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	10/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure residents' rights to be treated with dignity and respect were honored for seven of 35 sampled residents when:1. Staff were observed standing over Resident 25 and Resident 90 while assisting them to eat their lunch meal on 9/29/25; and,2. Resident 23, Resident 46, Resident 86, Resident 56, and Resident 4 who required the use of incontinent briefs (a type of absorbent material worn to soak up urine and/or contain feces) were told by unidentified nursing staff to urinate and/or defecate (feces) in their bed, due to the lack of available incontinent briefs during the weekend of Saturday 9/27/25 and Sunday 9/28/25. These failures had the potential to negatively impact Resident 25, Resident 90, Resident 23, Resident 46, Resident 86, Resident 56, and Resident 4's psychosocial well-being.Findings:1a. During an observation on 9/29/25, at 1:09 PM, in the shared dining room, Certified Nursing Assistant (CNA) 6 was observed standing over Resident 25, while Resident 25 was seated at the table, assisting Resident 25 to eat his lunch. During an interview on 9/29/25, at 1:10 PM, (CNA) 6 confirmed she was standing next to Resident 25, while he was seated in a chair, to assist him to eat his lunch. CNA 6 stated she should have sat down in a chair next to Resident 25 per facility expectations. CNA 6 further stated they did not always follow the policy due to time constraints and because they needed to feed other residents.1b. During an observation on 9/29/25, at 1:09 PM, in the shared dining room, CNA 4 was observed standing next to Resident 90, while she was seated in a chair at the table, to assist her to eat her lunch.During an interview on 9/30/25, at 8:18 AM, CNA 4 confirmed they were standing next to Resident 90 during the lunch meal yesterday. CNA 4 further stated the facility process was to sit down next to the residents while assisting with their meal. CNA 4 explained it was important to be seated at the same level as the residents to watch them eat and protect their right of dignity.During an interview on 9/29/25, at 1:11 PM, Licensed Nurse (LN) 10 confirmed CNA 4 and CNA 6 were standing over Resident 25 and Resident 90 while they assisted them with their lunch meal. LN 10 stated CNA 4 and CNA 6 should have been sitting next to the residents at the same level, so it was easier for the residents to eat. LN 10 further stated sitting next to the residents while assisting them with their meals was important to maintain the resident's dignity.During an interview on 10/2/25, at 11:21 PM, the Director of Nursing (DON) stated her expectation when residents were assisted with meals was that staff should be seated next to the residents, on the same level, and standing was not acceptable. The DON further stated being seated at the same level as the residents was important because the staff could not see if the residents were having a hard time properly chewing food which could lead to choking. The DON explained being seated with the residents, was important so the residents were not rushed and was more respectful and protected the resident's dignity. A review of the facility's policy and procedure titled, Dignity, revised February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being.feeling of self-worth.Residents are treated with dignity and respect at all times.When assisting with care .residents are supported.provided with a dignified dining experience.2a. A review of Resident 23's admission RECORD, indicated Resident 23 was admitted to the facility in Summer of 2022 with diagnoses including anxiety disorder (a mental health condition characterized by feelings of fear, worry, unease, and nervousness).A review of Resident 23'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 9/16/25, indicated Resident 23's BIMS (BIMS - Brief Interview for Mental Status - a screening tool used in long-term care to assess a resident's cognitive function [the mental processes like thinking, memory, and perception, that a person uses to understand and respond to their environment] Scoring = 13-15 indicates normal intact cognitive function, 8-12 moderate cognitive impairment, 0-7 signifies severe cognitive impairment) was 15 out of 15 indicated Resident 23 had normal intact cognitive function.A review of Resident 23's MDS, Section H: Bladder [part of the body that holds urine] and Bowel [part of the body that holds feces], dated 9/16/25, indicated Resident 23 was always incontinent (when a person has no control of when they pass urine or feces) of bladder and bowel. A review of Resident 23's care plan, (a personalized document that outlines a resident's healthcare needs, goals, and interventions) revised 6/10/24, indicated, . [Resident 23] has bowel and bladder incontinence.Impaired mobility [a limitation in a person's ability to purposefully move their body, affecting their independence].Requesting x4 [4 briefs to be in the residents room] large briefs.During a concurrent observation and interview on 9/29/25, at 10:20 AM, with Resident 23, in Resident 23's room, five incontinent briefs were observed in a small clear bag located on Resident 23's

