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	04/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, the facility failed to report to the Department an injury of unknown source in accordance with the facility's abuse policy and procedure (P&P) for one of one resident (Resident 1) when on 2/2/26, Resident 1 was found with an unexplainable left shoulder dislocation (an injury that occurs when the upper arm bone pops out of the cup shaped socket near the shoulder blade).This failure denied the Department the ability to conduct a timely investigation and placed Resident 1 at risk for abuse. In addition, the facility failed to comply with federal and state reporting regulations.Findings:A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included subarachnoid hemorrhage (SAH, a type of stroke characterized by bleeding in the space between the brain and the tissues that cover the brain), traumatic brain injury (a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high and causes the heart to work harder to pump blood).A review of Resident 1's Minimum Data Set [MDS, a comprehensive care assessment tool] Section C: Cognitive Patterns, dated 3/9/26, indicated that Resident 1's Brief Interview for Mental Status score was 00 (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).A review of Resident 1's MDS Section GG: Functional Abilities and Goals, dated 3/9/26, indicated that Resident 1 required maximal assistance and was totally dependent on others for all care needs.A review of Resident 1's Nurses Progress Notes, dated on 2/1/26, at 1:34 p.m., indicated, .patient [Resident 1] rp [Responsible Party, the person designated to direct the care of a loved one admitted into a nursing facility] stated to writer that patient looked like he did not feel good and pointed to patient left shoulder and stated that something was wrong and that the patient has a bad shoulder. patient appeared to be in some discomfort, writer informed rp that patient was changed and received wound treatment about 30 minutes prior and that patient was most likely recovering from this, rp disagreed and requested.x-ray [a quick painless test that captures images of the structures inside the body particularly bones]. administered PRN [as needed] pain medication and informed MD [medical doctor]. MD ordered.left shoulder x-ray.called [x-ray provider].scheduled left shoulder x-ray for tomorrow 2/2/26. rp at bedside and informed.A review of Resident 1's X-ray Report, indicated, .Date of Exam.02/01/2026 21:54 [9:54 p.m.].HISTORY.STIFFNESS/PAIN.SIGNIFICANT FINDINGS.LEFT SHOULDER X-ray Complete.Multiple views of the left shoulder show anterior [toward the front of the body] shoulder dislocation.There are no acute fractures [broken bones].A review of Resident 1's Nurses Progress Notes, dated 2/2/26, at 2:58 a.m., indicated, .shoulder x-ray result came back with a significant findings Left anterior shoulder dislocation .Called [MD] .send to ER [emergency department at acute care hospital] to fix the shoulder .Called the RP .During an interview on 4/1/26, at 12:20 p.m., with Resident 1's RP in Resident 1's room, the RP stated she asked staff to call the physician for an x-ray when she noticed that Resident 1 grimaced when she touched his shoulder on 2/1/26. The RP further stated staff that day (2/1/26) told her that Resident 1 had recently been cleaned and repositioned after providing incontinent care (skin care after (continued on next page)

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
	055735	A. Building B. Wing	04/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involuntary or accidental leakage of urine or feces). The RP stated the x-ray showed that Resident 1's left shoulder was dislocated.During an interview on 4/1/26, at 4:51 p.m., with the Director of Nursing (DON), the DON confirmed Resident 1's left shoulder injury was an injury of unknown origin. The DON further confirmed Resident 1's injury to the left shoulder was not reported. The DON acknowledged Resident 1's injury of unknown origin should have been reported.During a joint concurrent interview and record review on 4/2/26, at 2:03 p.m., with the Administrator (ADM) and the DON, Resident 1's Progress Notes, were reviewed. The ADM stated he talked to Resident 1's RP and the RP stated that the injury was due to contractures (when muscles, tendons, joints, or other tissues tighten or shorten causing loss of movement). The ADM further stated that he talked with the RP a day or so after the injury to Resident 1's left shoulder was discovered. The ADM stated he asked Resident 1's RP if Resident 1 fell and the RP said No, and the RP also stated that she did not notice any trauma to Resident 1's shoulder. The ADM further stated that he did not document the conversation that he had with Resident 1's RP but he spoke to the DON about it. The ADM stated the RP was happy with Resident 1's care at the facility. The ADM further stated that he followed the RP's lead and it did not lead him to suspect abuse. The ADM acknowledged that Resident 1 was under the facility's care. The ADM confirmed that the injury to Resident 1's left shoulder