

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 05/19/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823</p> <p>Based on interview, and record review, the facility failed to ensure residents remained free from neglect when activities of daily living (ADLs, essential self-care tasks related to personal care such as dressing, eating, bathing, grooming, and toileting) were not provided for two of the three sampled residents (Resident 1 and Resident 2) when:</p> <ol style="list-style-type: none"> 1. Certified Nursing Assistant (CNA) 1 left Resident 1 in a soiled incontinent (involuntary loss of urine or feces) brief (adult diaper, provides maximum absorbency for incontinence) for two hours; and, 2. CNA 1 left Resident 2 without completing incontinent care and CNA 1 slapped/tapped Resident 2's right leg with an open hand after Resident 2 asked CNA 1 to not touch her legs due to pain. <p>These failures resulted in Resident 1 and Resident 2 not being well-groomed and had the potential to cause skin breakdown (tissue damage caused by friction (when skin is rubbed or dragged over another surface such as bed sheets or clothing), shear (occurs when forces in opposite directions pull on the skin), moisture or pressure), and decreased psychosocial well-being. This failure also resulted in unnecessary pain and psychosocial distress to Resident 2.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 1's ADMISSION RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). <p>Review of Resident 1's MDS [Minimum Data Set, a comprehensive assessment tool], dated 4/23/25, indicated that Resident 1 was dependent on others for bathing and toileting.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's Progress Notes, dated 1/27/25, indicated, .On 1/27/2025 Activity Director notified SSD [Social Services Director] and Admin [Administrator] that resident's roommate had told herthat [sic] staff member neglected the resident leaving her in a soiled brief for approximately 2 hours on 1/17/2025 during PM shift. The staff member was immediately removed from the floor and was suspended pending investigation. Resident was interviewed by SSD and resident was non-interview able [sic] d/t [due to] impairment on [sic] cognition [having difficulty with one or more aspects of thinking and memory] .</p> <p>Review of Resident 1's Progress Notes, dated 1/27/25, indicated, .On 1/27/25 a grievance form was given to the DON [Director of Nursing] which stated that the resident was being neglected by her CNA who left her unattended in her soiled briefs [disposable underwear] for 2 1/2 hours .</p> <p>Review of Resident 1's bowel and bladder care plan, initiated 5/16/25, indicated, .Focus .The resident has bowel and bladder incontinence r/t [related to] Advanced Dementia .Goal .The resident will remain free from skin breakdown due to incontinence .Interventions .check the resident frequently throughout each shift, and as required for incontinence. Wash, rinse, and dry perineum [the layer of skin between the genitals]. Change clothing PRN [as needed] after incontinence episodes .</p> <p>During an interview on 5/16/25, at 9:39 a.m., with the Activities Director (AD), the AD stated Resident 3 had reported to her that she asked CNA 1 to change Resident 1 because Resident 1 was incontinent with stool (feces), but CNA 1 refused and stated that Resident 1 was not dirty. The AD further stated Resident 3 told CNA 1 that she could smell Resident 1, so CNA 1 checked Resident 1 and stated that she was fine. The AD stated Resident 3 stated that CNA 1 did not change Resident 1's incontinent brief for two hours. The AD further stated that she reported the incident to the Social Services Director (SSD).</p> <p>During a concurrent observation and interview on 5/16/25, at 10:20 a.m., with Resident 1, Resident 1 was observed seated in a wheelchair and was well-dressed and well-groomed. Resident 1 mumbled incoherently in response to questions and smiled.</p> <p>During an interview on 5/16/25, at 10:23 a.m., with Resident 3 (Resident 1's roommate) in her room, Resident 3 stated she asked CNA 1 several times to clean Resident 1 as Resident 1 was incontinent with stool and smelled, but CNA 1 checked Resident 1 and refused, stated that Resident 1 was not dirty. Resident 3 told CNA 1 that she could smell Resident 1. Resident 3 further stated that CNA 1 then stated that he needed to attend to another resident, and he would be back. Resident 3 stated after 30 minutes, she pressed the call light, but CNA 1 did not return to the room. Resident 3 further stated that after more than one hour, CNA 1 came back to the room. Resident 3 stated that Resident 1 had been in a soiled incontinent brief for two hours. Resident 3 further stated CNA 1 finally changed Resident 1's incontinent brief. Resident 3 stated she tried to look out for Resident 1 because Resident 1 was not able to speak and could not call for help on her own. Resident 3 stated she reported the incident to the AD and the SSD.