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview, and record review, the facility failed to develop a baseline care plan within 48 hours of admission as required, to address resident-specific care needs for 1 of 35 sampled residents (Resident 76). This failure placed Resident 76 at risk for not receiving effective person-centered care, and preventing to reach the highest potential for mental, emotional, and/or psychosocial health and well-being.Findings:A review of Resident 76's admission RECORD, indicated Resident 76 was originally admitted to the facility in 2017, readmitted in 2020 and then readmitted in 2021 with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung disease that cause progressive airflow obstruction and breathing difficulties), chronic diastolic congestive heart failure (a condition where the heart muscle is stiff and cannot relax properly during the filling phase called diastole. This prevents the heart from filling with enough blood, which can lead to symptoms of heart failure), hypertensive heart disease with heart failure (a condition where prolonged high blood pressure damages the heart and leads to heart failure), type 2 diabetes mellitus with diabetic chronic kidney disease (a condition where high blood sugar from poorly controlled type 2 diabetes damages the blood vessels in the kidneys, leading to their reduced ability to filter waste from the blood).A review of Resident 76's medical record indicated that a baseline care plan had not been created within 48 hours of admission, and/or re-admissions as required.During a concurrent interview and record review on 10/1/25, at 2:07 PM, with Licensed Nurse (LN) 9, Resident 76's medical record including care plans were reviewed. LN 9 confirmed that a baseline care plan had not been created within 48 hours of Resident 76's readmission in March 2021. LN 9 stated baseline care plans should be created within 48 hours of admission, and/or re-admission. LN 9 further stated it was necessary to create a baseline care plan and follow the interventions to provide person-centered care to meet Resident 76's physical and psychosocial needs. During a concurrent interview and record review on 10/2/25, at 12:30 PM, with the Minimum Data Set Coordinator (MDS) 2, (MDS, a healthcare professional, typically a registered nurse, who manages the detailed resident assessments required for long-term care facilities to receive reimbursement), Resident 76's care plans were reviewed. The MDS 2 confirmed that a baseline care plan had not been created for Resident 76. The MDS 2 further stated that a baseline care plan should be created within 48 hours of admission, or re-admission to provide quality of care. The MDS 2 stated a baseline care plan was an instruction guide providing directions for nursing staff to collaborate and deliver effective person-centered care. The MDS 2 further stated it was a requirement to follow the facility's policy and procedure (P&P) for baseline care planning. The MDS 2 stated the facility's P&P was not followed. The MDS 2 further stated there was a risk to negatively affect Resident 76's health that could lead to a decline in his physical health and psychosocial well-being. Review of the facility's P&P titled, CARE PLAN-BASELINE, dated 8/25/21, indicated, .A baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care shall be developed and implemented for each resident by the Interdisciplinary Team [a group of healthcare professionals from different fields who collaborate to create a holistic care plan for a patient].The baseline care plan is developed within 48 hours of a resident's admission.The baseline care plan includes the minimum healthcare information necessary to properly care for a resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide a resident centered care plan for 2 of 35 sampled residents (Resident 65 and Resident 76) when:1. Resident 65 was taking a blood thinner medication and there was no care plan developed to monitor for potential side effects or risk of bleeding; and,2. Resident 76 did not have a care plan for blood thinning medications. These failures placed Resident 65 and Resident 76 at risk for potentially serious complications and not receiving effective and person-centered care. Findings: 1. Review of Resident 65's admission RECORD, indicated Resident 65 was admitted with multiple diagnoses which included but not limited to DVT (Deep Vein Thrombosis – when a blood clot forms in a deep vein, usually in the leg), hypertension (high blood pressure), and abnormalities of gait and mobility. During a concurrent interview and record review on 10/1/25, at 