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated, .Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience .13. Seclusion .shall not be employed . During a review of a facility P&P titled, Abuse Prohibition Policy and Procedure, dated 2/23/21, the P&P indicated, .HealthCare Centers prohibit abuse, mistreatment .for all residents.This includes, but is not limited to .involuntary seclusion .Involuntary seclusion is defined as separation of a patient from other patients or from her/his room or confinement to her/his room (with or without roommates) against the patient's will .6.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion .is to tell the abuser to stop immediately and report the incident to his/her supervisor . During a review of a facility P&P titled, Resident Rights, revised 12/2021, the P&P indicated, .Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to; a. a dignified existence .d. to be free from .involuntary seclusion . During a review of a facility P&P titled, Dignity, revised 2/2021, the P&P indicated, .Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .1. Residents are treated with dignity and respect at all times .13. Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. addressing the underlying motives or root causes for behavior .