was not reported to the Department. The ADM and the DON both acknowledged that the cause of Resident 1's left shoulder dislocation should have been investigated to rule out abuse related to the injury of unknown origin.A review of a facility P&P titled, Abuse Prohibition Policy and Procedure, dated 5/23/21, indicated, .Policy.The Center will implement an abuse prohibition program through the following.Identification of possible incidents or allegations which need investigation.Investigation of incidents and allegations; and Reporting of incidents, investigations, and Center response to the results of their investigations.Federal Definitions.Injuries of unknown source are defined as an injury with both of the following conditions.The source of the injury was not observed by any person or the source of the injury could not be explained by the patient.The injury is suspicious because of the extent of the injury or the location of the injury.or the number of injuries observed at one particular point in time or the incidence of injuries over time.Purpose.To ensure that Center staff are doing all that is within their control to prevent occurrences of.injuries of unknown source.Process.1. The Center Executive Director.is responsible for operationalizing policies and procedures that prohibit.injuries of unknown source.6.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected.7. Upon receiving information concerning a report of suspected or alleged abuse.the CED (Center Executive Director) or designee will perform the following.7.2 Report allegations involving neglect, exploitation of mistreatment (including injuries of unknown source) .no later than two (2) hours after the allegation is made if the event results in serious bodily injury. Serious bodily injury is reportable. Only an investigation can rule out abuse, neglect, or mistreatment.7.2.1 Serious bodily injury is defined as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation.7.4 Notify local law enforcement, Ombudsman, Licensing District Office.and other agencies as required.7.6 Initiate an investigation within 2 hours of an allegation of abuse that focuses on.7.6.1 Whether abuse or neglect occurred and to what extent.7.6.2 clinical examination for signs of injuries.7.6.3 causative factors 7.6.4 interventions to prevent further injury.7.7 The investigation will be thoroughly documented.interview forms will be kept confidential in a file in the administrative office.9. The CED or designee will.9.2 Report findings of all completed investigations within five (5) working days to the Licensing District office.

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	04/02/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, and record review, the facility failed to investigate an injury of unknown origin for potential abuse for one of one resident (Resident 1) when Resident 1 was found with an unexplainable left shoulder dislocation (an injury that occurs when the upper arm bone pops out of the cup shaped socket near the shoulder blade) on 2/2/26.This failure placed Resident 1 and other residents in the facility at risk for unidentified abuse and had the potential to hinder protection from ongoing abuse.Findings:A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included subarachnoid hemorrhage (SAH, a type of stroke characterized by bleeding in the space between the brain and the tissues that cover the brain), traumatic brain injury (a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high and causes the heart to work harder to pump blood).A review of Resident 1's Nurses Progress Notes, dated on 2/1/26, at 1:34 p.m., indicated, .patient [Resident 1] rp [Responsible Party, the person designated to direct the care of a loved one admitted into a nursing facility] stated to writer that patient looked like he did not feel good and pointed to patient left shoulder and stated that something was wrong and that the patient has a bad shoulder. patient appeared to be in some discomfort, writer informed rp that patient was changed and received wound treatment about 30 minutes prior and that patient was most likely recovering from this, rp disagreed and requested.x-ray [a quick painless test that captures images of the structures inside the body particularly bones]. administered PRN [as needed] pain medication and informed MD [medical doctor]. MD ordered.left shoulder x-ray.called [x-ray provider].scheduled left shoulder x-ray for tomorrow 2/2/26. rp at bedside and informed.A review of Resident 1's X-ray Report, indicated, .Date of Exam.02/01/2026 21:54 [9:54 p.m.].HISTORY.STIFFNESS/PAIN.SIGNIFICANT FINDINGS.LEFT SHOULDER X-ray Complete.Multiple views of the left shoulder show anterior [toward the front of the body] shoulder dislocation.There are no acute fractures [broken bones].A review of Resident 1's Nurses Progress Notes, dated 2/2/26, at 2:58 a.m., indicated, .shoulder x-ray result came back with a significant findings Left anterior shoulder dislocation .Called [MD] .send to ER [emergency department at acute care hospital] to fix the shoulder .Called the RP .During an interview on 4/1/26, at 12:20 p.m., with