

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>50598</p> <p>Based on observations, interviews, and record review, the facility failed to protect resident ' s right to be free from physical abuse by a resident for two of five sampled residents (Resident 1 and Resident 5) when:</p> <ol style="list-style-type: none"> 1. Resident 2 splashed water on Resident ' s 1 face; and 2. Resident 2 spit on Resident 5. <p>This failure resulted in Resident 1 feeling uncomfortable and had the potential to affect Resident 1 ' s and Resident 5 ' s psychosocial well-being.</p> <p>Findings:</p> <p>Review of Resident 1 ' s ADMISSION RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event) and bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels, often involving periods of extreme highs (mania) and lows (depression)).</p> <p>Review of Resident 2 ' s ADMISSION RECORD, indicated Resident 2 was admitted to the facility with diagnosis of major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunity to sleep), and schizophrenia (a mental health disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/11/25, at 2:05 PM, Resident 1 stated Resident 2 came towards her yelling at her stating that Resident 1 was sitting outside of Resident 2 ' s room door. Resident 1 stated, shortly after that statement Resident 2 splashed a cup of water on her. Resident 1 also stated Resident 2 comes to her room on a nightly basis. Resident 1 stated she closes her bedroom door at night to ensure that Resident 2 would not enter her room while she ' s asleep. However, Resident 1 stated Resident 2 would still open her door quietly and stand at the foot of her bed and stare at her while she ' s asleep. Resident 1 stated she did not feel safe in her room due to how often Resident 2 returned to her room after each incident. Resident 1 explained about an incident when Resident 2 entered her room with a box under her shirt. Resident 1 stated she had no idea what was in that box, and it scared her. Resident 1 stated, Resident 2 came to her room last night as well. Resident 1 stated each time Resident 2 would come to her room she would yell, and the staff would come and get Resident 2. Resident 1 stated when Resident 2 would come to her room she would yell GO! and sometimes that would get Resident 2 to leave. Resident 1 stated, Emotionally I feel uncomfortable. Resident 1 stated she did not feel safe in her room.</p> <p>During an interview with Licensed Nurse (LN) 1, on 3/11/25, at 2:19 PM, LN 1 stated Resident 2 had interactions with other residents where Resident 2 would become extremely agitated and aggressive. LN 1 stated Resident 2 ' s behavior changed quickly and when angry, Resident 2 would throw cups of water on other residents and staff.</p> <p>During an observation on 3/11/25, at 2:26 PM, Resident 2 was noted to be walking unattended down the hallway away from her room towards Resident ' s 1 room. Resident 2 stopped, opened the shower room door, went in the shower room and closed the door behind her. After a few minutes Resident 2 exited the shower room with a sheet taken from the shower room and continued down the hallway unattended.</p> <p>During an interview on 3/11/25, at 9:37 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 had a known history of attacking other residents and staff. CNA 1 stated when a resident is continuously aggressive the facility would provide them a staff member that will sit with them throughout the day to prevent any altercations. CNA 1 stated that Resident 2 has never had a sitter but would benefit from one.</p> <p>During an interview on 3/13/25, at 10:16 AM, Resident 4 stated that Resident 2 used to be her roommate until Resident 2 poured water on her in the middle of the night while angry. Resident 4 stated, Resident 2 had an extensive history of verbal and physical altercations with the staff. Resident 4 stated, Resident 2 ' s behavior exacerbates at night. Resident 4 stated she was informed that she needed to move rooms due to Resident 2 ' s aggression and altercations between them.</p> <p>During an interview with Resident 1 on 3/13/25, at 11:06 AM, Resident 1 stated Resident 2 returned to her room last night in the middle of the night. Resident 1 stated when she told Resident 2 to get out of her room, Resident 2 responded by saying, I don ' t care what you say I can do what I want. Resident 1 stated after she yelled, the staff removed Resident 2 from her room. Resident 1 stated Resident 2 kept returning to her room. Resident 1 stated that she informed staff that she did not feel safe in her room and staff informed her that they did not know what to do.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Resident 3 (whom was Resident ' s 1 roommate at the time of the interview) on 3/13/25, at 11:11 AM, Resident 3 stated Resident 2 would come inside Resident 1's room at night and yell at Resident 1. Resident 3 stated Resident 2 has returned to Resident ' s 1 room five times thus far for the month of March. Resident 3 stated Resident 2 had a history of being aggressive with her and with staff including throwing coffee on them.</p> <p>Review of Resident 1 ' s care plan (outlines specific care needs, goals, and interventions to meet the goals), initiated on 12/28/24, indicated, .Focus Resident to resident altercation (victim). Resident(alleged abuser) [Resident 2] threw water at resident (victim) [Resident 1] on 12/28/24 . Goal Ensure the emotional and physical well-being of the resident and prevent further incidents .Interventions . Ensure that the resident is in a safe and quiet environment . Evaluate resident's emotional state for signs of fear, anxiety or agitation .</p> <p>2. Review of Resident 5 ' s care plan, last reviewed 4/23/25, in the section titled Diagnosis, indicated Resident 5 had the following diagnosis, major depressive disorder and dementia.