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	08/15/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for one of three sampled residents (Resident 4) when Certified Nursing Assistant (CNA) 1 and CNA 2 performed social media live streaming (the real-time broadcasting of video and audio content over the internet, allowing viewers to interact with the content creator as it is happening) in Resident 4's room during resident care activities. This failure had the potential to result in Resident 4 feeling a lack of privacy and hopelessness.Findings:A review of Resident 4's admission Record indicated that Resident 4 was admitted to the facility in 2025 with diagnoses which included Cerebral Infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke), End Stage Renal Disease (failure of the kidneys to function normally), and Aphasia (loss of ability to produce or understand language).During a concurrent observation and interview, on 8/15/25, at 10:21 a.m., in Resident 4's room, Resident 4 was laying in the bed. Resident 4 was unable to verbally respond to questions, but could shake his head yes or no. When asked about the incident regarding CNA 1 and CNA 2 recording a video in his room, Resident 4 did not respond. During an interview by phone on 8/14/25 at 3:43 p.m. with CNA 1, CNA 1 stated that she felt that the suspension was due to retaliation by the facility administration. CNA 1 stated that the facility changed the CNAs' assignments because the facility was short-staffed. CNA 1 stated that a grievance was filed with the corporate office regarding the staffing situation. CNA 1 stated that the Administrator (ADM), Assistant Director of Nursing (ADON), and the corporate office had a meeting. CNA 1 stated that the staffing issue was resolved. CNA 1 stated that three to four days ago the administration retaliated against her and a coworker, she recorded a video on Tik Tok. CNA 1 stated that her coworkers stalked her Tik Tok page. CNA 1 stated that she felt that she should not have been terminated. CNA 1 stated that she took responsibility for being on her personal cellphone during working hours. CNA 1 confirmed that she recorded the Tik Tok video on her cellphone while she performed her job duties at the facility. CNA 1 confirmed that she was in Resident 4's room when she recorded the Tik Tok video but stated that she was the only one on camera during the recording of the Tik Tok video. During an interview by phone on 8/14/25 at 3:54 p.m. with CNA 2, CNA 2 stated that she was pulled into the office on Monday and was asked if she had been on Tik Tok during working hours. CNA 2 stated that she said yes. CNA 2 stated that she was told that resident information was exposed while she was on Tik Tok. CNA 2 stated that she was at the North Nurses' Station in the corner when she recorded on Tik Tok. CNA 2 stated that only part of her face was showing while she recorded the video on Tik Tok. CNA 2 admitted that she should not have been on Tik Tok. CNA 2 stated that she was suspended, so she quit her job at the facility. During an interview by phone on 8/14/25 at 3:57 p.m. with Licensed Nurse (LN) 1, LN 1 stated that she was the one that reported the Tik Tok video incident. LN 1 stated that she was the assigned wound care nurse at the facility on the day of the incident. LN 1 stated that it was a Sunday, and she asked CNA 2, one of the CNAs on duty that day, to assist her in repositioning a resident, Resident 4, so that she could change his wound dressings. LN 1 stated that whenever she asked CNA 2 to help with resident care, her coworker, CNA 1, always came along to help. LN 1 stated that she needed additional supplies to change Resident 4's dressings, so she told the CNAs to reposition Resident 4 on his side and she would return to change the dressing. LN 1 stated that the CNAs were in the room with Resident 4 with the door closed while she went to get additional supplies. LN 1 stated that when she returned to the room, she began to change Resident 4's dressing on his coccyx (tailbone; the last bone at the base of the spine). LN 1 stated that the CNAs were in the room while she changed the dressing. LN 1 stated that after she finished changing the dressing, she noticed that she had forgotten her scissors, so she went to get them, then she went back to Resident 4's room and saw that CNA 2's cellphone was propped up and on Tik Tok live. LN 1 stated that they all left the room together and she stated that she said to CNA 2, I assumed your phone was not on, right? LN 1 stated that CNA 2 did not answer her question. LN 1 stated that she continued to change other residents' dressings because she thought that she had 24 hours to report the incident. LN 1 stated that she reported the incident the next morning at 6 a.m. LN 1 stated that she received an in-service and discovered that she should have reported the incident sooner. During an interview and concurrent record review of facility in-service education on 8/14/25 at 2:50 p.m. with the Director of Staff Development (DSD), the DSD stated that staff were not supposed to be on cell phones while providing resident care. The DSD stated that upon hire, staff received in-service education on cell phone use in the facility, and cell phone use by employees was also discussed in the employee handbook provided to

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to provide appropriate care and services with the use of enteral feeding (tube feeding, TF - the delivery of nutrients through a tube inserted directly into the stomach) for one resident (Resident 4) when Resident 4's tube feeding bag and tubing (containing nutrients to be delivered by a mechanical pump delivery system at a prescribed rate of flow) did not indicate the date and time it was put into use.This failure had the potential to produce bacterial growth in the tube feeding solution resulting in an infection.A review of Resident 4's admission Record indicated that Resident 4 was admitted to the facility in 2025 with diagnoses which included Cerebral Infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke), End Stage Renal Disease (failure of the kidneys to function normally), and Aphasia (loss of ability to produce or understand language). A review of Resident 4's Physician Order Summary, dated 6/5/25, indicated, .every shift Nepro [enteral formula] 75/ml [milliliters] @ 16 hours [infusion rate of flow]; on 2100 [9 PM], off 1300 [1 PM].During an interview and concurrent observation in Resident 4's room on 8/15/25 at 11:10 a.m. with Licensed Nurse (LN) 2, observed Resident 4's tube feeding bag did not have a label with the date the feeding was started. LN 2 stated that the tube feeding bag should be labeled with the date and time started, resident's name, and feeding solution. LN 2 confirmed that Resident 4's tube feeding bag was not labeled. LN 2 stated that the risk of not labeling the tube feeding bag was that staff would not know when the tube feeding was started, what type of tube feeding it was, and when to change the bag. During an interview on 8/15/25 at 11:15 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that it was her expectation that LNs checked the residents' orders for the type of enteral feeding formula and any flushes ordered before preparing the residents' tube feedings for administration. The ADON stated that when the LNs prepared the enteral feedings, her expectation was that the enteral feeding bags were labeled with the date and time hung, that the LNs checked the resident's identifiers before starting the feeding, and reset the feeding pump with the correct feeding rate of infusion. The ADON stated that the enteral feeding bags should be changed every 24 hours. The ADON stated that the risk of not labeling the enteral feeding bags was that staff would not know when the feeding was started and when the feeding bag needed to be changed. The ADON acknowledged that the facility policy was not followed.A review of a facility policy and procedure (P&P) titled, Enteral Tube Feeding via Syringe (Bolus), revised 11/18, the P&P indicated, .Purpose.The purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally. General Guidelines.3. Check the enteral nutrition label against the order before administration. Check the following information.a. Resident's name, ID, and room number; b. Type of formula; c. Date and time formula was prepared.g. Rate of administration (mL/hour) .