Resident 1's responsible party (RP) in Resident 1's room, the RP stated she asked staff to call the physician for an x-ray when she noticed that Resident 1 grimaced when she touched his shoulder on 2/1/26. The RP further stated staff that day (2/1/26) told her that Resident 1 had recently been cleaned and repositioned after providing incontinent care (skin care after involuntary or accidental leakage of urine or feces). The RP stated the x-ray showed that Resident 1's left shoulder was dislocated.During a joint concurrent interview and record review on 4/1/26, at 2:51 p.m., with the Director of Nursing (DON), the Social Services Director (SSD), and the Subacute Assistant Director of Nursing (ADON), Resident 1's electronic medical record (EMR) was reviewed. The DON stated there was no investigation into the cause of Resident 1's shoulder dislocation. The SSD stated the facility should have investigated to see if a cause for Resident 1's shoulder dislocation could be found.During a concurrent interview and record review on 4/2/26, at 2:03 p.m., with the Administrator (ADM) and the DON, Resident 1's EMR was reviewed. The ADM stated he knew that Resident 1 had a chronic shoulder issue. The ADM further stated that the shoulder issue was listed in Resident 1's EMR. The ADM stated that he talked with the RP a day or so after the injury to Resident 1's left shoulder was discovered. The ADM further stated that Resident 1's RP stated that Resident 1 had shoulder issues for years and was concerned about his arms being extended when repositioned. The ADM stated that he asked Resident 1's RP if Resident 1 fell and the RP said No, and the RP also stated that she didn't notice any trauma to his shoulder. The ADM further stated that he did not document the conversation that he had with Resident 1's RP but he spoke to the DON about it. The ADM and the DON both stated that they were (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	04/02/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not sure if the investigation was done to determine the cause of Resident 1's left shoulder dislocation. The ADM stated that he talked with Resident 1's RP during rounds but did not document the conversation. The ADM further stated that the RP was happy with Resident 1's care at the facility. The ADM stated that he followed the RP's lead and it did not lead him to suspect abuse. The ADM acknowledged that Resident 1 was under the facility's care. The ADM further acknowledged that an investigation after the discovery of Resident 1's left shoulder injury was not done. The ADM and the DON acknowledged that the cause of Resident 1's left shoulder dislocation should have been investigated to rule out abuse related to the injury of unknown origin.A review of a facility policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, dated 5/23/21, indicated, .Policy.The Center will implement an abuse prohibition program through the following.Identification of possible incidents or allegations which need investigation.Investigation of incidents and allegations; and Reporting of incidents, investigations, and Center response to the results of their investigations.Federal Definitions.Injuries of unknown source are defined as an injury with both of the following conditions.The source of the injury was not observed by any person or the source of the injury could not be explained by the patient.The injury is suspicious because of the extent of the injury or the location of the injury.or the number of injuries observed at one particular point in time or the incidence of injuries over time.Purpose.To ensure that Center staff are doing all that is within their control to prevent occurrences of.injuries of unknown source.Process.1. The Center Executive Director.is responsible for operationalizing policies and procedures that prohibit.injuries of unknown source.6.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected.7. Upon receiving information concerning a report of suspected or alleged abuse.the CED (Center Executive Director) or designee will perform the following.7.2 Report allegations involving neglect, exploitation of mistreatment (including injuries of unknown source) .no later than two (2) hours after the allegation is made if the event results in serious bodily injury. Serious bodily injury is reportable. Only an investigation can rule out abuse, neglect, or mistreatment.7.2.1 Serious bodily injury is defined as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation.7.4 Notify local law enforcement, Ombudsman, Licensing District Office.and other agencies as required.7.6 Initiate an investigation within 2 hours of an allegation of abuse that focuses on.7.6.1 Whether abuse or neglect occurred and to what extent.7.6.2 clinical examination for signs of injuries.7.6.3 causative factors 7.6.4 interventions to prevent further injury.7.7 The investigation will be thoroughly documented.interview forms will be kept confidential in a file in the administrative office.9. The CED or designee will.9.2 Report findings of all completed investigations within five (5) working days to the Licensing District office.

