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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta Oaks Post Acute	6940 Pacific Avenue Stockton, CA 95207

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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 - 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 implement safety measures to prevent accidents for one of three sampled residents (Resident 1) when on 3/31/26 while Certified Nursing Assistant (CNA) 1 was providing care alone to Resident 1 on a low air loss mattress (LAL -low air loss mattress, a specialized therapeutic surface featuring air-filled bladders with tiny holes that release a constant, gentle flow of air), Resident 1 fell off of the bed onto the concrete ground.This failure resulted in Resident 1 falling from an elevated bed (approximately 3 feet) onto the concrete ground which resulted in Resident 1 being sent to the emergency department with injuries that included, a fracture to Resident 1's cervical spine neck (C1 -a traumatic break of a bone at the top of the spine), a laceration (a torn, jagged, or ragged tear in the skin or soft tissue) to Resident 1's chin requiring nine sutures (used to close a wound by sewing the edges of the cut together using a thread to help with wound healing), and multiple bruises and injuries to Resident 1's face and body.Findings:A review of Resident 1's admission RECORD, indicated, Resident 1 was admitted to the facility in late 2023 with diagnoses that included, chronic respiratory failure (a long term condition where the lungs cannot properly oxygenate the blood), and anoxic brain damage (a type of brain injury caused by lack of oxygen to the brain leading to brain cell death).A review of Resident 1's Minimum Data Set, (MDS - a resident assessment tool), Section C: Cognitive Patterns, (an assessment of the mental abilities and functions the brain uses to think, learn, remember, pay attention, process information and solve problems) dated 2/28/26, indicated, Resident 1's, .Cognitive Skills for Daily Decision Making.Severely impaired-never/rarely made decisions.A review of Resident 1's MDS, Section B: Hearing, Speech, and Vision, dated 2/28/26 indicated that Resident 1 could not speak, was rarely/never understood, and rarely/never understood others.A review of Resident 1's MDS, Section GG: Functional Limitation in Range of Motion (ROM -the measurement of the distance and direction a body part can move), dated 2/28/26, indicated, .Upper extremity (shoulder, elbow, wrist, hand) .2 - Impairment on both sides.Lower extremity (hip, knee, ankle, foot) .2 - Impairment on both sides.A review of Resident 1's MDS, Section GG: Self-Care assessment dated [DATE], indicated Resident 1 was coded on the assessment tool as, 01. Dependent - Helper [nursing assistant] does ALL of the effort. Resident does none of the effort to complete the activity.assistance of 2 or more helpers is required.to complete the activity. for all hygiene (self-care skills and hygiene involved in toileting and cleaning) including bathing, dressing, and all movement of the body including, rolling side to side, and transferring in and out of bed.A review of Resident 1's Progress Note, written by LN 1, dated 3/31/26, indicated, .At approximately 1430 [2:30 PM] the resident experienced a witness fall from the bed during patient care by [CNA 1]. [CNA 1] remained present in the room at the time of the fall. Upon immediate evaluation, resident noted with laceration under chin with bleeding observed.Dermatologist [a doctor who specializes in the skin], RN [registered nurse], LVN [licensed vocational nurse], and [CNA 1] were present during evaluation. Dermatologist evaluated laceration and indicated that it may require sutures.Emergency services were called and resident was sent out to [HOSPITAL NAME] for further evaluation. [Resident 1] remained in position of fall until ambulance arrived with neck brace and slide (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sheet [used to easily reposition, turn, or transfer residents] to safety transfer.During an interview on 4/15/26 at 9 AM, CNA 1 confirmed she was working on 3/31/26 around 2 PM and was in Resident 1's room changing Resident 1's clothing, bedding, and performing personal hygiene care on Resident 1 when Resident 1 fell from the bed. CNA 1 explained she raised the bed in the air approximately 3 or more feet because CNA 1 stated she was tall and needed the bed to be high, at a working level. CNA 1 further stated she was working alone and did not get assistance from another staff member to provide care for Resident 1. CNA 1 explained she believed she could handle Resident 1 without assistance since, she was not heavy. CNA 