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	11/24/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to provide a safe discharge process for one resident (Resident 1) when:1. Resident 1 was discharged home without a clear plan of care to support his activities of daily living (ADL, tasks of everyday life including eating, dressing, bathing, or showering, and using the bathroom; activities related to daily care) needs;2. Resident 1 was discharged home while facing foreclosure (the action of taking back the property that was bought with borrowed money because the money was not being paid back as formally agreed);3. Resident 1 was discharged home without sufficient education regarding self-administration of discharge medications and fingerstick blood glucose (sugar) monitoring (FSBS, pricking one's fingertip to place a drop of blood on a blood glucose meter [a device used to measure the level of glucose in your blood] to keep blood glucose levels within a healthy range); and,4. Resident 1 was discharged home without an Interdisciplinary Team (IDT, a group of healthcare professionals who work together towards the goals of the residents) review of the discharge plan of care.These failures put Resident 1's health and well-being at risk, and potentially lead to Resident 1's rehospitalization in an acute care emergency department three days after discharge.A review of Resident 1's admission Record, indicated that Resident 1 was admitted to the facility in 2025 with diagnoses which included Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar), Hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high. This causes the heart to work harder to pump blood. Also known as high blood pressure), and Congestive Heart Failure (CHF, a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs). 1. A review of Resident 1's Minimum Data Set (MDS, a comprehensive care assessment tool) Section GG - Functional Abilities - Admission, dated 10/29/2025 indicated, .GG0115.Functional Limitation in Range of Motion.Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days.2. Impairment on both sides.Lower extremity (hip, knee, ankle, foot).GG0120.Mobility Devices.Check all that were used in the last 7 days.None were used.GG0130.Self-Care.A. Eating.06 Independent - Resident completes the activity by themselves with no assistance from a helper.B. Oral Hygiene.03 Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.C. Toileting Hygiene.02 Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.E. Shower/bathe self: the ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower .03 Partial/moderate assistance.F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.02.G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.03.Putting on/taking off footwear: The ability to put on and take off socks and shoes and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.03.I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and oral hygiene).03.GG0170.Mobility.A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.03.B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.03.C. Lying to sitting on side of bed: The ability to move from sitting on side of bed to lying flat on bed.03.D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.03.E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).03.F. Toilet transfer: The ability to get on and off a toilet or commode.03.I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.88. Not attempted due to medical condition or safety concerns. A review of Resident 1's MDS Section Q - Participation in Assessment and Goal Setting - Admission, dated 10/29/2025 indicated, .Q0110.Participation in Assessment and Goal Setting.Identify all active participants in the assessment process.A. Resident.Resident's overall goal for discharge established during the assessment process.1. Discharge to the community. A review of Resident 1's MDS Section C - Cognitive Patterns - Admission, dated 10/29/2025 indicated that Resident 1's Brief Interview for Mental Status (BIMS, a tool to assess cognition. The total possible BIMS score ranges from 00 to 15. 13 - 15: cognitively intact; 08 - 12: moderately impaired; 00 - 07: severe impairment) score was 14. A review of Resident 1's Physical Therapy (PT) Evaluation, dated 10/22/2025 indicated, .Reason for Referral: Patient (Resident) referred to PT due to new onset of decrease in strength, decreased neuromotor (relationship between the body's nerves and muscles) control.decrease in functional mobility, functional limitation with ambulation, falls/fall risk, increased need for assistance from others and compromised physical exertion level during activity.History of Falls.Has Patient fallen in past year? Yes.How many times? Exact number unknown.Was Patient injured from fall? No.Does Patient have a fear of falling? Yes. A review of Resident 1's Occupational Therapy (OT) Evaluation, dated 10/22/2025 indicated, .Reason for Referral: patient exhibits new onset of compromised physical exertion level during activity, decrease in functional mobility, decrease in strength, decreased coordination, falls/fall risk.increased need for assistance from others.Reason for Skilled Services: Patient requires skilled occupational therapy services.to address the following.increase.develop and instruct on.strategies and develop and instruct on.techniques in order to enhance this patient's quality of life by improving the ability to increase participation with functional daily activities and decrease level of assistance.without skilled therapeutic intervention, this patient is at risk for rehospitalization, decreased ability to return to