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	08/08/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	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

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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 - Few	Based on interview and record review, the facility failed to ensure adequate supervision and monitoring were maintained for one of six sampled residents (Resident 1) when staff did not verify Resident 1's Wanderguard (a monitoring device that alerts staff when a resident approaches a restricted area and attempts to exit a designated zone) placement every shift. This failure potentially contributed to Resident 1 leaving the facility on 4/7/25 without staffs' knowledge and placed Resident 1 at risk for injury.Findings:During a review of Resident 1's clinical record titled, admission RECORD, the record indicated Resident 1 was admitted to the facility with multiple diagnoses including cerebral infarction (long -term effect or complications following a stroke (blood supply to parts of the brain is blocked or reduced) and type 2 diabetes mellitus (high levels of sugar in the blood).A review of Resident 1's clinical record titled, Interdisciplinary Care Conference, (a meeting of a group of healthcare professionals for the purpose of discussing, identifying, addressing, implementing, and reviewing plans to meet the needs regarding a resident's care) dated 4/8/25, indicated that Resident 1's mother called the facility on 4/7/25 at 3:43 p.m. to report that Resident 1 had contacted her stating that he had left the facility and was standing outside of the bank. The facility activated an elopement (a resident leaving a healthcare facility without authorization or staffs' knowledge) code and began searching for Resident 1 without success. On 4/7/25 at 4:23 p.m., Resident 1's mother returned him to the facility. During a concurrent interview and record review on 8/7/25, at 3:46 p.m., with the Sub-acute Director (SUD), Resident 1's medical records were reviewed. The SUD verified that staff had not followed the doctor's order verifying and documenting the placement and working order of Resident 1's Wanderguard (when battery was low; it would show a red light on the strap that indicated the battery needed to be replaced) every shift. The SUD verified that staff did not follow the facility's policy and procedures for the Wanderguard system.During a concurrent interview and record review on 8/7/25, at 4:16 p.m. with Licensed Nurse (LN) 1, Resident 1's Physician orders were reviewed. LN 1 stated that for residents who are using the Wanderguard system, staff are required to verify that it was placed on the resident every shift. LN 1 confirmed that Resident 1's medical records contained a physician's order directing staff to check the placement each shift; however, there was no documentation showing the checks were completed by the staff. LN 1 stated that Resident 1 was placed at risk for injury if he were to leave the facility undetected.Review of Resident 1's physician order, documented in the electronic medical record titled, Order Summary, dated 4/7/25, at 6:05 p.m., indicated the physician ordered staff to check Resident 1's Wanderguard placement every shift.During a concurrent interview and record review on 8/8/25, at 9:13 a.m. with the Administrator (ADM), the ADM stated that her expectation was for staff to verify placement of the Wanderguard each shift. The ADM confirmed that staff were not documenting these placement checks as required by policy and as ordered by the doctor. The ADM further stated that failure to follow this policy places Resident 1 at risk for elopement.During a concurrent interview and record review on 8/8/24, at 10:41 a.m. with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON reviewed Resident 1's medical record and validated that staff had not checked Resident 1's Wanderguard placement each shift. The DON stated this placed Resident 1 at risk for elopement again without staff's knowledge.Review of a facility policy titled, Tab Alarms, Bed Alarms, Wanderguard System revision date 12/12/24, indicated, .The Wanderguard would be used for residents at risk for elopement. 7. The Wanderguard bracelets are checked daily.