4:01 PM, with Licensed Nurse (LN) 3, LN 3 stated Resident 65 was taking apixaban (blood thinner medication) for DVT. LN 3 confirmed there was no order to monitor the side effects of apixaban since it was prescribed upon admission on [DATE]. LN 3 stated she never recorded monitoring of apixaban side effects in the Medication Administration Record (MAR). LN 3 further stated it was essential to monitor the side effects of apixaban, such as bleeding, tarry (black) stools, or dark urine, due to its potential adverse and serious complications. LN 3 stated further not monitoring these side effects was unacceptable. During a concurrent interview and record review on 10/2/25, at 9:36 AM, with Director of Nursing (DON), the DON stated that staff should monitor Resident 65 for bleeding each shift and check the mouth, urine, and stool for any signs of bleeding due to apixaban use. The DON confirmed there were no orders or care plans to monitor the side effects of apixaban for Resident 65. The DON stated that staff were expected to monitor the side effects, particularly since apixaban could cause serious and potentially life-threatening adverse reactions. The DON further stated without adequate monitoring, there was a risk that Resident 65 might experience internal bleeding, including the possibility of gastrointestinal (GI) bleeding (bleeding visible in the stool or vomit), which could remain undetected. During a review of the facility's Policy and Procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/21, 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.III. Procedure 1. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas b. Incorporate risk and contributing factors associated with identified problems.5. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 76's admission RECORD, indicated Resident 76 was readmitted in 2021 with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung disease that cause progressive airflow obstruction and breathing difficulties), chronic diastolic congestive heart failure (a condition where the heart muscle is stiff and cannot relax properly during the filling phase called diastole. This prevents the heart from filling with enough blood, which can lead to symptoms of heart failure), hypertensive heart disease with heart failure (a condition where prolonged high blood pressure damages the heart and leads to heart failure), type 2 diabetes mellitus with diabetic chronic kidney disease (a condition where high blood sugar from poorly controlled type 2 diabetes damages the blood vessels in the kidneys, leading to their reduced ability to filter waste from the blood). Review of Resident 76's medical record titled, Medication Review Report, dated 10/1/25, indicated Resident 76 had an active order for aspirin (blood thinner medication) 81 MG (milligram, unit of measurement) chewable tablet orally one time a day for DVT prophylaxis (prevention) which was started on 6/4/22, and also an active order for Eliquis (blood thinner medication) 5 MG 1 tablet orally two times a day for DVT prophylaxis that was started on 12/17/24. During a concurrent interview, and record review on 10/1/25, at 2:07 PM, with LN 9, Resident 76's medication review report and care plans were reviewed. LN 9 confirmed that Resident 76 was taking aspirin and Eliquis as blood thinner medications for DVT prophylaxis. LN 9 further confirmed that a care plan for blood thinner medications had not been created. LN explained the importance of care planning and stated a care plan was a guiding tool for nursing staff to provide person-centered care to meet Resident 76's medical and physical needs. LN 9 further stated to coordinate care, nurses should create care plans and MDS coordinator would review and revise care plans quarterly and annually to ensure care plans were applied to residents' conditions to prevent or reduce declines in residents' health status. During a concurrent interview and record review on 10/2/25, at 10:34 AM, with the DON, Resident 76's medication record, care plans, and the P&P titled, CARE PLAN COMPREHENSIVE, dated 8/25/21 were reviewed. The DON confirmed Resident 76 had active orders for blood thinner medications such as aspirin which was started on 6/4/22 and Eliquis with a start date of 12/17/24, and there was no corresponding care plan for Resident 76. The DON stated her expectation from nursing staff was to create a person-centered care plan for blood thinners and implement interventions that were applicable to Resident 76's health status. The DON further stated a care plan was a written document to communicate Resident 76's care and overall health conditions properly. Review of the facility's P&P indicated, .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 1. Each resident's comprehensive care plan is designed to.h. Aid in preventing or reducing declines in the resident's functional status and/or functional levels.2 . The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The DON acknowledged that the facility's P&P was not followed. The DON stated her expectation was not met by nursing staff.