1 stated when she was ready to roll Resident 1 from her right side to her back, Resident 1 began to, wiggle her legs. CNA 1 further stated she was standing on the other side of the bed and Resident 1 was facing away from CNA 1. CNA 1 added when Resident 1 began to wiggle her legs, Resident 1's legs slipped off the mattress. CNA 1 explained she grabbed Resident 1's upper body with her hands but due to Resident 1 being heavier than CNA 1, CNA 1 could not hold on and Resident 1 slipped out of her hands out of the bed and onto the ground. CNA 1 explained she went to the other side of the bed to check on Resident 1 and saw Resident 1 had landed on her back between the bed and the window and was bleeding. CNA 1 further explained she went outside of Resident 1's room to call for help. CNA 1 further explained that Resident 1's Licensed Nurse (LN) 1 and a lot of other staff, came into Resident 1's room. CNA 1 confirmed Resident 1 was on a LAL mattress. CNA 1 stated she did not recall seeing Resident 1 hit her head but confirmed the small side rails were up near Resident 1's head during care. CNA 1 confirmed she was aware Resident 1 would sometimes move or wiggle during care. Additionally, CNA 1 confirmed Resident 1 did not have floor mats on the ground.During an interview on 4/15/26 at 9:58 AM, with LN 1, LN 1 confirmed on 3/31/26 she was the nurse for Resident 1 and was sitting at the nurses station around 2:30 PM when she saw CNA 1 come out of Resident 1's room and stated that Resident 1 fell out of bed and was bleeding. LN 1 stated she, LN 2 and a doctor went into the room to help. LN 1 stated she found Resident 1 naked on her back on the ground between the bed and the window. LN 1 further stated she observed Resident 1 bleeding from her chin with a 2-3-inch laceration. LN 1 explained LN 2 held Resident 1's head still on the ground and LN 1 called 9-1-1. LN 1 stated the consultant dermatologist (a doctor specializing in diagnosing and treating conditions of the skin) came in the room and stated the laceration under Resident 1's chin was large and deep and needed sutures to be repaired. LN 1 further explained when the paramedics came she told them the events of what CNA 1 stated occurred. LN 1 stated that CNA 1 explained she was providing care by herself to Resident 1 and somehow Resident 1 managed to fall out of bed. LN 1 further stated the sub-acute unit (a specialized unit providing around the clock respiratory care for medically stable residents) staff were supposed to work in pairs when providing clothing changes, hygiene care, and bedding changes, due to the residents having so many tubes like Resident 1. LN 1 explained that Resident 1 had a tracheostomy tube (a long tube inserted into a surgically created opening in the neck and windpipe to create an airway), a nasogastric tube (a thin tube through the nose down into the stomach commonly used for feeding and medication) and a foley catheter (a flexible indwelling tube inserted into the bladder to continuously drain urine into a collection bag). LN 1 further explained Resident 1 was total dependent care, was not alert or aware (state of reduced consciousness) of what was happening, could not control body movement, was known to slightly move her feet or hands during care, and was a fall risk. LN 1 confirmed Resident 1 also was on a LAL mattress which was also a fall risk due to the nature of the mattress.During an interview on 4/14/26 at 10:16 AM, LN 2 confirmed he was near the nurses' station on 3/31/26 at 2:30 PM, when CNA 1 came out of Resident 1's room and stated that Resident 1 had fallen out of bed. LN 2 stated he rushed to Resident 1's room with LN 1 and other staff. LN 2 stated he found Resident 1 on her back, naked, and on the ground between the bed and the window. LN 2 explained there was a lot of blood and went to Resident 1's head to stabilize the head and spine until the paramedics arrived. LN 2 confirmed he was familiar with Resident 1's care and explained Resident 1 was known to wiggle around and have unpredictable movement of her hands and feet when (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	she was in pain, or something was wrong. LN 2 confirmed Resident 1 was a total dependent care and was on a LAL mattress. Additionally, LN 2 confirmed a LAL mattress could be slippery and residents could slide off of them easily which was why the facility always required at least two staff members when providing care.During a concurrent interview and record review on 4/15/26 12:42 PM, with the Director of Nursing (DON), Resident 1's electronic medical record (EHR - a digital version of a resident's chart used to document progress, medication, treatment plans and diagnoses) was reviewed. The