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	04/02/2026

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview, and record review, the facility failed to complete and document a significant change in status assessment (Significant Change in Status Assessment, SCSA, refers to a comprehensive assessment that must be completed when the Interdisciplinary Team [IDT, a team of professional staff or a care team consisting of different disciplines who work together towards the goals of their residents] has determined that a resident meets the significant change guidelines for either major improvement or decline) for one of one resident (Resident 1) when Resident 1 was found with a left shoulder dislocation (an injury that occurs when the upper arm bone pops out of the cup shaped socket near the shoulder blade) on 2/2/26.This failure had the potential to result in unmet care needs for Resident 1 when the plan of care for Resident 1 was not current. This failure also had an increased risk on impacting the quality of care and the well-being for Resident 1. Findings: A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included subarachnoid hemorrhage (SAH, a type of stroke characterized by bleeding in the space between the brain and the tissues that cover the brain), traumatic brain injury (a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high and causes the heart to work harder to pump blood).A review of Resident 1's Care Plan Report, initiated on 2/2/26, indicated, .Focus.Resident has dislocated left shoulder.Goal.Shoulder shall be fixed after sending to ER [acute care facility emergency department, ED].Date Initiated.02/02/2026.Target Date.05/24/2026.Interventions/Tasks.Administer pain medication.Immobilize [to keep from moving] the left upper extremity to prevent further damage to the left shoulder.Monitor resident for pain, swelling of the shoulder.Send to ER per MD order to fix dislocated left shoulder.A review of Resident 1's Physician Order Summary, indicated, .NO RNA [Restorative Nursing Aide Program, RNA, nursing aide program that helps residents to maintain their function and joint mobility] services to Left shoulder until further notice.Order Status.Active.Order Date.02/03/2026.During a joint concurrent interview and record review on 4/1/26, at 1:30 p.m., with the Physical Therapist (PT), Restorative Nursing Aide (RNA) 1, and RNA 2, RNA treatment forms for Resident 1 were reviewed. The PT and the RNAs stated they were familiar with Resident 1. The PT stated that he updated Resident 1's RNA orders two weeks ago. The PT further stated Resident 1 had upper and lower extremity passive range of motion (PROM, when someone physically moves or stretches a part of your body) ordered, then the order was changed to just lower extremity PROM. The PT stated the orders were changed because Resident 1 had a dislocated left shoulder. The PT further stated that PROM was also provided for Resident 1's right elbow to right wrist. RNA 1 stated Resident 1's RP did not want Resident 1 to have PROM to his upper arms, and no showers because of his left shoulder dislocation. RNA 1 further stated Resident 1 was always repositioned with two-person assistance. RNA 1 stated the staff used a sling beneath Resident 1 to reposition him when needed. RNA 1 further stated that pillows were used and/or a rolled towel to support Resident 1's left arm. RNA 1 stated the sling and pillows were provided by Resident 1's RP. RNA 2 stated the RNAs gave Resident 1's PROM every Monday, Wednesday and Friday. The PT, RNA 1, and RNA 2 stated they did not participate in Resident 1's Interdisciplinary Team Meetings. The PT, RNA 1, and RNA 2 further stated they had therapy plan of care meetings weekly for the RNAs. RNA 1 and RNA 2 stated that the MDS Coordinator (a nurse that collects data related to residents in order to develop and evaluate a comprehensive care plan and to make sure the facility gets payment from Medicare and Medicaid) set up the meetings and documented meeting notes in the residents' electronic medical records (EMRs).During a concurrent interview and record review on 4/1/26, at 2:51 p.m., with the Director of Nursing (DON), the Social Services Director (SSD), and the Subacute Assistant Director of Nursing (ADON), Resident 1's (electronic medical record) EMR was reviewed. The DON stated that she would need to check to see (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	04/02/2026

