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	08/01/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to provide one to one supervision (a designated staff to provide constant monitoring to prevent or redirect resident from engage in harmful act) to one of three sampled residents (Resident 2, with known behavioral issues), to prevent the physical altercation between Resident 1 and Resident 2 on 6/7/25.This failure resulted in Resident 2 suffering multiple bruises and a laceration to the right side of his face and Resident 1 suffering two fractures in his left hand. Findings:Review of Resident 1's admission RECORD indicated that Resident 1 was admitted to the facility with diagnoses that included but were not limited to unspecified mental disorder to known physiologic condition (a clear link between a physical condition and the mental symptoms, but the exact nature of the mental disorder is not clear), unspecified other stimulant abuse (continued use of amphetamine-type substances, cocaine, and other stimulants that can impact health), and cognitive communication deficit. Review of Resident 1's eINTERACT Change in Condition Evaluation dated 6/7/25, indicated that Resident 1 was involved in a resident-to-resident physical altercation and indicated the following, .AFTER THE RESIDENT WAS PUNCHED IN THE FACE, HE PROCEEDED TO GET UP FROM HIS WHEELCHAIR AND PUNCH ANOTHER RESIDENT X 5 ON THEIR FACE.RESIDENT HAD SWELLING TO HIS R [Right] EYE AND SWELLING TO HIS LEFT KNUCKLES.Review of Resident 1's Interdisciplinary (IDT - a group of professionals from various disciplines who work together to provide comprehensive care to a patient or group of patients) Care Conference Note - V 5 dated 6/8/25, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS - a test used to get a snapshot of how well you are functioning cognitively at the moment the test is taken) score of 12, indicating Resident 1 had mildly impaired cognitive function. Review of Resident 2's admission RECORD indicated that Resident 2 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it), hemiplegia and hemiparesis following a cerebral infarction on the left, non-dominant side (paralysis and weakness of left side of the body after stroke), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified psychosis not due to a substance or known physiological condition (condition with symptoms that involves a disconnection from reality and the world, but does not fit into established categories of mental health disorders) and anxiety disorder. Review of Resident 2's eINTERACT Change in Condition Evaluation dated 6/7/25, indicated that Resident 2 was involved in a resident-to-resident physical altercation and indicated the following, .STAFF WITNESSED SEEING THE RESIDENT GETTING PUNCHED X 5 ON THE FACE BY ANOTHER RESIDENT.RESIDENT HAD IMMEDIATE SWELLING AND CONTUSION [bruise].Review of Resident 2's Interdisciplinary Care Conference-V5 note completed on 6/8/25, indicated that Resident 2 had a BIMS score of 13, indicating that Resident 2 was cognitively intact.During a concurrent observation and interview on 8/1/25, at 9:55 a.m., Certified Nursing Assistant (CNA) 1 was noted to be sitting outside of Resident 2's bedroom within visual site of Resident 2, who was asleep in his bed. CNA 1 stated she was providing one-to-one supervision for Resident 2. CNA 1 stated that Resident 2 was receiving one-to-one supervision on all shifts due to Resident 2's history of physical and verbal aggressive behaviors with other residents. CNA 1 stated the risk of not having Resident 2 on one-to-one supervision, was that Resident 2 could become aggressive with another resident and there would be no one closely monitoring him to step in and redirect Resident 2 before the altercation escalated. CNA 1 stated that her role in providing Resident 2 with one-to-one supervision was to monitor and ensure she watched Resident 2, to make sure he didn't start a fight with anyone.During an interview with Resident 2 on 8/1/25, at 11:15 a.m., Resident 2 was sitting up on the right side of his bed. Resident 2 was noted to have a small amount of discoloration under his right eye. Resident 2 stated that the eye was still tender and painful at times. Resident 2 stated that he was in the hallway when Resident 1 came up to him and asked him for a cigarette. Resident 2 stated that when he told Resident 1 that he did not have any cigarettes, Resident 1 said to him f. y., so Resident 2 said he said the same thing back to Resident 1. Resident 2 stated that when he did that, Resident 1 stood up and hit him. Resident 2 stated he then hit Resident 1 back but could not remember where he hit him. Resident 2 stated that Resident 1 then started to hit him repeatedly, causing a right black eye. Resident 2 stated that Resident 1 was a bad man, and he was glad Resident 1 was no longer in the facility. During a phone interview on 8/1/25, at 11:48 a.m. with Licensed Nurse (LN) 1, LN 1 stated that on 6/7/25 at approximately 11:00 p.m. she heard a loud commotion in the hallway while she was at the center nurse's station. LN 1 stated that she