DON reviewed the document titled, Lift Transfer Reposition, dated 2/13/26, and confirmed the document indicated that Resident 1 required two staff for repositioning (moving and changing of body position) in bed. Additionally, the DON reviewed the Interdisciplinary Care Conference (IDT -a structured meeting where healthcare professionals from various specialties meet with residents and resident families to develop, review, or update a personalized treatment plan) meeting dated 4/1/26, and confirmed from the interviews with staff (unnamed) and CNA 1 the bed was not in the low position on 3/31/26. The DON further confirmed Resident 1 was sent out to the emergency department on 3/31/26 and was diagnosed with a laceration to the chin requiring nine sutures and a neck fracture to Resident 1's C1. The DON stated the cause of the fall was determined to be due to CNA 1 providing care to Resident 1 alone and not the required two staff members for major care. The DON further stated the fall could have been prevented if CNA 1 had used two staff members and had turned/rolled Resident 1 towards CNA 1 instead of away from her. The DON confirmed CNA 1 turned Resident 1 away from her which placed Resident 1 on the side of the bed without a barrier to prevent Resident 1 from falling. The DON explained it was her expectation that staff providing major care which includes showering, personal hygiene care, bedding change and repositioning a resident should always be at least 2 staff members.A review of CNA 1's employee file document titled, Certified Nursing Assistant Skills Performance Evaluation, dated 12/13/25, indicated, .SKILLS.Repositioning resident in bed (2-person assist for residents using LAL mattress) . had a check mark in the box marked, yes, which indicated she was checked-off and understood the facility protocol.A review of Resident 1's activities of daily living (ADL- activities of daily living -routine self-care tasks that individuals perform daily to maintain independence and hygiene such as bathing, dressing, eating, and mobility) care plan, dated 11/20/23, indicated .[Resident 1] has an ADL Self Care Performance Deficit r/t [related to] ANOXIC BRAIN DAMAGE. [Resident 1] needs dependent assistance with ADLS. The care plan further indicated Resident 1 was totally dependent on staff for toilet use, bathing, grooming, bed mobility (changing positions in bed), personal hygiene, dressing and transferring.A review of Resident 1's skin care plan, dated 11/28/23, indicated, .Preventative: [Resident 1] has high risk/or at risk for pressure ulcer (localized injury to the skin or soft tissue usually over bony areas caused by prolonged pressure) or skin impairment.[Resident 1] needs LAL mattress for pressure redistribution.A review of Resident 1's [HOPITAL NAME] medical record document titled, Emergency Department Notes, dated 4/1/26, indicated, . [Resident 1] HISTORY OF PRESENT ILLNESS.Chief Complaint.ACCIDENT.presents to the Emergency Department following an accident. She fell at her facility and sustained a laceration to her chin as well as an acute [sudden onset medical condition] C1 fracture confirmed on MRI [MRI - Magnetic Resonance Imaging, a painless medical test that uses a powerful magnet, radio waves and a computer to produce detailed images of organs and soft tissues] .Laceration was repaired.[Resident 1].presenting to the ED [Emergency Department] after a fall with an acute C1 fracture. Neurosurgery (a physician who diagnoses and treats disorders of the brain, spine, and nerves) consulted after initial assessment and chart review.recommendations include Aspen [a ridged, two-piece cervical collar designed to restrict neck movement to promote healing after injury] collar for 3-4 months.A review of Resident 1's, Weekly Non-Pressure Report [skin assessment], dated 4/2/26, indicated, .Wound [number] 1.Location [NAME] -Surgical Site with 9 sutures.Comments/Observations. [Resident 1] returned to facility from acute care hospital noted with 9 dissolvable clear sutures. Periwound [around the wound] noted with purplish-yellow bruising.Wound [number] 2.Location R [right] Clavicle [a slender, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	S-shaped bone acting as a strut between the shoulder blade and chest bones] - Reddened/denuded skin [an area where the top layer of skin has been removed or damaged].[Resident 1] returned to facility from acute care hospital noted with reddened/denuded skin, 60 [percent] skin, 40 [percent] dermis [middle layer of skin].Wound [number] 4.Location Periorbital Eyes [surrounding both eyes] - Diffuse [spreading widely] bruising.A review of the facility's policy and procedure titled, Fall Management, dated 5/2021, indicated, .PURPOSE To reduce risk of falls and minimize the actual occurrence of falls. To address injury and provide care for a fall.Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.1. Identify patient's fall risk by reviewing the Nursing Documentation. 2. Communicate patient's fall risk status to caregivers.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) received medications as ordered by the physician and was free of significant medication errors (one which could jeopardize the residents health and safety) when on 4/1/26 Resident 2 was given two of Resident 4's medications in error.This failure may have contributed to Resident 2 being sent out to a hospital for vomiting blood on 4/6/26. In addition, this failure had the potential to interact with Resident 2's other medications causing additional harm to Resident 2's health and safety.Findings:A review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility with diagnoses which included, acute respiratory failure (a sudden-onset where the lungs cannot get enough oxygen into the blood), encounter for tracheostomy (a long tube inserted into a surgically created opening in the next and windpipe to create an airway), dependance on respirator/ventilator (machine that assists the resident to breath) posthemorrhagic anemia (a rapid drop in red blood cells caused from blood loss) thrombocytopenia (low platelet count [tiny cell fragments that help blood clot] in the blood) chronic kidney disease stage 3B (moderate to severe kidney damage) and Atrial Fibrillation (a common heart rhythm disorder characterized by a rapid, irregular, or fluttering heartbeat).A review of Resident 2's Medication Administration Record (MAR -official legal document sued by healthcare professionals to track and record every medication administered to a patient) dated April 2026, indicated Resident 2 was on the following daily medications to prevent blood clots (a gel-like solid or semi-solid mass formed when blood platelets and proteins thicken), Aspirin 81 mg, (a common non-steroidal Anti-inflammatory drug used for pain, reduce fever and prevent blood clots/mg -milligram, a unit of measure) and Clopidogrel Bisulfate 75 mg, (a prescription antiplatelet medication used to prevent serious blood clots).During a concurrent interview and record review on 4/14/26 at 12:29 PM, with Licensed Nurse (LN) 3, LN 3 reviewed and confirmed he wrote a, Change In Condition, progress note (CIC/COC -a documented update in a patient's medical record that describes a significant shift in their physical, mental, or functional health), dated 4/1/26, which indicated, .[Resident 2] noted to have received medications intended for another resident [Resident 4], including Heparin [a high alert, anticoagulant commonly used as an injection under the skin for the prevention of blood clots] and Keppra [used to prevent seizures]. Resident assessed immediately.no signs of distress noted.no active bleeding observed. 10:35 [AM] Nurse Practitioner and director of subacute [provides specialized 24/7 respiratory care for medically stable patients] services notified. Orders received to hold [Resident 2s] scheduled medications and initiate bleeding precautions with close monitoring. LN 3 confirmed he gave Resident 2 a Heparin Injection Solution of 5000 units (5000 units - equivalent to 1 milliliter-a unit of measure) and injected the Heparin into Resident 2's upper left quadrant (location of his abdomen if divided in four quarters) and Levetiracetam (generic brand for Keppra) 750 mg (mg= milligram a unit of measure) via 7.5 mL (mL= milliliters, a unit of measure) placed into Resident 2's gastrostomy tube (G-tube -a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids and medications). LN 3 stated after administration of these two medications he left the room to check Resident 2's orders in the MAR and realized he was looking at Resident 4's MAR and had given Resident 4's medications to Resident 2. LN 3 explained he made the mistake because he did not follow the medication rights of administration that included, right resident, right medication, right dose, right time, and right documentation. LN 3 stated usually there was a photograph of the resident in the MAR but Resident 4 did not have a photograph in his MAR. LN 3 further stated he did not verify Resident 2's identity by confirming his name or checking for a wrist band to confirm he had the right resident prior to giving the medication. LN 3 stated once he realized his mistake he notified the nurse practitioner (NP) who was in the facility. LN 3 explained he continued to monitor Resident 2 for the rest of the day for side effects of bleeding. LN 3 explained that Resident 2 was placed on monitoring every 30 minutes