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a SCSA was completed by the MDS Coordinator for the left shoulder dislocation.During a concurrent interview and record review on 4/1/26, at 4:49 p.m., with the MDS Coordinator (MDS-C), Resident 1's EMR was reviewed. The MDS-C shared the Resident Assessment Instrument (Resident Assessment Instrument of MDS, RAI; a comprehensive assessment and care planning process used by the nursing home industry) definition of SCSA for completing the MDS form. The MDS-C stated a SCSA MDS form was completed when there was a fracture, decline in the resident's condition in more than one area, if resident was on a ventilator (a mechanical device that assisted a resident to breathe) or removed from the ventilator, or when a resident had a gastrostomy (G-tube, tube placed for fluids and nutrition for residents who cannot take food by mouth) placed or removed, for example. The MDS-C further stated there was a fourteen-day window to complete the SCSA MDS form. The MDS-C stated the risk of not completing the SCSA MDS form was that Resident 1 could experience pain, discomfort with the RNA Program and Activities of Daily Living (ADLs, tasks of everyday life including eating, dressing, bathing, or showering, and using the bathroom), and that the care plan was not revised. The MDS-C confirmed that a SCSA MDS was not completed for Resident 1's shoulder dislocation.During a concurrent interview and record review on 4/2/26, at 10:35 a.m., with the MDS-C, the MDS RAI Assessment Guidelines document was reviewed. The MDS-C stated the Administrator thought that Resident 1 may not have met criteria for an SCSA. The MDS-C confirmed that Resident 1 had a significant change in status based on the RAI definition. The MDS-C acknowledged that a SCSA should have been completed for Resident 1. The MDS-C further acknowledged that the facility policy was not followed.A review of a facility policy and procedure (P&P) titled, Assessments for the RAI, updated October 2025, indicated, . 03. Significant Change in Status Assessment.The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an admission assessment, and its completion dates.depend on the date the IDT's determination was made that the resident had a significant change.A significant change is a major decline or improvement in a resident's status that.1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered ?self-limiting' (will not resolve without intervention) .2. Impacts more than one area of the resident's health status; and.3. Requires interdisciplinary review and/or revision of the care plan.A SCSA is appropriate when.There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and.The resident's condition is not expected to return to baseline within two weeks.A review of a facility P&P titled, Care Plan - Baseline, dated August 25, 2021, the P&P indicated, .Purpose.An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident.Procedure.7. Assessments of residents are ongoing, and care plans are reviewed and revised as information about the resident and the resident's condition change.8. The Interdisciplinary Team is responsible for evaluating and updating of care plans.a. When there has been a significant change in the resident's condition.

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	04/02/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, and record review, the facility failed to ensure resident Interdisciplinary Team Care Conferences (IDT, a care plan meeting with the resident and family members where interdisciplinary team members from different healthcare disciplines discuss, identify, address, implement and review plans to meet needs regarding the resident's care) were conducted quarterly for three of three sampled residents (Resident 1, Resident 2 and Resident 3) when IDT Care Conferences were not documented quarterly in 2025 for Resident 1, Resident 2, and Resident 3.These failures had the potential for unmet care needs for Resident 1, Resident 2 and Resident 3.Findings:a. A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility in 2023 with diagnoses which included subarachnoid hemorrhage (SAH, A type of stroke characterized by bleeding in the space between the brain and the tissues that cover the brain), and 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).A review of Resident 1's IDT Care Conference Notes 2025, indicated that an IDT Care Conference with Resident 1's Responsible Party (RP, the person designated to direct the care of a loved one admitted into a nursing facility) was held on 1/17/25 regarding skin assessment findings, on 7/16/25 regarding possible discharge and supplies needed, on 8/14/25 regarding possible hospice, and on 11/25/25 regarding discharge planning.During an interview on 4/1/26, at 12:20 p.m., with Resident 1's RP in his room, the RP stated that Resident 1's primary physician at the facility had not discussed the plan of care with her. The RP further stated that she had not attended IDT Care Conference meetings to discuss Resident 1's care in about a year.During a concurrent interview and record review on 4/1/26, at 2:51 p.m., with the Director of Nursing (DON), the Social Services Director (SSD), and the Subacute Assistant Director of Nursing (ADON), Resident 1's electronic medical record (EMR) was reviewed. The DON stated the IDT Care Conference meetings were held initially upon admission, whenever there were concerns voiced by the residents and/or family, then quarterly. The DON further