

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Delta Oaks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>Based on interview and record review, the facility failed to refer one of two sampled residents (Resident 1) to a psychiatrist (a medical doctor who can diagnose and treat mental health conditions) as recommended by the Interdisciplinary Team (IDT, a group of professionals who have a role in the Resident's care) and ordered by the physician after Resident 1 had a behavioral manifestation of agitation during an altercation with another resident (Resident 2) on 10/24/25. This failure could potentially result in increased agitation episodes for Resident 1 and a risk of getting involved in another altercation incident. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted with diagnoses which included muscle weakness and difficulty walking. A review of Resident 1's medical record titled IDT Care Conference dated 10/27/25, indicated, Resident 1 had an altercation with another resident (Resident 2) and the IDT recommended a psychiatric evaluation and treatment for episodes of agitation. A review of Resident 1's Order Summary, dated 10/29/25, indicated, .Psych Evaluation and Treatment # [number of] agitation .During a concurrent interview and record review on 12/26/25, at 2:40 PM, with the Assistant Director of Nursing (ADON), Resident 1's IDT care conference note was reviewed. The ADON stated an IDT meeting was held after the altercation incident and the team recommended a psychiatric evaluation and treatment for episodes of agitation for Resident 1. The ADON stated she was not sure if the psychiatric referral was done. The ADON stated that when a resident was referred for a psychiatric evaluation, they needed to inform the social services department. During a concurrent interview and record review on 12/30/25, at 9:23 AM, with the Social Service Assistant (SSA), Resident 1's electronic health record (EHR) was reviewed. The SSA confirmed that there was an IDT meeting after the altercation incident and it was recommended that Resident 1 was to be referred for a psychiatric evaluation. The SSA stated they had a psychiatrist that would come to the facility. The SSA stated that the Social Services department was responsible for sending the referrals. The SSA stated she was not sure if Resident 1 was seen by the psychiatrist. The SSA stated they had a portal with the contracted company where the psychiatrist made their notes from the visit, but she did not have access to it. The SSA stated that the psychiatrist did not send the notes to the facility and confirmed Resident 1's EHR did not contain any notes from the psychiatrist. During a concurrent interview and record review on 12/30/25, at 10:33 AM, with the Director of Nursing (DON), Resident 1's EHR was reviewed. The DON stated Resident 1 had a history of agitation. The DON further stated that Resident 1 had a verbal argument with Resident 2 and tried to hit Resident 2. The DON confirmed that there was an order for a psychiatric evaluation from the physician for Resident 1 dated 10/29/25. The DON stated it was the responsibility of social services to send the referrals for psychiatric consultations. The DON stated she was not sure if Resident 1 was seen or not, and she did not have access to the psychiatrist's portal. The DON stated that the psychiatrist usually emailed the social services department the visit notes and the social services would upload them into the resident's chart. The DON confirmed she did not see any psychiatric notes in the medical</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055735
		If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Delta Oaks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>chart of Resident 1. The DON stated that it was important for the facility to know what the recommendations of the psychiatrist were. The DON further stated that the psychiatrist should at least tell the facility what the recommendations were for the resident after their visit. The DON stated that if the facility was not aware of the recommendations of the psychiatrist, the facility would not be compliant with the psychiatric services, and it would affect the resident's psychosocial health.</p>		