for four hours and continued monitoring for side effects of bleeding every shift for (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	72 hours (3 days).During an interview on 4/15/26 at 10:31 AM, in Resident 2's room, Resident 2 confirmed he was sent out to a hospital about one week ago for vomiting blood. Resident 2 could not speak due to his tracheostomy tube (a curved tube inserted into a surgically created opening in the windpipe to provide an airway) but was able to answer yes or no by shaking his head up and down for yes and side to side for no. Resident 2 held up two fingers when asked how many times he vomited blood. Resident 2 shook his head yes when asked if LN 3 explained to him he was given another residents medication by accident. When staff asked Resident 2 if someone had told him the reason he was vomiting blood, he shook his head no. When Resident 2 was asked if the doctors at the hospital determined the cause of vomiting blood, he shook his head no. When asked if Resident 2 had previously ever vomited blood, had blood in his urine or feces, had unexplained bruising or nose bleeds, Resident 2 shook his head no. When asked how many days Resident 2 was hospitalized for vomiting blood, Resident 2 held up 3 fingers.During an interview on 4/15/26 at 10:55 AM, with LN 2, LN 2 confirmed he sent Resident 2 out to the Emergency Department (ED) on 4/6/26, per Nurse Practitioner (NP) order. LN 2 explained he was the nurse taking care of Resident 2 on 4/6/26 when another staff member told him that Resident 2 was vomiting blood. LN 2 stated he went into Resident 2's room to check and he observed, coffee ground emesis (vomit containing old, oxidized blood from an upper gastrointestinal bleed (GI)). LN 2 further stated from his experience he knew it was most likely due to a GI bleed (gastrointestinal bleed -a symptom of an underlying disease involving blood loss anywhere within the digestive tract). LN 2 explained the NP was in the facility, so he called him to come and assess Resident 2 and confirm his findings. LN 2 stated the NP came to Resident 2's bedside and ordered Resident 2 to be sent out to a hospital to be further evaluated. LN 2 further explained that Resident 2 was given in error a Heparin injection five days previously and reported that information to the Emergency Medical Technician's when he transferred Resident 2 to their care.During an interview on 4/15/26 at 11:08 AM, with the NP, the NP confirmed he came to Resident 2's room on 4/6/26 and observed that Resident 2 had vomited blood. The NP stated he observed the bloody vomit and observed blood on the floor next to Resident 2's bed. The NP confirmed he gave the order for Resident 2 to be sent to the hospital for further evaluation. The NP stated he was aware of the previous medication error when Resident 2 received Heparin approximately five days prior. The NP stated he was not sure if Resident 2 vomiting blood was related to the medication error and sent Resident 2 to the hospital as a precaution.During an interview on 4/15/26 at 12:06 PM, with the Medical Director (MD), the MD stated he was not aware that Resident 2 received Heparin and Levetiracetam (Keppra) in error and confirmed the medication error should not have happened. The MD stated he did not believe the accidental Heparin was the cause the Resident 2's vomiting blood but could not be sure due to the combination of other blood thinning medications Resident 2 was on. The MD confirmed that Heparin was considered a high-alert medication (drugs with a heightened risk of causing significant patient harm, or death, when used in error). During a concurrent interview and record review on 4/15/26 at 12:42 PM, with the Director of Nursing, the Interdisciplinary Care Conference (IDT -a structured meeting where healthcare professionals from various specialties meet with residents and resident families to develop review or update a personalized treatment plan) note dated 4/2/26 was reviewed. The DON confirmed the medication error that occurred with Resident 2 was reviewed by the care conference team and determined the medication error could have been prevented by LN 3 if he used the safe medication administration practice and followed facility policy and procedures. The DON stated her expectation was that each nurse following the safe rights of medication administration, check the residents picture, and the name on the medication should match the name in the MAR.A review of Resident 2's, [HOSPITAL NAME] medical record document titled, Discharge Summary, dated 4/9/26 indicated, .Discharge diagnosis.Coffee ground emesis.A review of Resident 2's, [HOSPITAL NAME] medical record document titled, History and Physical, dated 4/6/26, indicated, .