prior level of functioning, falls, further decline in function and increased dependency upon caregivers. A review of Resident 1's PT Treatment Encounter Note, dated 11/7/2025 indicated that Resident 1 actively participated with skilled interventions. A review of Resident 1's OT Treatment Encounter Note, dated 11/7/25 indicated that Resident 1 was compliant with skilled interventions. A review of Resident 1's PT Discharge Summary, dated 11/7/25 indicated, .Short-Term (STG) #1 - Patient will improve ability to safely transfer from lying on the back to sitting on the side of the bed, feet flat on the floor with set up/clean up in order to participate in activities of daily living and participate in self care [sp] activities.Baseline 10/22/2025.Section GG: Partial/Moderate Assist.Discharge 11/7/2025 Section GG: Partial/Moderate Assist.STG #2 - Patient will improve ability to safely and efficiently transfer to and from a bed to a chair (or wheelchair) with supervision/stand by assist with implementation of compensatory strategies.Baseline 10/22/2025.Section GG: Partial/Moderate Assist.Discharge 11/7/2025.Section GG: Partial/Moderate Assist.STG #3 - Patient will safely ambulate on level surfaces 60 feet using two-wheeled walker with supervision/stand by assist with adequate cardiopulmonary (heart and lung) function and with functional dynamic balance.Baseline 10/22/2025.Section GG: Substantial/Maximal Assist.Discharge 11/7/2025.Section GG: Substantial/Maximal Assist. A review of Resident 1's OT Discharge Summary, dated 11/7/2025 indicated, .STG #2.1 - Met on 11/7/2025.Patient will improve ability to complete toilet/commode transfers with set up/clean up with use of compensatory strategies, and adaptive/assistive devices, with improved strength and with ability to right self to achieve/maintain balance, with implementation (continued on next page)

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conferences (Interdisciplinary Team, a group of healthcare professionals who work together towards the goals of the residents) were held, and the resident and family were included to discuss the resident's discharge plan. The SSA stated that everything had to be in line for the resident's discharge: Social Services checked to make sure the durable equipment (example, walker or wheelchair) was delivered as applicable, checked to make sure that transportation was arranged if needed, coordinated discharge with the resident, family and home health even if the resident was their own Responsible Party (RP). The SSA confirmed that she did not see nursing progress notes on teaching Resident 1 how to check blood glucose (FSBS) before and after medications for diabetes, or notes on teaching Resident 1 about self-medication administration in his EMR. During an interview and concurrent record review of Resident 1's Care Plan Report, on 11/17/25 at 12:33 p.m. with the facility Administrator in Training (AIT) and the SSA, the AIT stated that the nursing staff documented teaching Resident 1 to monitor his FSBS and about signs and symptoms of hypoglycemia (low blood glucose) on the Care Plan Report per the Minimum Data Set Nurse (MDS, a long-term care facility nurse who specializes in assessing the needs of long-term care residents). During an interview and concurrent record review of Resident 1's Care Plan Report on 11/17/25 at 12:36 p.m. with the MDS, the MDS stated that the Care Plan Report documented the licensed nurses (LNs) teaching Resident 1 about the LNs checking his FSBS prior to giving him his medications for diabetes, and teaching Resident 1 about signs and symptoms of hypoglycemia (low blood glucose) to watch for while in the facility. The MDS stated that education for Resident 1 regarding checking his own FSBS and giving his own medications at home should have been documented on a progress note or on a discharge assessment in his EMR. During an interview by phone with the Social Services Director (SSD) on 11/18/25 at 3:00 p.m., the SSD stated that she no longer worked at the facility. The SSD stated that the LNs usually did the discharge teaching with the residents and families. The SSD stated that she informed the charge nurse working on 11/6/25 that Resident 1 was to be discharged on 11/9/25 and needed teaching. The SSD stated that she did not remember the charge nurse's name that she reported the impending discharge to. The SSD stated that the charge nurse stated that she would pass the information along. During an interview by phone with LN 1 on 11/24/25 at 3:20 p.m., LN 1 stated that she was notified that Resident 1 was being discharged on the day of discharge. LN 1 stated that the notification of discharge was short notice. LN 1 stated that on 11/7/25, she was asked to place an order for Resident 1 to be discharged on 11/8/25. LN 1 stated that the notice of discharge was cancelled, so she thought that Resident 1 was not going to be discharged . LN 1 stated that on the morning of 11/9/25 she was told to provide discharge teaching for Resident 1. LN 1 stated that she reviewed all of Resident 1's discharge medications, including Insulin and FSBS with Resident 1, and Resident 1 voiced understanding. LN 1 stated that during the discharge teaching on the morning of discharge, she had Resident 1 watch her as she checked his FSBS and administered his insulin. LN 1 acknowledged that she did not have Resident 1 demonstrate to her how he would self-check his FSBS or how he would self-administer his insulin injection before he was discharged . 4. During an interview and concurrent record review of Resident 1's Electronic Medical Record (EMR) on 11/7/25 at 11:53