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 03/05/2026
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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate care and supervision (an intervention and means of mitigating the risk of an accident) for one out of two sampled residents (Resident 1) to ensure resident safety when, the facility staff did not take immediate action to locate Resident 1 when Resident 1 left the facility for more than four hours past his expected return time for a medical appointment on 10/16/25.This failure resulted in Resident 1 eloping from the facility on 10/16/25 and Resident 1 did not return to the facility until approximately 29 hours later. Resident 1 was transferred to hospital, was positive for illicit drug use (use of illegal drugs (e.g., heroin, cocaine) and/or inappropriate use of prescription medications), and missed scheduled intravenous (IV; administering fluids medication directly into a vein using a needle or tube in the hand) Ertapenem medication (an antibiotic used to treat severe infections like pneumonia, and urinary tract infections caused by bacteria) administration, his blood sugar checks, and insulin (injectable medication to lower blood sugar for diabetic patients) dose over a 24 hour period. Resident 1 left the facility with a Right Upper Arm Peripheral Intravenous Central Catheter (PICC; a long flexible tube inserted into a large vein of the upper arm to the heart to give medications, fluids, and for blood draws).Findings: During a record review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025, indicating Resident 1 had diagnoses of acute osteomyelitis (infection in the bone, through the blood stream or nearby infected tissue) right ankle and foot, cellulitis (a deep bacterial infection of the skin, causing, redness, swelling and tenderness) of right lower limb non pressure (a wound not caused by pressure) chronic ulcer of the right heel and foot, type 2 diabetes (when the body cannot use insulin correctly and sugar increase in the blood stream), long term current use of insulin, asthma, difficulty walking, and generalized muscle weakness.During a concurrent interview and record review on 3/6/26, at 12:02 p.m., with the Director of Nursing (DON), Resident 1's Progress Notes were reviewed. The DON confirmed Resident 1 left the faciity on [DATE] for a scheduled medical appointment and did not return to the facility until 10/17/25, at 5:16 p.m.A review of Resident 1's Progress Notes, the Progress Notes indicated, .Effective Date: 10/16/2025 18:00 [6 p.m.]. Type: Nurse Progress Note. LATE ENTRY. Note: Received call from the charge nurse that resident signed out for his appointment with nurse and did not return yet. Charge nurse also stated that he left yesterday too with his friend but did return around 1830pm [6:30 p.m.]. Writer informed the charge nurse to call the resident cell phone and the contact listed on the profile to see and also notified MD [medical doctor] and admin [administrator].During a record review of Resident 1's Progress Notes, the progress note indicated, .Effective Date: 10/17/2025 06:57. Note: Per PM nurse, resident verbalized to AM nurse that he had an appointment on 10/16/25 at 1:30 p.m. which he independently scheduled, including his own transportation. The Resident has not returned to facility since leaving for the appointment. PM nurse attempted to contact resident via cell phone with no answer. Writer also attempted to call resident's cell phone with no answer as well, voicemail left requesting resident return to the facility. Emergency contact [family member] was called but no answer. Writer also contacted resident's other listed contact [family member], no answer. Director of Nursing, (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: 055735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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	Administrator, and [MD] notified and aware.During a record review of Resident 1's Progress Notes, indicated, .Created Date 10/17/2025 23:12:29 [11:12 PM] . SS [Social Services] met with the patient in the hallway after he returned to the facility, as he was heading back to his room. the patient expressed that his experience outside the facility was quite frightening for him .During a review of Resident 1's progress notes titled Situation Background Assessment Recommendations (SBAR), dated 10/17/25, indicated, . the change in condition, symptoms, or signs observed and evaluated is/are: Other change in condition: resident was out of the facility without MD order for extended periods of time. No changes observed. This started on: 10/16/2025 . Primary Care Clinician Notified: Yes, Date: 10/17/2025, Time 5:00 p.m., Testing; other: (describe) toxic screening [toxicology screen or tox screen checks blood, urine, or saliva for drugs, alcohol, and/or toxins].During a review of Resident 1's Emergency Department Discharge Instruction, dated 10/17/25, the document indicated, .reason for visit, drug screening, discharge diagnosis. Encounter for drug screening, foot osteomyelitis [a serious