STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055735	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta Oaks Post Acute	6940 Pacific Avenue 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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, and record review, the facility failed to provide adequate supervision for one of five sampled residents (Resident 1) when Resident 1's physician order to monitor every 15 minutes for suicidal ideation (thinking about, considering, or being preoccupied with the idea of death and suicide) was not followed. This failure resulted in Resident 1 causing harm to himself by cutting his arms and legs multiple times with a razor blade on 8/8/24 and being admitted to an acute care hospital for treatment. Findings: A review of Resident 1's admission RECORD, indicated, he was admitted to the facility in May of 2024, with diagnoses which included, suicidal ideations, depression (mood disorder that causes a persistent feeling of sadness, low mood, and lack of interest in previously enjoyed activities) and psychoactive substance abuse (misuse or excessive use of substances that affect mental processes and behavior). A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section D-Mood, dated 5/27/24, indicated, .Over the last 2 weeks, have you been bothered by any of the following problems .Feeling down, depressed or hopeless .Symptom Presence 1 [Yes] .Symptom Frequency 3 [12-14 days (nearly every day)] .Feeling bad about yourself-or that you are a failure or have let yourself or your family down .Symptom Presence 1 [Yes] .Symptom Frequency 1 [2-6 days (several days)] . A review of Resident 1's clinical document titled, Progress Notes, dated 8/7/24, at 11:30 AM, indicated, .After resident was assisted back to bed from falling this writer left room to go get residents medications. Another LN [licensed nurse] was in the room with resident and reported that resident took a pair of scissors and held them to his neck and stated, I should just end it all right now. Per LN resident started laughing after. Scissors were taken from resident. Room was checked for any other objects resident could hurt himself with .Resident was placed on q15 min [every 15 minute] checks, and the kitchen was notified to give plastic utensils . A review of Resident 1's clinical document titled, Order Summary Report, order date 8/7/24, indicated, . Change meal utensil to plastic utensil before meals for suicidal ideation .Monitor for suicidal ideation Q 15 every shift . (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 - Actual harm Residents Affected - Few	A review of Resident 1's clinical document titled, Care Plan Report, initiated 8/7/24, indicated, .Focus . Resident/Patient is at risk for suicidal impulses/ideations of self-harm related to - 8/7/24- resident held scissors to his neck and stated I should just end it all right now .Goal .Resident/Patient will remain safe from self-harm .Interventions .q 15 min checks x 24 hours .plastic utensils during meals . A review of Resident 1's clinical document titled, Progress Notes, dated 8/8/24, at 4:50 PM, indicated, . 11:30am [on 8/8/24] nurse notified by activity staff that resident was actively cutting himself. Nurse quickly went to resident room and when entering room, nurse seen resident attempting to continuously cut left forearm. Nurse then asks resident, can you tell me what's going on? Resident then responding saying, I'm trying to kill myself what does it look like .Nurse asked resident if he would allow staff to dress wounds as he was losing a lot of blood .resident continued to self-harm, resident would ask where is the artery [blood vessel that carries blood away from the heart]?, as he was cutting left arm and behind left leg . A review of Resident 1's clinical document titled, Progress Notes, dated 8/8/24, at 5:03 PM, indicated, . Interdisciplinary [group of healthcare professionals who assess and coordinate care] Progress Notes .On 8/7/24 .resident was noted with a pair of scissors in his hand and was holding the scissors to his neck stating, I should just end it all right now! .Resident was placed on Q15min checks and kitchen was notified for plastic utensils to be given .On 8/8/24, resident was still on Q15 monitoring for suicide watch, resident interacted with staff on 10 occasions from beginning of shift until 11:30, time of incident .Paramedics were called for 5150 [involuntary psychiatric hold for someone who is a danger to self or others] .resident taken to [Hospital Name] for further treatment and evaluation . A review of Resident 1's clinical document titled, ED [emergency department] Note- Physician, with a visit date on 8/8/24, indicated, .History Of Present Illness .Per EMS [Emergency Medical Services] report, patient cut himself multiple times with a razor blade just prior to arrival and had an estimated 500cc [cubic centimeters, a unit of measure, 500cc = approximately 2 cups] of blood loss on scene .Medical Decision Making .[Resident 1] is tearful, states that he is depressed and wanting to end his life. Placed on a 1799 hold [a short-term, 24 hour psychiatric detention used in California hospitals] for danger to self . A review of Resident 1's clinical document titled, Physician Progress Notes, with a visit date on 8/8/24, indicated, .