</p> <p>During an interview with LN 3 on 4/23/25 at 2:04 PM, LN 3 stated Resident 2 spat on Resident 5 inside of Resident ' s 5 room. LN 3 stated Resident ' s 2 bedroom was at the opposite end of the facility however Resident 2 would wander and end up on the opposite side of the building.</p> <p>Review of Resident ' s 5 clinical record titled, Progress Notes, dated 12/24/24, indicated, .Nursing observations, evaluation, and recommendations are: Reported from ADON [Assistant Director of Nursing], [Resident 2] witnessed by another staff on duty [Resident 2] (abuser) spitting on another [Resident 5] (victim) .</p> <p>A record review of Resident 5 ' s clinical record titled, Social Services Progress Note, dated 12/25/24, indicated, .Follow up on resident-to-resident altercation from yesterday incident. No changes in psychosocial wellbeing .[Resident 5] able to recall that she was spit by the said [Resident 2] .</p> <p>Review of Resident 5 ' s care plan, initiated 11/14/24, indicated, Focus .Resident to resident altercation-Focus on ensuring safety, providing emotional support, and promoting respectful communication and social interactions .Goal . Ensure the resident feels safe and secure in the environment .</p> <p>Review of Resident 5 ' s clinical record titled, Social Services Progress Note, dated 12/29/24, indicated, . Follow upon resident-to-resident altercation today and spoke to [Resident 5]. She reports that the [Resident 2] from South station .once again came to her room. [Resident 5] said that their room was closed, and she heard someone yanking at the doorknob and it eventually opened and saw the [Resident 2] from South station .at the door by her bed yelling at [Resident 5] and told her that [Resident 5] is on her bed. [Resident 5] said that she told the resident from South station to get the hell out of here and yelled for the nurse. [Resident 5] said that a nurse came and brought a wheelchair and took .[Resident 2] .back to South station .</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 4/23/25 at 2:25 PM, the ADON was able to confirm the occurrence of the altercation between Resident 2 and Resident 5 after reviewing the documentation of the incident. The ADON stated the risk of the altercation to Resident 5 was physical and psychosocial affects. The ADON stated the risk could be that Resident 5 did not feel safe in her home, not feel heard, and could have a negative effect on her wellbeing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on 3/13/25, at 11:57, the DON confirmed there were multiple altercations Resident 2 had with other residents. The DON stated given the history of Resident 2 the facility should have provided Resident 2 with a one-to-one support of a staff member to always be with Resident 2. The DON stated the facility should have implemented behavior monitoring to monitor the Resident 2 ' s behavior. The DON stated monitoring Resident 2 ' s behavior would have allowed the facility the opportunity to observe behavior patterns, develop a baseline of behaviors, and possibly prevent future occurrences of abuse from occurring.</p> <p>Review of the facilities five-day follow-up report, following the resident to resident incident, dated 12/29/24, indicated, .Incident On 12/24/24, A staff member witness Resident [2] spitting on Resident [5] . Q30 [every] minutes visual safety check initiated on Resident [2] . 12/25/24 .SSD followed up with Resident [2] on resident-to resident altercation from yesterday when the resident [2] was reported spitting on another resident in North Station .</p> <p>A review of a facility provided document titled, Resident Rights dated 12/21, indicated, .Federal and State law guarantee certain basic rights to all residents of this facility. These rights include the resident right to .Be free from abuse, neglect .</p> <p>A review of an undated facility provided document titled, QAPI-Role of the Social Serviced Director, indicated, .Developing and implementing policies and procedures for the identification of medically related social and emotional needs of the resident .Develop preliminary and comprehensive assessments of the social service needs of each resident .</p> <p>A review of an undated facility provided document titled, Abuse Prohibition Policy and Procedure, indicated, . Purpose: to ensure that the Center staff are doing all that is within their control to prevent occurrences of abuse .Understanding the behavioral symptoms of patients that may increase the risk of abuse and neglect and how to respond .The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation .Options for room changes will be provided based on the situation .The Center will protect the patients from further harm .Provide the patient with a safe environment by identifying the persons whom he/she would feel safe .Assign a representative from Social Services or a designee observe the patients feelings concerning the incident .Analyze occurrences to determine what changes are needed, if any, to prevent further occurrences .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>50598</p> <p>Based on interview and record review, the facility failed to implement corrective action for one of five sampled residents (Resident 1) when the recommended services following a facility investigation related to a resident to resident physical abuse allegation when, the Interdisciplinary Team (IDT; a group of healthcare professionals) recommended a psychological evaluation (a comprehensive assessment of an individual's mental health and cognitive abilities conducted by a qualified mental health professional like a psychologist or psychiatrist) for Resident 1 following a resident-to-resident altercation that occurred on 12/29/24 and Resident 1 had also requested a psychological evaluation, but the psychological evaluation was not initiated.</p> <p>This failure had the potential to negatively affect Resident 1's psychosocial well-being.</p> <p>Findings:</p> <p>Review of Resident 1 ' s ADMISSION RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event) and bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels, often involving periods of extreme highs (mania) and lows (depression)).