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	06/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one out of three sampled residents (Resident 1) was assessed for risk of substance abuse (a condition characterized by use of substances, such as illicit drugs, despite negative consequences) when the electronic medical record did not reflect a history of substance abuse and no nursing plan of care was initiated upon admission. This failed practice may have contributed to health hazards when Resident 1 tested positive for possible illicit drug use as manifested by a sudden change in vital signs, mental status, and a hospital emergency room admission. Findings: During a review of Resident 1's electronic medical record titled, History and Physical (H&P), dated 9/3/24, the record indicated Resident 1 was admitted to the facility on [DATE], for generalized weakness, was wheelchair bound with back injury, had blood pressure and a history of methamphetamine use (often referred to as meth use, refers to the consumption of methamphetamine, a highly addictive synthetic stimulant illicit drug) as noted by Medical Doctor (MD) 1. The record further indicated Resident 1 was a transfer from another nursing facility in the area and was in the hospital shortly before. During a concurrent interview and record review on 6/24/25, at 11 AM, with the Assistant Director of Nursing (ADON), Resident 1's medical record titled, Interdisciplinary Care Conference, (or IDT, a team of health care workers that care for the residents) was reviewed. The IDT record, dated 2/18/25, indicated Resident 1 was transferred to hospital's emergency room on 2/17/25 at 12:30 PM. The IDT note indicated the symptoms were altered mental status and complaint of hard time breathing. The IDT record further indicated, Episode of verbal aggressiveness toward staff, and increased confusion prior to transfer to hospital emergency room. During a review of Resident 1's records from Hospital A's emergency room visit, dated 2/17/25, the record indicated Resident 1 was admitted with altered mental status, delirium (a sudden and temporary state of confusion and disorientation that affects a person's mental abilities), and the drug screening was positive for meth (or methamphetamine). The record under Social History, further indicated a history of Substance Abuse (use of illicit drugs) including the use of methamphetamine. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/25, at 11 AM, with the ADON, Resident 1's medical record titled, History and Physical (or H&P), written by MD 1, dated 9/3/24, was reviewed. The H&P record upon admission to the facility indicated Resident 1 had history of methamphetamine use. Further review indicated the history of illicit drug abuse was not reflected in the electronic health record under diagnosis and in the nursing assessment of care. During a concurrent interview and record review on 5/23/25, at 2:27 PM, with the Licensed Nurse as the MDS coordinator (MDS, or the Minimum Data Set {MDS}, a standardized assessment tool used to evaluate the health and functional status of residents as required by federal government), Resident 1's medical record was reviewed. The MDS stated once a resident was admitted to the facility; the diagnosis history from the previous hospital or facility stay were entered in the medical record. The MDS stated the doctor's H&P additionally used to add any current or past diagnoses into the medical record. The MDS confirmed that Resident 1's history of substance abuse such as methamphetamine was not addressed upon admission and was not documented in the diagnosis history despite the hospital's record and MD 1's H&P notations. During a concurrent interview and record review on 5/23/25, at 2:38 PM, with the MDS, Resident 1's medical record was reviewed. The MDS confirmed no nursing plan of care for Resident 1 was created upon admission for history of illicit substance abuse. The MDS stated the history of substance use was not noted in the MDS documents. During an interview on 5/23/25, at 2:18 PM, with Licensed Nurse (LN) 1, LN 1 recalled caring for Resident 1. LN 1 stated Resident 1 was non-compliant with medication use and following the facility's safety routines. LN 1 stated Resident 1 was often verbally abusive and refused supervised smoking areas and timeframes. LN 1 further stated Resident 1's wife visited him, brought bags of items including food, cigarette plus lighter and he would not give the dangerous items to the unit for safe keeping. LN 1 stated when his blood pressure was dangerously high, he would refuse to go to the hospital per doctor's order. During a review of Resident 1's medical record titled, Social Services Assessment & Documentation, dated 12/22/24, the record indicated Resident 1 and his wife were homeless living in their car. The record under Substance Use History, indicated Resident 1's use of amphetamine (illicit substances) since age [AGE] with 3 to 6 times per week use in addition to Crack/Cocaine (illicit substances) use since age [AGE] with 1-2 times per week use and Marijuana (cannabis or weed) use since age of 16 with frequency of use recorded as Daily/Multiple times/day. The record additionally indicated date of last use per Resident's comments for: amphetamine last use was 8 months ago; Crack/Cocaine last use was in 2024, and Marijuana last use was 2 years ago, The record further indicated, The resident not cooperative when talking about this [Substance Use Disorder] and became irritable. During a concurrent interview and record review on 6/24/25, at 11:25 AM, with the ADON, Resident 1's medical record was reviewed. The ADON confirmed after the positive drug test and re-entry to the facility, Resident 1 was noted to have very high blood pressure despite use of his blood pressure medications on 2/21/25. Resident 1 refused going back to the hospital based on doctor's order and refused to do tests. The ADON stated there was no care plan to address substance use issue prior to the positive drug test. The ADON stated Resident 1's non-compliance with smoking hazards was addressed on 1/28/25, four months after admission. The ADON stated the facility had resources to address substance use issue and ensure resident's safety moving forward via staff education. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/25, at 11:48 AM, with the ADON, Resident 1's Plan of care dated 1/28/25 was reviewed. The plan of care for Aggressive Behavior, indicated, Resident smoked unsupervised and stated he can smoke whenever he wants. [Resident] keep smoking paraphernalia in his possession that wife brings to him on her visits, and he will not give them up. The ADON stated Resident 1 and his wife were noncompliant and did not follow the facility's policy on smoking safety. The ADON was not sure what exactly was brought into the facility by the resident's wife, besides food items and smoking supplies. During an email communication with the facility's Administrator (Admin), on 6/24/25, the Admin indicated, The admission process falls into the comprehensive care planning process as well as the substance abuse policy .the updated CMS (stands for the Centers for Medicare & Medicaid Services, a federal agency) guidelines include management of residents with Substance Use Disorder. Staff is being in serviced and trained to include these guidelines and implement them in the admission process and the clinical meeting. Review of the facility's policy titled, Care Plan Comprehensive, dated 8/25/21, the policy indicated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each Resident. The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment. The policy under procedure indicated, Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and systematic clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process .The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS) . Assessments of residents are ongoing, and care plans are reviewed and revised as information about the resident and the resident's condition change .The Interdisciplinary Team is responsible for evaluation and updating of care plans .