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services were provided when one of 35 sampled residents (Resident 97) did not receive the appropriate range of motion (ROM - the distance and direction a joint can move) services. This failure had the potential to result in decreased ROM, further functional decline, and/or pain and discomfort for Resident 97. Findings:During a review of Resident 97's clinical record titled, admission RECORD, the record indicated Resident 97 was admitted to the facility with a diagnosis that included hemiplegia (inability to move of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted), and functional quadriplegia (a person is unable to move their arms and legs, and needed total care from nursing staff).A review of Resident 97's clinical record titled, Care Plan, dated 4/23/24, indicated Resident 97 was dependent on nursing staff for activities of daily living (ADL, basic self-care tasks that individuals perform to maintain their daily lives).A review of Resident 97's clinical record titled, Section GG - Functional Abilities, (part of a comprehensive assessment) dated 8/4/25, indicated Resident 97 had impairments with ROM to both sides of the upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot).During a concurrent interview and record review on 10/1/25 at 1:42 p.m. with the Director of Rehab (DOR), Resident 97's clinical record titled, Joint Mobility Screen, dated 9/19/25 was reviewed. The joint mobility screen indicated Resident 97's right-wrist, left-hand, and right-hand had severe impairment (reflecting approximately 25% or less of full ROM). The DOR verified Resident 97 was not on restorative nursing therapy (a therapy program where nursing staff, often with guidance from physical and occupational therapists, works with a resident to restore or maintain their independence). The DOR stated Resident 97 should have been offered restorative nursing therapy for passive range of motion (PROM, if a person can't move their own joint, a caregiver or nurse gently moves it for them) exercises. The DOR further stated Resident 97 could potentially experience pain and discomfort due to loss of range of motion. During an interview on 10/2/2 at 10:10 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 97 should have been offered restorative nursing therapy services when he experienced a decline in ROM. The ADON further stated Resident 97 was at risk of further decline in the ROM of his joints.During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, dated 7/2017, the P&P indicated, .Residents will receive restorative nursing care as needed to help promote optimal safety and independence.Residents may be started on restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.Restorative goals may include.Developing, maintaining or strengthening his/her physiological and psychological resources.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure a safe and hazard free environment when:1. Safe water temperatures were not maintained in 2 of 4 sampled resident bathrooms; and,2. Resident 10's post mobility assessment was not done after she fell in the bathroom. These failures had the potential to cause physical injuries to residents who resided in the facility.Findings: 1. During a concurrent observation and interview on 10/1/25, at 2:59 PM, with the Regional Maintenance Consultant (RMC) and the Maintenance Director (MD), the MD stated they checked the water temperature monthly. Water temperatures were checked in different areas of the facility with the RMC and the MD. During the testing, water temperatures were found to be 80 degrees Fahrenheit (°F, a measurement of temperature) in room [ROOM NUMBER], 130°F in room [ROOM NUMBER], 125°F in the kitchen and laundry, 118°F in room [ROOM NUMBER], and 135°F in room [ROOM NUMBER]. The boiler tanks were set to 120°F for the subacute (a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility) and long-term areas, while the kitchen and laundry areas had boiler temperatures set to 160°F. During an interview on 10/1/25, at 3:56 PM, with the Director of Staff Development (DSD) and the Infection Preventionist (IP), both the DSD and IP stated that the water temperature on the resident bathrooms and shower rooms should be 120°F or under and if it was more than 120°F, it could cause burns on the residents. During a concurrent observation and interview on 10/1/25, at 4:10 PM, with Certified Nursing Assistant (CNA) 1, CNA 1 was observed in the hallway with Resident 17 who was in a shower bed about to go into the shower room. CNA 1 stated the water in the shower should be warm and not hot because there would be a risk of burning the skin of the resident. During an interview on 10/1/25, at 4:15 PM, with Licensed Nurse (LN) 1, LN 1 stated the water temperature in the resident's bathroom should be below 120°F and if it did exceed 120°F it could cause skin irritation, burns and skin breakdown. LN 1 further stated the water temperature should be lukewarm and under 120°F. During an interview on 10/2/25, at 9:33 AM, with Resident 67 in room [ROOM NUMBER], Resident 67 stated the water in the bathroom would get too hot, but he did not report it. Resident 67 further stated if the water in the bathroom was too hot, he just stopped using it. Resident 67 stated he was mobile and used the bathroom by himself. During an interview on 10/2/25, at 9:11 AM, with the Sub-acute Director (SAD), the SAD stated the water should be at an appropriate temperature and it should not cause scalding. The SAD further stated if a resident or staff used the hot water, it would burn their skin. During an interview on 10/2/25, at 10:04 AM, with the Director of Nursing (DON), the DON stated the water used by the residents should be below 120°F, and if it was more than 120°F, there would be chances for burn and skin damage. The DON stated water temperature between 130°F -135°F used for showers or washing hands was not acceptable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the undated facility policy and procedure (P&P) titled, Safety of Water Temperatures, the P&P indicated, .Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperature of no more than 120F (48.8C), or the maximum allowable temperature per state regulation. A review of the facility's P&P titled, Safety and Supervision of Residents, dated 2001, Revised July 2017, the P&P indicated, .Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include:.h. Water Temperatures. 2. A review of Resident 10's admission RECORD, indicated Resident 10 was admitted to the facility in 2024 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life; a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), and diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A review of Resident 10's Change in Condition SBAR [a communication tool for sharing information with teams and stands for Situation, Background, Assessment, and Recommendation or Requests] Communication Form and Progress Note, dated 5/27/25, indicated, .The change in condition.is.Falls.This started on 05/27/2025.Does the resident have pain? Yes.Description/location of pain: Left trochanter (hip), /Left thigh (front), /Left thigh (rear), /Left knee (front), /Left knee (rear), /Left lower leg (front), /Left lower leg (rear).Intensity of pain (rate on a scale of 1-10, with 10 being the worst): 10.Summarize your observations and evaluation: At 0555 [5:55 a.m.] CNA heard pt [resident] calling out yelling that she fell and is in pain. CNA entered the room and found pt sitting on the floor in the bathroom in a puddle of urine. CNA called writer and full head to toe assessment completed, no skin condition found. Pt refused to be pulled up into wheel chair [sp] stating her whole left leg and left hip hurt too much.Dr [physician].was notified and order was to send her to the ER [acute care facility emergency department]. A Review of Resident 10's Interdisciplinary Care [IDT, a group of healthcare professionals with various levels of expertise who work together toward the goals of their residents] Conference Meeting Notes, dated 5/27/25 indicated, .Type of Interdisciplinary Care Conference.Fall Incident.Name and Title of Attendees.Director of Nursing [DON], Assistant Director of Nursing [ADON], Minimum Data Set Coordinator [MDS], Health Information Management [HIM], Director of Staff Development [DSD], Social Services Assistant [SSA].Date and time of fall incident.05/27/2025 05:30 [5:30 a.m.].Fall Report.CNA reported to LN that resident is on the floor. Immediately went to assess and resident is observed sitting on the bathroom floor between the toilet and sink; puddle of urine is also noted on the floor and no urine or bm [bowel movement] is noted in toilet bowl. Resident wasn't wearing any pants and noted to be barefooted at the time of fall. Resident denies hitting head. Two CNA's [sp] and two LN [sp] attempted to transfer resident in w/c [wheelchair] but resident was in severe pain stating her left hip and left leg is hurting. RN (LN) on duty stated to not touch resident since resident is in severe pain. RN called MD [physician] and ordered for resident to be sent out. Staff stayed with resident until [ambulance] arrived. [Ambulance] then assisted resident off the floor and into the gurney.History of falls.None.IDT Recommendations.Rehab Referral.Transfer to acute care hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 10's Care Plan Report, dated 5/27/25, indicated .Focus.The resident has had an actual fall on 5/27/25 with left leg & hip pain.date initiated.5/27/2025.Goal.The resident's left leg pain will resolve without complication.Interventions.Educating resident on asking for assistance