[Resident 2] presented to the hospital with coffee-ground emesis. Currently hemodynamically stable [stable blood flow]. Hemoglobin around 8 [normal range 13.5 to 17.5 grams (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	per deciliter [g/dL -unit of measure].Monitor H/H [Hemoglobin and Hematocrit -key components of blood measuring tests. Hemoglobin - Hgb/Hb is the iron-rich protein that transports oxygen, Hematocrit Hct- is the percentage of total blood volume composed of red blood cells. They are primarily used to diagnose anemia and monitor blood loss].Transfuse [common medical procedure where donated blood or blood products are delivered into a patient's bloodstream] if hemoglobin less than 7.A review of Resident 2's, medical record, Care Plan Report, dated 3/24/26, indicated, .[Resident 2] is at risk for injury or complications related to the use of anticoagulation/antiplatelet therapy. Atrial Fibrillation, Medications: (Clopidogrel Bisulfate).Goal.[Resident 1] will not exhibit signs/symptoms of bleeding.Interventions/Tasks.Observe for active bleeding.A review of Resident 2's, medical record, Care Plan Report, dated 4/1/26, indicated, .[Resident 1] At risk for side effects r/t [related to] incorrect medication administration.Notify MD for any worsening s/sx [signs and symptoms].A review of Resident 4's, MAR dated, March 2026, indicated, .Heparin Sodium Porcine [pork derivative] Injection Solution 5000 UNIT/ML.Inject subcutaneously every 12 hours.LevETIRAcetam Oral Solution 500 MG/ML.Give 7.5 ml via G-Tube every 12 hours related to ENCEPHALOPAHTY [disease or damage of the brain that alters its function].EPILEPSY [chronic neurological disorder with recurring seizures caused by sudden electrical activity in the brain].A review of the facilities policy and procedure titled, Administering Medications, revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed.9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking identification band; b. Checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.26. Medications ordered for a particular resident may not be administered to another resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure medications were stored safely and securely for a census of 116, when on 4/14/26 Licensed Nurse (LN) 5 left medications on top of a medication cart (a mobile cart containing medication used for administration of medication to residents) and left the medication cart unlocked when she walked away from it. These failures had the potential for medication diversion (medication taken by someone it was not intended for), and unsafe medication use in the facility.Findings: During an observation on 4/14/26 at 9:23 AM, with LN 5, LN 5 was observed preparing medications by removing them out of the medication cart, putting the medications into a medication cup and leaving them on top of the medication cart. LN 5 was observed walking away from the medication cart to retrieve something from another cart down the hall. LN 5 left approximately 7 medications on top of the medication cart unattended and left the medication cart unlocked. During an interview on 4/14/26 at 9:41 AM, LN 5 confirmed she left medications unattended on top of the medication cart and left the medication cart unlocked when she walked away from it. LN 5 explained she was supposed to remove the medications from the top of the cart and lock the cart prior to leaving it. LN 5 added that it was important to secure the cart and medications to prevent another resident or person from taking medications from the cart. During an interview on 4/15/26 at 12:42 PM, with the Director of Nursing (DON), the DON stated it was her expectation that medication never be left unattended on top of a medication cart. The DON further stated it was her expectation that the medication cart should never be left unlocked when unattended. The DON explained that it was important because some residents were confused and they could possibly take the medication from the medication cart, which could be harmful to the residents. A review of a facility policy and procedure (P&P) titled, Administering Medications, revised April 2019, indicated, .19. During administration of medications, the medication cart is kept closed and locked when out of the sight of the medication nurse.No medications are kept on top of the cart. A review of a facility P&P titled, Security of Medication Cart, revised April 2007, indicated, .The medication shall be secured during medication passes.The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.The cart must be locked before the nurse enters the resident's room.Medication carts must be securely locked at all times when out of the nurse's view.