bone infection], right, Methamphetamine use [an illicit drug], Opiate use [a class of natural, semi synthetic and synthetic drug], . drug Screen Panel (10/17/25). Ur [urine] Amphet/Methamphet [Amphetamines/Methamphetamine; powerful, synthetic central nervous system (CNS) stimulants that accelerate messages between the brain and the body] - Positive, Ur Opiates [A substance used to treat pain or cause sleep] - Positive.During an interview on 3/10/26, at 1:27 p.m., with Licensed Nurse (LN) 1, LN 1 stated the day shift nurse endorsed to her Resident 1 had left with his friend for an appointment and was expected to be back at a certain time, between 6 p.m. and 7 p.m. LN 1 further stated Resident 1 had a history and an incident of leaving the facility without staff's knowledge prior. LN 1 stated she did not remember whether she called the Physician when Resident 1 did not come back at 6 p.m., or at his expected time of return. LN 1 further stated it was an unusual occurrence when Resident 1 left on 10/16/25 and did not return at the expected time of return, if it was not approved by the Physician. LN 1 further stated the normal protocol she followed for an unusual occurrence was to have notified the Administrator (ADM) and the DON and to follow whatever instructions they had given to her.During an interview on 3/11/26, at 3:05 p.m., with LN 1, LN 1 confirmed she did not call the police on 10/16/26, when Resident 1 did not return to the facility at his expected time of return to the facility. LN 1 stated by not calling the police could affect Resident 1's safety and facility staff would want to know his whereabout, when he would return, was he ok, and had he been admitted to the hospital.During a record review of resident 1's Interdisciplinary Care Conference notes (IDT), dated 10/20/25, the IDT notes indicated, .Resident had an oop [out on pass] which was initiated on 10/15/2025 for one day pass, MD approved. On 10/16/2025 Resident signed out at the nursing station stating that he was going out for an appointment. Per resident he made his own appointment and already has his transportation set up to be picked up. Resident left the facility at 12:30 p.m., resident returned at 17:16 p.m. [5:16 p.m.], on 10/17/25 accompanied by his friend. As per interviewed with the resident upon his returned, he stated that he did not know that he needed to get another order to go out on pass for 10/16/25 since he already had an order for 10/15/25.Resident educated regarding risk and benefits of going out with an IV line. MD gave order to check the lab. Lab result shows positive for Methamphetamine.During a concurrent interview and record review on 3/6/25 at 12:10 p.m., with the DON, the facility's policy and procedure (P&P), titled, Leave of Absence without Notice, was reviewed. The DON confirmed based on the definition of elopement, it was considered an elopement when Resident 1 left the facility and did not return till the next day on 10/17/25. The DON stated that when a resident left on a out on pass or had left for his appointment and did not return after 4 hours, or at the expected time of return, nursing staff should have immediately followed the facility's policy and first called the administration and Physician, then law enforcement. The DON further stated LN 1 did not call the physician until 10 p.m., on 10/16/25, when Resident 1 left for an appointment and did not return past his expected time of return. The DON stated staff did not call the police until the next day on 10/17/25 at around 7 a.m. The DON further stated the expectation of nurses was to call the patient and family and if they could not reach any of them, to (continued on next page)

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 03/05/2026

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	have called the physician and police. The DON admitted nursing staff should have followed up with the community medical center to see whether Resident 1 was there or where he had been. The DON added the facility's process for giving residents an out on pass, they need to have a physician's order to go out. The DON stated if the resident was going to a scheduled appointment, the facility would enter the appointment into the orders, the resident must sign out on the sign out sheet, and the facility should have known where the location was that resident had gone to, the contact number, and who they went with. The DON stated not calling the physician and police immediately when they found out Resident 1 had not returned hours past his appointment time, put Resident 1's safety at risk. The DON added the facility did not know whether something had happened to Resident 1, whether he was at a local hospital, and did not know his whereabouts. The DON confirmed Resident 1 had missed a dose of his Ertapenem antibiotic medication and Resident 1 had a PICC and anything could have happened to the PICC line.During an interview on 3/11/26, at 12:38 p.m., with the Assistant Director of Nursing (ADON), the ADON confirmed the facility did not call the police the night Resident 1 did not return to