stated the resident and/or the resident's RP/Power of Attorney (POA), Social Services, Licensed Nurses (LNs), Case Managers, the DON/ADON, Dietary Manager, and the Activity department head attended as applicable. The DON stated if for example a resident's family wanted to discuss care with the team, had medication concerns, and/ or wanted to provide updates then an IDT Care Conference meeting would be scheduled. The DON further stated the physician did not attend the IDT Care Conference meetings. The DON stated the IDT Care Conference assessment tool and meeting notes were documented in the residents' EMR. The DON further stated care concerns for the resident were also addressed during IDT Care Conference meetings. During a concurrent interview and record review on 4/2/26, at 10:45 a.m., with the DON, Resident 1's IDT Quarterly Care Conference Notes, were reviewed. The DON confirmed that the IDT care conferences were not completed quarterly in 2025 for Resident 1. The DON stated the risk of not completing the IDT care conferences quarterly was that care concerns were not addressed and the resident's care plan was not updated. The DON acknowledged that the facility policy was not followed.b. A review of Resident 2's admission RECORD, indicated that Resident 2 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) and cerebral infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke).A review of Resident 2's IDT Quarterly Care Conference Notes 2025, indicated that Resident 2 had an IDT meeting for a fall incident on 6/30/25, an IDT meeting for weight on 7/22/25, and an IDT Quarterly Care Conference on 11/20/25.During a concurrent interview and record review on 4/2/26, at 10:45 a.m., with the DON, Resident 2's IDT Quarterly Care Conference Notes, were reviewed. The DON confirmed that the IDT care conferences were not completed quarterly in 2025 for Resident 2. The DON stated the risk of not completing the IDT care conferences quarterly was that (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	04/02/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care concerns would not be addressed and the resident's care plan was not updated. The DON acknowledged that facility policy was not followed.c. A review of Resident 3's admission RECORD, indicated that Resident 3 was admitted to the facility in 2024 with diagnoses which included cerebral infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high which causes the heart to work harder to pump blood).A review of Resident 3's IDT Quarterly Care Conference Notes 2025, indicated that an IDT Quarterly Care Conference dated 1/13/25 was not attended by Resident 3 or Resident 3's RP, an IDT Quarterly Care Conference dated 4/16/25 for the Restorative Nursing Aide Program (RNA, nursing aide program that helps residents to maintain their function and joint mobility) was not attended by Resident 3 or Resident 3's RP, an IDT Quarterly Care Conference dated 7/10/25 for weight had no documented attendees listed, and an IDT Quarterly Care Conference dated 7/22/25 for weight was not attended by Resident 3 or Resident 3's RP.During a concurrent interview and record review on 4/2/26, at 10:45 a.m., with the DON, Resident 3's IDT Quarterly Care Conference Notes, were reviewed. The DON confirmed that the IDT care conferences were not completed quarterly in 2025 for Resident 3. The DON stated the risk of not completing the IDT quarterly care conferences was that care concerns would not be addressed and the resident's care plan was not updated. The DON acknowledged that facility policy was not followed.A review of a facility policy and procedure (P&P) titled, Care Planning - Interdisciplinary Team, dated 8/25/21, indicated, .Purpose.Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.Procedure.1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the comprehensive assessment (MDS, Minimum Data Set a comprehensive care assessment tool).2. The care plan.is developed by an Interdisciplinary Team which includes but is not necessarily limited to the following personnel.a. The resident's Attending Physician.b. A registered nurse with responsibility for the resident.c. The Dietary Manager/Dietitian.d. The Social Services Worker responsible for the resident.e. The Activity Director/Coordinator.g. To the extent practicable, the participation of the resident and the resident's representative(s).h. The Charge Nurse responsible for the resident's care.others as appropriate or necessary to meet the needs of the resident or as requested by the resident.3. The resident, the resident's family and/or the resident's representative are encouraged to participate in the development of and revisions to the resident's care plan.4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.A review of a facility P&P titled, Care Plan Comprehensive, effective date 8/25/21, indicated, .8. The Interdisciplinary Team is responsible for evaluating and updating of care plans.d. At least quarterly.