

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 05/22/2025
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>47368</p> <p>Based on observation, interview, and record review, the facility failed to protect four of nine sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) to be free from abuse (verbal, mental, or physical abuse) when:</p> <ol style="list-style-type: none"> 1. Resident 1 struck the left side of Resident 2's face on 3/10/25; 2. Resident 1 open handed slapped Resident 3's forehead on 3/18/25; 3. Resident 1 hit Resident 3's right ear on 3/24/25; and 4. Resident 4 had a verbal altercation with Resident 1 and Resident 4 kicked Resident 1's knee on 4/17/25. <p>These failures removed Resident 1, Resident 2, Resident 3, and Resident 4's right to be free from abuse and had the potential to result in psychosocial outcomes.</p> <p>Findings:</p> <p>During an interview on 4/14/25, at 1:46 p.m., Resident 3 stated, . some Vietnam man tried to hit me here, Staff move him away from me .</p> <p>During an interview on 5/22/25, at 9:48 a.m., Resident 1 stated, .sometimes I get angry. Vietnamese guy make me angry .</p> <p>During an interview on 4/14/25, at 1:14 p.m., Certified Nurse Assistant (CNA) 1 stated, Resident 1 had been on one-to-one care (1:1; care involves a nurse or caregiver providing support specifically to one individual). CNA 1 further stated Resident 1 had anger issues and Resident 1 used to fight with other residents before being placed on one-to-one care. CNA 1 stated Resident 1 tried to hit other residents in the past.</p> <p>During an interview on 4/14/25, at 2:09 p.m., Licensed Nurse (LN) 1 stated Resident 1 tried to hit Resident 3 in the past. LN 1 further stated the facility staff had been aware that Resident 1 did not like Resident 3 and facility staff had tried their best to keep both Resident 1 and Resident 3 separate from each other.</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 05/22/2025
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 5/22/25, at 10:24 a.m., the Activities Director (AD) stated on 4/17/25 she had witnessed Resident 1 and Resident 4 had a verbal argument in the hallway outside the physical therapy room and she had separated both Resident 1 and Resident 4 away from each other. The AD further stated she had witnessed Resident 1 had a physical altercation with Resident 3 in the activities room. The AD stated she was aware that Resident 1 and Resident 3 had physical altercations in the past. The AD stated Resident 1 went behind Resident 3 and hit Resident 3's right ear. The AD stated she should have checked to see that Resident 3 was not in the activities room prior to bringing Resident 1 in the activities room. The AD stated at the time of the altercation Resident 1 was on one-to-one care and his one-to-one care staff was moving Resident 5 out of the way to make room for other residents in the activities room.</p> <p>During an interview on 5/22/25, at 11:36 a.m., the Activities Assistant (AA) stated Resident 1 was placed on one-to-one care because had got into arguments with Resident 3 in the past. The AA stated as soon as she turned away to help move Resident 5 and make room for other residents in the activities room, Resident 1 wheeled his wheelchair towards Resident 3 and slapped Resident 3. AA stated she should have stayed with Resident 1 since she was assigned to provide one-to-one care to Resident 1. AA further stated if she had stayed with Resident 1 it would have prevented Resident 1 from hitting Resident 3. The AA further stated she should have waited for other staff members to make space for residents in the activities room.</p> <p>During an interview and concurrent record review on 5/22/25, at 1:49 p.m., the Assistant Director of Nursing (ADON) confirmed Resident 1 was placed on one-to-one care from 3/05/25 to 5/09/25. The ADON stated Resident 1 was on one-to-one care to provide safety to other residents and to make sure other altercations did not occur. The ADON stated during one-to-one care staff is assigned to always stay with Resident 1 and to make sure Resident 1's behavior was being managed. The ADON stated facility staff did not follow one-to-one care interventions with Resident 1 when the altercations had happened.</p> <p>During an interview on 5/22/25, at 4:10 p.m., the Administrator (ADM) stated the expectation was to always have staff have their eyes on Residents when one-to-one care was being done. The ADM stated staff providing one-to-one care did not keep their eyes on Resident 1 which resulted in altercations. The ADM stated, injury to either one of them could occur if staff providing one-to-one care is not present or keeping a visual on them .</p> <p>Review of Resident 1's IDT NOTE, dated 3/11/25, written by the Director of Nursing (DON), indicated, . Resident has a history of being verbally and physical aggressive with both staff and other residents. Resident involved in multiple physical altercations with peers .during a scheduled smoke break where he physically struck out at another resident following a verbal exchange .Current Interventions in Place: 1:1 Supervision .</p> <p>Review of Resident 1's IDT NOTE, dated 3/19/2025, written by the DON, indicated, .Resident (alleged abuser) open handed slapped resident (victim) on the forehead leaving noted redness .Per CNA witness resident (victim) was sitting in the hallway/north station sleeping in the wheelchair when resident (alleged abuser) went up to him and slapped him .IDT is recommending a 1:1 for this resident .</p> <p>Review of Resident 1's IDT NOTE, dated 3/25/25, written by the DON, indicated, .while encouraging the resident to the activity room, the resident made his way through the doorway (which was crowded), surpassed his 1:1 and hit another resident .continue 1:1 .</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 05/22/2025
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>Review of Resident 2's IDT NOTE, dated 3/11/25, written by the Social Services Director (SSD), indicated, . On 3/10/2025 Activities Director witnessed this resident was involved in an altercation as the victim. It was reported that the resident and another resident (the perpetrator) were in the hallway when the perpetrator struck the victim on the left side of the face .</p> <p>Review of Resident 3's IDT NOTE, dated 3/25/25, written by the DON, indicated, .the resident was in the activities room, when he was approached by another resident who hit him to his right ear .residents right ear was red and warm to the touch .</p> <p>Review of Resident 4's IDT NOTE, dated 4/18/25, written by the DON, indicated, .resident kick another resident in the knee then resident was separated at once .</p> <p>Review of Resident 1's Social Service Progress Note, dated 4/17/25, written by the SSD indicated, .Resident was involved in a peer altercation .another resident allegedly attempted to kick [Resident 1] before staff intervened and separated both individuals .Resident appeared agitated and expressed frustration, stating, He keeps bothering me, I had to defend myself .</p> <p>Review of Resident 1's Social Service Progress Note, dated 3/18/25, written by SSD indicated, .Resident stated that he can recall the incident with the other resident telling SSD that the other resident called him a monkey. He said that he got upset and struck out at the other resident .</p> <p>Review of Resident 1's Care Plan, initiated on 3/5/25, the interventions indicated, .placed resident on 1:1 to closely monitor for behaviors and prevent further altercations .</p> <p>Review of Resident 2's Social Service Progress Note, dated 3/11/25, written by SSD indicated, .Resident met with SSD following an altercation with another resident. Resident was visibly upset but denied ongoing fear or anxiety. Expressed frustration, stating, I didn't deserve that .</p> <p>During a review of a facility policy and procedure (P&P) titled Abuse and Neglect - Clinical Protocol, revised 3/2018, the document indicated, .Treatment/Management .1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect .Monitoring and Follow-up .2 basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately .</p> <p>During a review of an undated facility lesson plan titled What is 1 to 1 Care? indicated, .1 to 1 care involves a nurse or carer providing support specifically to one individual .1:1 SUPERVISION .The patient must be within your line of vision and within reach at all times. The patient must not be left alone .</p>		