the facility after his medical appointment. The ADON further stated she had to call the police when she came on her shift at 7 a.m., on 10/17/25. The ADON stated it was expected for the nurse to have called the physician, the DON, the ADM, the family, and then the police. The ADON further stated Resident 1 was under their care and they were trying to keep him safe. The ADON added Resident 1 had left with a PICC line and this posed a very high risk. The ADON further stated there could have been harm to Resident 1, as the facility did not know in which condition Resident 1 was in. The ADON confirmed it was an unusual occurrence when Resident 1 left the facility for a medical appointment, did not return hours past his return time, and the facility was unaware of his wellbeing. The ADON further stated the policy for an unusual occurrence was to notify the supervisor, the ADM, the physician, and law enforcement based on the situation. The ADON stated Resident 1 had a history of leaving the facility on a pass and would not return at the expected time of return.A review of Resident 1's Order Summary Report, indicated, . Ertapenem sodium Injection Solution Reconstituted 1 GM [gram; a unit of measurement] (Ertapenem Sodium) use 1 gram intravenously one time a day for osteomyelitis until 10/28/2026 23:59. Communication Method. Prescriber Written. Order Status Completed. Order Date. 09/23/2025. End Date. 10/28/2025. Heparin Sodium (Porcine) injection Solution 5000 UNIT/ML (Heparin Sodium (Porcine) [blood thinner used to prevent and treat blood clots] injection 1 ml subcutaneously [under the skin] every 8 hours for DVT [deep vein thrombosis, blood clot] prevention. Order Date. 09/22/2025. Start Date 09/22/2025. End Date [none].A review of Resident 1's Care Plan, indicated, . Focus. Resident is at risk for injury or complications related to the use of anticoagulant/antiplatelet therapy. Medication: Heparin. Date initiated: 10/01/2025. Created on: 10/01/2025. Canceled Date: 11/12/2025. Interventions. Anticoagulant to be given as ordered. Monitor for cyanosis and pallor [a pale, reduce color in the skin caused by decreased blood flow]. Date Initiated: 10/02/2025. Revision on: 11/12/2025. Observed for active bleeding, i.e. hematuria [blood in the urine], bruising, . nose bleeds, bleeding gums, etc. Date Initiated: 10/01/2025. Created on: 10/01/2025. Revision on: 11/12/2025.During a review of Resident Medication Administration Record (MAR), indicated, . Insulin Glargine subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously at bedtime for Type 2 DM -Start Date-09/22/2025 2100 -D/C Date-10/29/2025 1414.[10/16, 10/17, 10/18 marked as] AW Away from center. Heparin. injection Solution 5000 UNIT/ML. Inject 1 ml subcutaneously every 8 hours for DVT prevention.[10/15, 10/16, 10/17, marked x; not given].During an interview on 3/11/26, at 3:56 p.m., the DON confirmed an X on the MAR meant the medication was not given.During a review of facility's document, titled Location of Administration Report, indicated, . Schedule for [DATE]. Ertapenem Sodium. 1. use 1 gram intravenously one time a day for Osteomyelitis until 10/28/25. [was marked on] 10/17 [as] AW [resident was not available] .A review of facility's policy and procedures (P&P), titled, Wandering and Elopements, revised 2019, the P&P indicated, .Policy statement. The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining (continued on next page)

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	03/05/2026

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	the least restrictive environment for residents. 3. If a resident is missing, initiate the elopement/missing resident emergency procedure: . a. Determine if the resident is out on an authorized leave or pass; . b. If the resident was not authorized to leave, initiate a search of the building (s) and premises; and. c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squad, etc.) .A review of facility's P&P titled, Out On Pass, revised 4/11/25, the P&P indicated, . Purpose. To provide residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning.Policy. It is the policy of the Facility to meet residents' physical and psychological needs when going out on pass. The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights. Procedure. 2. If at any time the nursing staff believe the resident's use of the out on pass order conflicts with the resident's plan of care or jeopardizes the resident's health or safety, the nursing staff will hold the out on pass order until the attending physician/psychiatrist (if applicable) are notified. a. A new out on pass order will be obtained once the attending physician/psychiatrist can determine the resident can safely leave the facility. 4. Licensed Nurse. a. Prior to the resident leaving on pass, licensed nurse will assess the resident's physical and mental status and ensure that: .i. The resident and responsible person (if applicable) has been instructed of any special needs of the resident during the pass as applicable. ii. There is a physician order for medication to be given while on pass.