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	06/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided for a census of 103 when several nursing staff were on their personal cellphones during work hours. This failure had the potential to cause psychosocial harm and/or potential injury to all residents. Findings: During a concurrent observation and interview on 6/13/25, at 3:15 p.m., Certified Nursing Assistant (CNA) 1 confirmed she was on her cellphone while working on the floor monitoring residents in the dining room across the Nurses' Station 3 and 4. CNA 1 stated being on the cellphone could affect the residents and lead to delay in the response times. CNA 1 further stated as per facility policy staff should not use their cellphones while working on the floor. During a concurrent observation and interview on 6/13/25, at 3:22 p.m. , Licensed Nurse (LN) confirmed she was on her cellphone while working on documentation. LN stated being on the cellphone while working had the potential to not to meet residents' needs and provide proper care. During a concurrent observation and interview on 6/13/25, at 3:29 p.m., at the Sub Acute Nurses' Station, Restorative Nursing Assistant (RNA) 1, and CNA 2 confirmed they were on their cellphones. RNA 1 stated as per facility policy use of cellphone was not allowed on the floor. RNA 1 further stated there was a potential to be distracted, and accidents could happen. CNA 2 stated being on the cellphone while on the floor had the potential to not to meet residents' needs. During an interview on 6/17/25, at 9:52 a.m., Resident 1 stated that he had seen nursing staff talking and/ or chatting on their cellphones when they were in the hallway passing by his room. Resident 1 further stated he felt there could be a risk for not paying their full attention to the residents that might need help. During a phone interview on 6/17/25, at 2:30 p.m., the Director of Staff Development (DSD) stated according to the facility employee handbook, staff should not use their personal cellphone during work hours, and cellphones should be on silent mode while on the floor. The DSD further stated her expectation was not met by staff. During an interview on 6/18/25, at 11:05 a.m., Resident 2 stated she observed the nursing staff talking on their personal cellphones in the facility hallways on multiple occasions. Resident 2 further stated it was not professional for the nurses to be on their personal cellphones during work hours. Resident 2 expressed her concern about other residents at the facility who could have been at risk for neglect due to the staffs' preoccupation with their cellphones. During a concurrent interview and record review on 6/18/25, at 11:34 a.m., with the Director of Nursing (DON), the facility document titled, EMPLOYEE HANDBOOK, dated 11/01/23, and an undated facility policy titled, Telephones, Employee Use of, were reviewed. A review of the EMPLOYEE HANDBOOK, indicated, .PERSONAL ELECTRONIC DEVICES.Employees should conduct personal business during meal breaks and other rest periods. This includes the use of personal communication devices (including cell phones) for personal business (including personal phone conversations and text messages.employees must refrain from the use of any form of personal electronic communication devices during normal work hours. Further review of the facility policy titled, Telephones, Employee Use of, indicated, .All persons must exercise thoughtfulness and courtesy in using telephones.2. Cellular phones may be used for personal calls and text messaging during meal and break periods. Employee cell phones should remain off and/or silent during all other work hours. The DON confirmed the facility policy and employee handbook were not followed. The DON stated it was not professional to use cellphones, and she did not expect staff to use cellphones during work hours in the nurses' stations, hallways, during shift endorsement, residents' rooms, and other common areas. The DON further stated there was a potential for a delay in providing care and placing residents' health at risk.