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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta Oaks Post Acute	6940 Pacific Avenue Stockton, CA 95207

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 116, when on 4/14/26: 1. Licensed Nurse (LN) 4 did not perform hand hygiene (the action of cleansing hands to remove germs, dirt, and microorganisms (bacteria/viruses) includes washing with soap and water or a alcohol-based hand sanitizer) between glove changes while providing tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe to create an alternative airway) inner cannula tube (a removable, hollow liner that fits inside the main body (outer cannula) of a tracheostomy tube) care and suctioning to Resident 1 (procedure that uses a vacuum-connected hollow tube to remove mucus, saliva, and secretions from a patient's breathing tube); and, 2. LN 5 did not wear the appropriate personal protective equipment (PPE - specialized clothing and equipment used by healthcare professionals to minimize exposure to infectious agents and hazardous material) when LN 5 accessed and administered medications to Resident 2 via gastrostomy tube (G-tube -a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids and medications); and, 3. Certified Nursing Assistant (CNA) 3 and CNA 4 were observed removing a shower chair (a water resistant, non-slip 4 legged seat with wheels designed to transport a patient to and from a shower room) from a resident room that had a sign posted Contact Precautions, (infection control measure used in healthcare setting with patients known or suspected to have a serious illness that could easily be transmitted by direct or indirect contact with items in the patient's environment) without sanitizing it. These failures had the potential to spread infections to residents residing in the facility, negatively impacting their health and well-being.Findings:1. During an observation on 4/14/26 at 8:49 AM, with LN 4, in Resident 1's room, LN 4 was observed putting on sterile gloves (disposable, individually packaged medical gloves completely free from microorganisms) to change Resident 1's disposable inner cannula. LN 4 was observed removing the sterile gloves and replacing them with non-sterile gloves from a box in Resident 1's room and continued providing care to Resident 1. LN 4 did not perform hand hygiene between glove changes. LN 4 continued to suction Resident 1 with non-sterile gloves. LN 4 was observed removing her gloves a second time and replacing them with another pair of gloves. LN 4 did not perform hand hygiene a second time after removing gloves.During an interview on 4/14/26 at 8:59 AM, with LN 4, LN 4 confirmed she did not complete any form of hand hygiene after changing gloves twice and continued to suction Resident 1 using non-sterile gloves. LN 4 explained the expectation and policy in the facility was to perform hand hygiene before putting on gloves and after removing gloves. LN 4 further explained the risk to (Resident 1) for not completing hand hygiene properly was infection.2. During an observation on 4/14/26 at 9:26 AM, with LN 5, in Resident 2's room, LN 5 was observed preparing to administer Resident 2's medications by placing the medications on a side table, performing hand hygiene and putting on gloves. LN 5 was observed accessing Resident 2's G-Tube and checked for proper placement by pushing air into it with a large syringe and listened for the sound of the air in Resident 2's stomach. LN 5 stated she heard the air and grabbed a syringe and flushed the G-tube with 30mL (mL -milliliters unit of measure of fluids/liquid) of water. LN 5 was observed taking one crushed medication at a time and mixing it with 10mL of water and then pouring 2-3 medications separately into Resident 2's G-tube. LN 5 then realized she forgot to put on a protective gown that was required since Resident 2 was on Enhanced Barrier Precautions (EBP -an infection control strategy used in nursing homes that requires use of gowns and gloves during high-contact resident care activities to reduce the transmission of infections). LN 5 retrieved a gown from the door to Resident 2's room and placed it on.During an interview on 4/14/26 at 9:41 AM, LN 5 confirmed she forgot to put on the required PPE gown while she accessed and poured medications into Resident 2's G-tube. LN 5 explained that anytime a resident had an indwelling line (is a thin, flexible, hollow tube inserted into the body and left in place for an extended period to deliver fluids, medications, or to drain bodily fluids), like a G-tube staff were (continued on next page)

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