</p> <p>During an interview on 5/16/25, at 10:37 a.m., with Licensed Nurse (LN) 1, LN 1 stated she had not heard about the incident with CNA 1 and Resident 1. LN 1 further stated that if a resident reported to her that a CNA did not provide incontinent care, she would pull the CNA aside and ask the CNA when the assigned residents received care. LN 1 stated she would go with the CNA to check the assigned residents. LN 1 further stated if the assigned residents had not received incontinent care, she would report the incident to the charge nurse and the Director of Nursing and document the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 5/16/25, at 1:58 p.m., with CNA 1, CNA 1 stated he changed Resident 1's incontinent brief earlier that day. CNA 1 further stated he went back to Resident 1's room two hours later, and Resident 3 stated that he needed to change Resident 1. CNA 1 stated he told Resident 3 that he would change Resident 1 after dinner because he could not change Resident 1 during dinner. CNA 1 further stated that Resident 3 stated she was going to file a report, but he did not realize she was talking about him. CNA 1 stated he was fired from the facility. CNA 1 then abruptly ended the call.</p> <p>During an interview on 5/16/25, at 2:15 p.m., with the SSD, the SSD stated Resident 1 did not verbalize much and smiled and nodded her head a lot. The SSD confirmed that Resident 3 reported that CNA 1 left Resident 1 in a soiled incontinent brief for two hours. The SSD stated the complaint was investigated. The SSD further stated she provided follow-up visits with Resident 1 and did not see any change in Resident 1's behavior after the incident. The SSD stated that she believed CNA 1 was terminated.</p> <p>During an interview on 5/16/25, at 3:10 p.m., with CNA 2, CNA 2 stated she worked with CNA 1. CNA 2 further stated that CNA 1 came to work on time. CNA 2 stated some of the residents complained that CNA 1 left them exposed in the middle of providing incontinent care and did not come back to finish. CNA 2 further stated that she could not remember the names of specific residents who complained.</p> <p>During a concurrent interview and record review of CNA 1's employee file with the facility Administrator (ADM) on 5/16/25, at 3:18 p.m., the ADM stated that Resident 3 complained that CNA 1 did not provide incontinent care to Resident 1 for two hours. The ADM stated that the complaint was investigated. The ADM confirmed that CNA 1 was terminated from the facility. The ADM further confirmed that the facility policy was not followed.</p> <p>2. A review of Resident 2's ADMISSION RECORD, indicated that Resident 2 was admitted to the facility with diagnoses including anxiety disorder, weakness, need for assistance with personal care, functional quadriplegia (a state of complete immobility due to severe physical disability or frailty, without any underlying structural damage to the brain or spinal cord), and hidradenitis suppurativa (a chronic skin condition that attacks hair follicles causing painful recurring abscesses [a localized collection of pus that forms in body tissues or organs] and scarring of the skin) to both legs.</p> <p>A review of Resident 2's MDS dated [DATE], indicated Resident 2 needed moderate assistance (helper lifts, holds, or supports trunk of body and limbs) with toileting and personal hygiene.</p> <p>A review of Resident 2's Care Plan Report, initiated 8/5/24, indicated, .Focus .Impaired physical functioning r/t [related to] ADL function/mobility impairment .incontinent in bowel and bladder .Goal .Will remain well groomed, dressed, and assisted by staff as needed .Interventions .BED MOBILITY requires 1-person support Rolling Left to Right - Partial/Moderate assistance .Toileting Hygiene - Partial/Moderate assistance to Dependent .</p> <p>A review of Resident 2's Care Plan Report, initiated 3/17/25, indicated, .Skin breakdown with cuts extending from the vaginal area to the anus, related to previous bumps and underlying skin condition .Interventions . Keep the area clean and dry; provide gentle cleansing with mild soap and water or perineal wipes .</p> <p>(continued on next page)</p>		

