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	08/21/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure necessary doctor's orders and equipment monitoring were in place for an implemented pressure ulcer/injury (PU/PI; refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence) intervention for one of three residents (Resident 4) when, Resident 4 did not have an order for a Low Air Loss Mattress (LAL - alternating pressure and air circulation, which improves blood flow) to include equipment settings (typically based on the patient's weight, pressure sore risk, and skin condition) specific to Resident 4 and there was no documented monitoring to ensure the proper overall function and correct settings of the LAL mattress Resident 4 was using.This failure had the potential for Resident 4 to experience further skin breakdown. Findings:During a review of Resident 4's admission RECORD, the record indicated Resident 4's admission diagnosis included acute respiratory failure with hypoxia (a condition wherein the lungs cannot adequately transfer oxygen to the blood), dysphagia (difficulty swallowing food and liquids), PU of sacral region that was unstageable (a deep wound near the buttocks that cannot be given a severity rating because it's covered by dead tissue), PU of left lower back stage 3 (a deep hole that has gone through the top layers of skin and into the fatty tissue underneath), hemiplegia (significant or complete inability to move and control muscles on one side of the body), and pressure induced deep tissue damage of other sites.During an observation on 8/20/25, at 2:50 p.m., Resident 4 was observed resting on a LAL mattress.During a concurrent interview and record review on 8/20/25, at 3:15 p.m., with Treatment Nurse (TN- a nurse who provides wound care treatment) 1, Resident 4's Treatment Administration Record (TAR - an account of treatment orders, dates and times wound care was performed), dated 8/25, was reviewed. TN 1 verified Resident 4's TAR did not indicate a LAL mattress was in place and the TAR also did not indicate a LAL mattress was being monitored for effectiveness. TN 1 verified Resident 1 was using a LAL mattress and stated there should have been a physician's order for nursing staff to check Resident 4's LAL mattress each shift to ensure the LAL was being used correctly. TN 1 further stated when the LAL mattress was not monitored for proper function and settings, it could have caused the development of new wounds or worsening of older wounds.During an interview on 8/20/25 at 4:27 p.m., with the Assistant Director of Nursing (ADON), the ADON stated a LAL mattress was an external device tool used to manage and prevent ulcers, and the LAL mattress required a physician's order. The ADON further stated the physician's order for a LAL mattress was important because the LAL mattresses settings had to be adjusted for each resident to ensure proper use (settings customized based on things such as the resident's weight, pressure sore risk, and skin condition in order to reduce pressure on bony parts of the body).During a review of an undated facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, the P&P indicated, .the nurse shall describe and document/report the following.Current treatments, including support surfaces. The P&P also indicated, . Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident or substitute decision-maker.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. Building B. Wing	08/21/2025

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stockton Nursing Center	4545 Shelley Court Stockton, CA 95207

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide appropriate behavioral health treatment and services to meet the psychosocial needs for one of three sampled residents (Resident 1) when: 1. Resident 1 displayed episodes of anger, and repeated resident to resident altercations, and Resident 1's Psychiatric Initial Eval, (a comprehensive evaluation focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders) dated 12/10/24, included treatment goals and recommended follow-up psychiatric visits were not provided, nor documented in Resident 1's clinical health record; 2. Resident 1's Physician Progress Notes, dated 3/14/25, 4/1/25, 4/29/25, 5/9/25, and 5/30/25 indicated an assessment and plan for monitor and follow-up with psychiatry, and Resident 1 was not provided psychiatry consultation or visits until 6/9/25; 3. Resident 1's PASRR Individualized Determination Report (PASRR - a federally required screening process designed to ensure that individuals with serious mental illness (SMI), intellectual disability (ID), or related conditions are not inappropriately placed in nursing facilities) recommended specialized add-on services, dated 6/10/25, were not implemented, or followed up on and there was no record of them being reviewed with the medical doctor, which resulted in specialized services including psychotherapy/counseling (a form of talk therapy where a trained professional helps patients address problematic thoughts, feelings, and behaviors to improve emotional well-being and mental health), psychology consultation, psychiatry consultation (a medical appointment with a mental health professional, such as a psychiatrist or psychologist to diagnosis mental health conditions, create treatment options, and provide support and guidance) and/or follow-up care, and neuropsychology (studies the physiological processes of the nervous system and relates them to behavior and cognition) consultation not being provided; and, 4. Resident 1's mental health consult note, via telehealth care (use of technology, video, or phone to provide long distance mental health care), dated 6/9/25, included a plan and recommendations of cognitive therapy, psychiatric evaluation, and medication recommendations, and the consultation note was not communicated to medical doctor and the licensed nursing staff to make the medication adjustments or provide the recommended evaluation and therapy. These deficient practices had the potential to negatively affect Resident 1's psychosocial (the mental, emotional, social, and spiritual effects of a disease) well-being and removed Resident 1's right to receive recommended care and services. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was originally admitted to the facility in the spring of 2024 with diagnoses which included paranoid schizophrenia (persistent delusions of persecution, grandeur, or jealousy, often accompanied by hallucinations), major depressive disorder (persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and psychosis not due to a substance or known physiological condition (psychotic symptoms, such as hallucinations or delusions, are present, but they do not meet the criteria for a specific disorder or when a definitive cause is not identified). During a concurrent observation and interview on 8/20/25, at 4:17 p. m., Resident 1 stated Certified Nursing Assistant (CNA) 1 was here to watch him. Resident 1 stated the bells bothered him and they were supposed to ring the bell when they needed the nurse. Resident 1 stated he was annoyed by the bells and so he went into another resident's room to tell them to stop ringing their bell, and the resident yelled at him, so he hit the resident. Resident 1 stated prior to coming to the facility he was receiving mental health services through county behavioral health. Resident 1 stated he was living by himself, but people called the police on him because he was crazy, and the police took him and then he had to stay at the hospital. During a concurrent observation and interview on 8/21/25, at 3:53 p.m., in Resident 1's room, Resident 1 was observed sitting on his bed, with the television on, and a staff member was observed to be sitting on a chair inside his room next to the doorway. Resident 1 stated he would like to have mental health therapy. Resident 1 stated he used to talk to someone before coming here and he was not sure how long he was receiving mental health services. Resident 1 stated they put a call light in his room so there was no more bell. Resident 1 stated it was better because it would not make noise, and he liked the new call light. During an interview on 8/21/25, at 3:58 p.m., CNA 2 stated she was working as Resident 1's one-on-one (ONO) for the day and was often his ONO. CNA 2 stated Resident 1 liked to have someone to talk to and would take him for smoke breaks. CNA 2 stated she was able to persuade Resident 1 to stay out of conflict with other residents. CNA 2 stated Resident 1 seemed lonely, was paranoid, and had trust issues. CNA 2 stated Resident 1 would hold on to a grudge and keep it to himself and then would eventually get his