to the restroom.Send to ER for further eval for leg pain.Use non-skid footwear when ambulating or transferring. During an interview on 9/29/25, at 2:41 p.m., with LN 2, LN 2 stated that she was not on duty when Resident 10 fell. LN 2 stated that she would completed a fall assessment on a resident if she saw that the resident was weak, after a resident's fall incident, when the resident was admitted , and if there was a change in the resident's condition. LN 2 further stated that she would also update the resident's care plan. During a concurrent interview and record review on 9/29/25, at 4:10 p.m., with the DON, Resident 10's electronic medical record (EMR) was reviewed. The DON stated the expectation was that upon admission, staff would check the resident's history to see if they were independent or needed assistance with activities of daily living (ADLs, tasks of everyday life including eating, dressing, bathing, or showering, and using the bathroom; activities related to daily care), if they had a history of falls, and if they needed assistance going to the bathroom. The DON further stated that she also expected staff to do a care plan upon admission if the resident was at risk for falls. The DON stated that the rehabilitation department (a specialized unit within an organization, such as a health care facility, that focuses on providing services and support for individuals recovering from injuries, illnesses, or disabilities) did quarterly joint mobility screens (a tool used to assess and evaluate a person's mobility and stability during movement. It identifies imbalances in mobility and stability, which can indicate functional movement deficiencies) on residents, and did the joint mobility screens after a resident had a fall. The DON confirmed that Resident 10 had a quarterly joint mobility screen done on 5/23/25, which was before Resident 10's fall. The DON further confirmed that Resident 10 did not have a joint mobility screen done after she fell. The DON stated that the risk of not completing the joint mobility screen after Resident 10 fell was that the resident would be at an increased risk of falls because the staff would not know the mobility status. The DON confirmed that the facility policy was not followed. A review of a facility P&P titled, Fall Risk Assessment, revised July 2013, indicated, .The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.Policy Interpretation and Implementation.1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls.2. The nursing staff will ask the resident and/or his/her family about any history of falls.5. The attending physician and nursing staff will. assess the resident for medical conditions.or sensory impairments.that may predispose to falls.9. The staff and attending physician will collaborate to identify and address modifiable risk factors. A review of a facility P&P titled, Falls Management, revised November 2012, indicated, .Policy.It is the policy of this facility that our physical environment remains as free of accident hazards as possible. Residents will be assessed for fall risk and interventions will be implemented to reduce the risk of falls.Procedure for risk Identification/Prevention: 1. On the day of admission, each resident is assessed by a licensed nurse using a Fall Risk Assessment tool to determine possible risk of sustaining a fall.3. Residents' fall risk will be re-assessed with each significant change of condition.

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Delta Oaks Post Acute	6940 Pacific Avenue Stockton, CA 95207

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review the facility failed to ensure proper hydration (process of providing fluid to the body) for one of 35 sampled residents (Resident 5) when Resident 5's water was out of reach.This failure placed Resident 5 at risk of dehydration (condition where your body loses more fluid than it takes in, resulting in insufficient water for its normal functions). Findings:A review of Resident 5's, clinical record titled, admission RECORD, indicated Resident 5 was admitted to the facility with a diagnosis that included Chronic congestive heart failure (a condition where the heart can't pump blood efficiently, causing a backup of fluid in the body and leading to symptoms like shortness of breath, fatigue, and swelling).A review of Resident 5's clinical record titled, Care Plan, dated 4/24/25, indicated Resident 5 was at risk for dehydration because he used a diuretic medication (medications that increase urine output, helping the body eliminate excess fluid).During a concurrent observation and interview on 9/29/25 at 11:31 a.m., with Regional Minimum Data Set (MDS- a standardized clinical assessment) Support (RMDS, a support person who reviews MDS assessments), in Resident 5's room, Resident 5 unsuccessfully attempted to reach his water pitcher on a nightstand. RMDS stated the water pitcher should have been