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<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 5/19/25, at 9:47 a.m., with Resident 2 in her room, Resident 2 stated CNA 1 provided care to her, and she was one and done with him. Resident 2 further stated that CNA 1 was providing incontinent care for her when another CNA entered the room and asked him for help with another resident. Resident 2 stated CNA 1 asked her if he could go help his coworker, and Resident 2 stated that he could go after he was finished helping her. Resident 2 further stated that CNA 1 left before finishing her care. Resident 2 stated her soiled incontinent brief was untaped and she was uncovered. Resident 2 further stated that she was upset. Resident 2 stated after CNA 1 left the room, an Occupational Therapist (OT) came into her room for her therapy, and she told the OT what happened. Resident 2 stated the OT stated that she would assist her with changing her incontinent brief. Resident 2 further stated that CNA 1 returned, and she asked him why he left her in the middle of providing incontinent care for her. Resident 2 stated CNA 1 stated, We black folks have to stick together! Resident 2 further stated, Don't tell me about black folks sticking together! You are young, and I am [AGE] years old - you don't know what I have done for my people! Resident 2 stated she told CNA 1 that the OT would help her with changing her incontinent brief, and that he could leave the room. Resident 2 further stated CNA 1 insisted that he would help. Resident 2 stated that during care, she told CNA 1 to be careful with her dressings on her legs because her legs were sore. Resident 2 further stated that after they finished changing her incontinent brief, CNA 1 slapped her right leg with his flat hand and said, Okay! Resident 2 stated that she cried out because it hurt. Resident 2 further stated she asked CNA 1 why he did that after she told him not to touch her legs, but he did not answer why he did it. Resident 2 stated that she was done with CNA 1 providing care for her. Resident 2 further stated that she reported the incident to the ADM.</p> <p>During an interview on 5/19/25, at 11:10 a.m., with the Occupational Therapist (OT), the OT stated she remembered the incident that occurred between CNA 1 and Resident 2 in Resident 2's room. The OT further stated that Resident 2 was sensitive regarding her legs because her legs were contracted (permanent tightening of the muscles, skin, tendons and nearby tissues that causes the joints to shorten and become very stiff) and had sores on them that required dressing changes and pain medication. The OT stated Resident 2 instructed staff to let her know before touching or moving her legs due to the pain. The OT further stated Resident 2 did not like staff touching the dressings on her legs. The OT confirmed that Resident 2 told her that CNA 1 left her in the middle of changing her incontinent brief when she entered her room on the day of the incident. The OT stated CNA 1 came back into the room to assist with Resident 2's incontinent brief change. The OT further stated that Resident 2 told CNA 1 not to touch the dressings on her legs. The OT stated CNA 1 tapped on Resident 2's right leg with an open hand and said, Okay! The OT further stated that Resident 2 said, Ow! Why did you do that after I told you not to?! The OT stated CNA 1 tapped Resident 2's leg with a flat hand again. The OT further stated Resident 2 was upset and was yelling, so she told the charge nurse on duty and reported the incident to the Director of Rehabilitation.</p> <p>During an interview on 5/19/25, at 2:25 p.m., with the ADM, the ADM confirmed that Resident 2 complained that CNA 1 left in the middle of providing incontinent care for her. The ADM stated that the complaint was investigated. The ADM confirmed that the facility policy was not followed.</p> <p>A review of a facility policy and procedure titled, Abuse and Neglect - Clinical Protocol, revised 3/18, indicated, .Neglect, .means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility policy and procedure (P&P) titled, Diarrhea and Fecal Incontinence, revised 9/10, indicated, .The purpose of this procedure is to provide guidelines that will aid in preventing the resident's exposure to feces. Preparation .1. Review the resident's care plan to assess for any special needs of the resident .General Guidelines .2. Residents must be cleaned after each episode of incontinence .</p> <p>A review of a facility P&P titled, Activities of Daily Living (ADLs), Supporting, revised 3/18, indicated, .Policy Statement .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain .grooming and personal .hygiene .Policy Interpretation and Implementation. 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .and in accordance with the plan of care, including appropriate support and assistance with .c. Elimination (toileting): Staff will do rounds prior to all meals to ensure that ADL needs are met .</p>		