[Hospital Name] TRAUMA TERTIARY [specialized medical care] SURVEY NOTE .INJURIES FROM admission .Multiple 3-8 inch lacerations [cuts in the skin] along the L [left] anterior [the front] forearm and the L popliteal fossa [shallow depression at the back of the knee joint] .PHYSICAL EXAM .Upper Extremities [arms]: Several lacerations to the L forearm .with three deep lacerations repaired with .sutures [thread used to close a wound] .Lower Extremities [legs]: Several lacerations to the L popliteal fossa and calf [lower leg], some are sutured .and some remain unsutured with no active bleeding . During an interview on 4/8/25, at 1:25 PM, Activity Assistant (AA) 1 stated on 8/8/24, she walked into Resident 1's room and asked him how he was. AA 1 further stated Resident 1 replied that he was saying goodbye to himself. AA 1 stated Resident 1 had a razor blade and multiple cuts on his arm. AA 1 further stated Resident 1 showed her his arm and sliced it in front of her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/8/25, at 3:06 PM, LN 2 stated on 8/8/24, he was called into Resident 1's room by AA 1. LN 2 further stated he was not sure how many times Resident 1 had cut himself. LN 2 stated Resident 1 talked about his family and wanting to die. LN 2 further stated he tried talking to Resident 1 to stop the situation from getting worse. LN 2 stated he was not sure how Resident 1 obtained a razor, but it could have been from another resident. LN 2 further stated Resident 1's q 15 minute checks were supposed to be documented by the Certified Nurse Assistants (CNA). During an interview on 4/8/25, at 3:10 PM, LN 3 stated on 8/8/24, she was called into Resident 1's room by AA 1. LN 3 stated when she entered his room Resident 1 laughed, made an odd statement, and cut himself. LN 3 further stated Resident 1 was very mobile and could have obtained razors from another resident. During an interview on 4/8/25, at 4:14 PM, CNA 3 stated she was surprised by Resident 1's behavior on 8/8/24. CNA 3 stated she was not aware Resident 1 could behave like that. CNA 3 further stated Resident 1 was friends with everyone and could have obtained a razor from another resident. A review of a facility provided form, used by staff to document Resdient 1's activities every 15 minutes, titled, [facility name] AM [morning] Shift, dated 8/8/24, indicated, time periods from 7:15 AM - 2:45 PM in 15 minute increments. Further review of the record indicated there was no documentation on the form to indicate the 15 minute checks had been completed. During an interview on 4/9/25, at 3:13 PM, the Administrator (ADM) confirmed the 15 minute check form dated 8/8/24, had no documentation from 7:15 AM -until Resident 1 was sent to the hospital on 8/8/24, to indicate Resident 1 was monitored by staff. The ADM stated staff may have stopped monitoring Resident 1 because he had no further behavioral episodes. The ADM could not state who decided to stop the 15 minute observations. The ADM stated the 15 minute observations were initiated due to Resident 1 acting differently. The ADM was unable to provide documentation to indicate the 15 minute checks were discontinued or that the 15 minute checks were completed on 8/8/24. During an interview on 4/10/25, at 8:20 AM, the Assistant Director of Nurses (ADON) stated on 8/8/25, at approximately 11 AM, as she was leaving the building, she observed Resident 1 headed out the front door. The ADON further stated Resident 1 indicated he wanted to go home. The ADON stated she encouraged Resident 1 to talk with a social worker and directed him back into the building. The ADON further stated when a resident was on 15 minute checks the CNA or LN would check on the resident and document their activity in the allotted time frame on the monitoring form. The ADON stated the purpose for Resident 1's q 15 minute checks was to prevent Resident 1 from having suicidal behaviors. The ADON further stated if the q 15 minute checks were not documented the facility could not show that Resident 1 was monitored during that time. The ADON further stated it was her expectation that the 15 minute documentation would have been completed. During an interview on 4/10/25, at 8:47 AM, Resident 1's Primary Medical Doctor (PMD) stated she had ordered every 15 minute suicidal ideation monitoring on 8/7/24 after Resident 1 threatened himself with scissors. The PMD further stated she was not aware that the monitoring had not continued. The PMD stated the facility staff should have continued to monitor Resident 1 to have prevented the incident from occurring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy titled, Suicide Threats, revised 2007, indicated, .Resident suicide threats shall be taken seriously and addressed appropriately .If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present . A review of a facility job description titled, Licensed Practical (Vocational) Nurse (LPN)/(LVN), revised 2022, indicated, .Duties and Responsibilities .Maintain documentation of all nursing care and services provided to the residents; use nurse's notes, flow sheets and electronic medical records according to facility policy . Safety .Functions .Ensure each resident receives adequate supervision .to prevent accidents .