within Resident 5's reach. RMDS also stated water within reach was important to have access to maintain adequate hydration and without access, Resident 5 was at risk for dehydration.During a concurrent observation and interview on 10/1/25 at 10:00 a.m., with the certified nursing assistant (CNA) 8, in Resident 5's room, Resident 5's bedside table was observed against the wall with his water pitcher on the bedside table. Resident 5 stated the staff had moved the bedside table when they picked up his breakfast tray. CNA 8 verified Resident 5's water pitcher was not within reach and stated CNA 8 had moved the bedside table when he picked up the breakfast trays and forgot to put the bedside table back within reach of Resident 5.During an interview on 10/1/25 at 10:10 a.m. with the Licensed Nurse (LN) 7, LN 7 stated Resident 5 was on diuretic medication and Resident 5 was at risk of dehydration. LN 7 further stated Resident 5 should have always had a water pitcher within reach to prevent dehydration.During an interview on 10/1/25 at 2:20 p.m. with the Director of Nursing, (DON) the DON stated that because Resident 5 was on a diuretic medication, he was at increased risk for dehydration; and therefore, should have had water available at the bedside.A review of the facility's undated policy and procedure titled, Resident Hydration and Prevention of Dehydration, dated indicated, .this facility will strive to provide adequate hydration and to prevent and treat dehydration.Nurses' Aides will provide and encourage intake of bedside snack and meal fluids, on a daily routine basis.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to provide medically- related social services for 1 of 35 sampled residents (Resident 19) when the facility failed to honor Resident 19's requests and wishes to be transferred to a facility closer to home.This failure placed Resident 19's health and psychosocial well-being at risk for potentially serious complications which could have impacted his quality of life and could have lowered his self-esteem (confidence in one's own worth or abilities). Findings:A review of Resident 19's clinical record titled, admission RECORD, indicated Resident 19's admitting diagnoses included cerebral palsy (a group of disorders that affect movement, muscle tone, and posture due to brain damage) and paresthesia of skin (an abnormal sensation characterized by tingling, prickling, burning, or numbness in the skin).During an interview on 9/29/25, at 8:34 AM, with Resident 19, Resident 19 stated that before his admission to the facility, he lived in a different area of the state. Resident 19 stated that he was admitted to the facility in 2019 and since the admission date, he had requested multiple times to be transferred to a facility that was closer to his home. Resident 19 further stated he was upset that the facility was not working proactively on his transfer/discharging to a different facility. Resident 19 stated, I have the right to request to live in the area that I want.A review of Resident 19's various clinical records indicated Resident 19 expressed his desire and requested assistance to be transferred to a facility closer to home. A review of the following clinical records indicated the following:- Care Plan, date initiated on 11/23/20, indicated, .Resident [Resident 19] is requesting to discharge and live independently in [CITY NAME].,-Care Plan Meeting, dated 2/1/24, indicated, .Resident [Resident 19] also requests assistance in alternate placement, however, resident [Resident 19] does not receive any income and has no living family in the [COUNTY Name] county area., -Social Services Assessment & Documentation, dated 2/2/24, indicated, .C. Mental Health & [and] . 5. Comments .Wellness Comments.Resident [Resident 19] mental health/ wellbeing appears compromised d/t [due to] placement in the facility far from [COUNTY NAME] where resident [Resident 19] was previously residing.,- Social Service Progress Note, dated 12/18/24, indicated, .SS [Social Services] spoke with.R/T [related to] that he [Resident 19] is requesting to be transferred back to his hometown [CITY NAME] ., - Social Service Progress Note, dated 5/5/25, indicated, .Resident [Resident 19] states he wants to be medically discharged to a financial institution in [CITY NAME].,- Nurses Progress Note, dated 7/22/25, indicated, .Resident [Resident 19] made writer aware he would like to speak with SS [Social Services] regarding his discharge.,- Nurses Progress Note, dated 9/3/25, indicated, .Resident [Resident 19] was observed laying with his feet off the bed, holding onto the side rail. Writer asked resident [Resident 19] if we can help reposition him back in bed. Resident [Resident 19] responded.I told myself September 3rd will be the day I leave.Resident [Resident 19] yelled at writer .7 years, 7 years I have been here. I'm leaving.,- Social Service Progress Note, dated 9/3/25, indicated, .The