</p> <p>Review of Resident 1 ' s care plan, initiated 12/9/24, indicated, .resident uses mood stabilizer(anticonvulsant) medication for behavior management .for Bipolar Disorder, manic severe with psychotic features m/b [manifested by] withdrawn/flat affect .Interventions .referral for psych [psychological] consultation as needed .</p> <p>Review of Resident 1 ' s care plan, initiated on 12/28/24, indicated, .EPISODIC: Resident to resident altercation (victim) . Ensure the emotional and physical well-being of the resident and prevent further incidents .Evaluate resident's emotional state for signs of fear, anxiety or agitation .Monitor for delayed emotional responses, such as withdrawal or agitation .</p> <p>During an interview on 3/11/25, at 2:05 PM, Resident 1 stated Resident 2 came towards her yelling at her stating that Resident 1 was sitting outside of Resident 2 ' s room door. Resident 1 stated, shortly after that statement Resident 2 splashed a cup of water on her. Resident 1 also stated Resident 2 comes to her room on a nightly basis. Resident 1 stated she closes her bedroom door at night to ensure that Resident 2 would not enter her room while she ' s asleep. However, Resident 1 stated Resident 2 would still open her door quietly and stand at the foot of her bed and stare at her while she ' s asleep. Resident 1 stated she did not feel safe in her room due to how often Resident 2 returned to her room after each incident. Resident 1 explained about an incident when Resident 2 entered her room with a box under her shirt. Resident 1 stated she had no idea what was in that box, and it scared her. Resident 1 stated, Resident 2 came to her room last night as well. Resident 1 stated each time Resident 2 would come to her room she would yell, and the staff would come and get Resident 2. Resident 1 stated when Resident 2 would come to her room she would yell GO! and sometimes that would get Resident 2 to leave. Resident 1 stated, Emotionally I feel uncomfortable. Resident 1 stated she did not feel safe in her room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stockton Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 1 on 3/13/25, at 11:06 AM, Resident 1 stated Resident 2 returned to her room last night in the middle of the night. Resident 1 stated when she told Resident 2 to get out of her room, Resident 2 responded by saying, I don ' t care what you say I can do what I want. Resident 1 stated after she yelled, the staff removed Resident 2 from her room. Resident 1 stated Resident 2 kept returning to her room. Resident 1 stated that she informed staff that she did not feel safe in her room and staff informed her that they did not know what to do.</p> <p>Review of Resident 1 ' s Social Service Progress Note, dated 12/29/24, indicated, .Received a report that [Resident 1] had a resident-to-resident altercation with another resident from the South station. Interviewed [Resident 1] and she said that .[Resident 2] .came to her room at 3am this morning and yelled at her and told her that [Resident 1] is on her bed. [Resident 1] said that the other resident continue[d] yelling and screaming at her to get out of her bed and throw a water on her. [Resident 1] roommate in bed B said she press her call light for the staff to assist the other resident out of the room. [I]n spite of staff helping the other resident to get out of the room, the other resident is resistive and spit at staff as well. [Resident 1] and her roommate in bed B stated that .[Resident 2] keep coming to their room almost every day 3-4-5x a day. [Resident 1] was reassured that the other resident will be closely monitored so she will not come back and bother them in the room again. [Resident 1] was referring to [name of mental health services provider] for psych eval [psychological evaluation] for the possible negative impact of the other resident behavior towards her .</p> <p>During a concurrent interview and record review with the Social Services Director (SSD) on 3/11/25, at 2:37 PM, a review of Resident 1 ' s clinical record titled, Progress Notes, dated 12/30/24, indicated the facility conducted an Interdisciplinary Team (IDT; a group of healthcare professionals) meeting on 12/30/24 following a resident-to-resident altercation in which Resident 1 was the alleged victim. The IDT meeting recommended that Resident 1 had a psychological evaluation initiated after Resident 2 threw water on Resident 1. After reviewing Resident 1 ' s clinical record the SSD was unable provide information on a psychological evaluation being completed for Resident 1. The SSD stated Resident 1 should have had a psychological evaluation and it was not initiated.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on 3/13/25, at 11:57 AM, after reviewing Resident 1 ' s clinical record titled, Progress Notes, dated 12/30/24, the DON confirmed the recommendations of the IDT meeting initiated on 12/30/24 included Resident 1 receiving a psychological evaluation due to the abuse she experienced from Resident 2. The DON confirmed although the IDT recommended the psychological evaluation, the evaluation was not initiated. When asked if the psychological evaluation should have been initiated, the DON stated, Of course, it should have been initiated and recommended after the altercation. The DON stated the interventions listed in the IDT meeting was the responsibility of all that were in attendance to carry out what was discussed. The DON stated the importance of a psychological evaluation was to make sure that Resident 1 felt safe in her home and was aware that the incident was not of any fault of her. The DON stated Resident 1 was a risk of having psychosocial issues related to the altercation such as anxiety, depression, appetite changes, weight-loss, questioning what occurred, her safety, and issues with non-compliance.</p>		