patient [Resident 19] expressed.I have been stuck in this place for seven years.I can live on the streets., - .Change in Condition Evaluation ., dated 9/24/25, indicated, .Review Findings and Provider Notifications.4.Writer was called to resident's [Resident 19] room for reported single episode of self harm. Resident [Resident 19] stated he is upset d/t [due to] not being able to live in [CITY NAME] .Resident [Resident 19] stated, It was a brief moment of sadness.,- Nurses Progress Note, dated 9/24/25, indicated, .resident [Resident 19] reported single episode of self harm. Resident [Resident 19] stated he was upset that he has not been moved back to his hometown.Resident [Resident 19] stated.it's been too long, 7 years I have been here.,- Social Service Progress Note, dated 9/25/25, indicated, .The patient [Resident 19] expressed that he has been in the facility for seven years.He has been trying to return to [COUNTY NAME], specifically [CITY NAME], his home city. Over the years, he [Resident 19] has met numerous staff members, but none have been able to help him achieve this goal. Patient [Resident 19] expressed that he considers himself philosophical and intelligent, but feels that no one ever wants to listen to him.he feels like he has been in this facility forever. During a concurrent interview and record review on 10/1/25, at 1:20 PM, with the Social Service Director (SSD), Resident 19's clinical records titled, Care Plan Meeting, dated 2/1/24; Social Services Assessment & Documentation, dated 2/2/24; Social Service Progress Note, dated 12/18/24; Nurses Progress Note, dated 9/3/25 and 9/24/25; and Social Service Progress Note, dated 9/25/25 were reviewed. The SSD explained the process of transfer/discharge to other facilities and stated that upon residents' requests to transfer or discharge, the SSD contacted facilities, or area that residents preferred to be transferred to, and if beds were available. The SSD stated they would send residents' medical records and social service notes to those facilities and then would follow up with the

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide medications which met the needs of 1 of 35 sampled residents (Resident 46) when on 10/2/25 the following medications were not administered and left on the residents bedside table:Nephro-Vite 1 tablet (used to treat vitamin deficiencies in people with kidney disease),Senna 1 tablet (used to treat constipation); and,Sevelamar - 2 tablets (used to treat high phosphate in the blood in people with kidney disease).This failure had the potential for Resident 46 to experience worsening kidney disease (a decline in kidney function over time), hyperphosphatemia (medical condition characterized by elevated levels of phosphate in the blood in people with kidney failure), and constipation (a condition in which there is difficulty in emptying the bowels or hard feces).Findings:A review of Resident 46's admission RECORD, indicated Resident 46 was admitted to the facility in 2024, with diagnoses which included, chronic kidney disease stage 4 severe (CKD -kidneys are severely damaged and their function is significantly reduced) and dependence on renal dialysis (a medical treatment that artificially replaces the function of the kidneys when they are unable to do so).During a concurrent observation and interview on 10/2/25, at 7:13 AM, in Resident 46's room, a medication cup with 4 pills was observed left on Resident 46's bedside table. Resident 46 stated it was common for the nurse to leave the medications at bedside for her. Resident 46 further stated she liked to take her medications with coffee and was waiting for coffee to be delivered by her Certified Nursing Assistant (CNA).During a concurrent interview and record review on 10/2/25, at 7:23 AM, with Licensed Nurse (LN) 13, Resident 46's Medication Administration Record (MAR - a legal document that serves as a detailed log of all medications given to a patient by healthcare professionals) was reviewed and LN 13 was able to identify the 3 medications given, a total of 4 tablets. LN 13 confirmed she left the medications at bedside for Resident 46 to take when her CNA brought her coffee. LN 13 stated she knew it was against policy to leave medications unattended at bedside. LN 13 further stated the expectation for nurses administering medication was to watch and encourage the resident's to take their medications. LN 13 reviewed Resident 46's record and stated she had not been evaluated to self-administer medications and could not find documentation of it was in her care plan. LN 13 stated the risk of leaving medications unattended in a resident's room was that another resident could take the medication and not knowing whether the resident the medication was intended for, took the medication. During an interview on 10/2/25, at 11:29 AM, with the Director of Nursing (DON), the DON stated that medications should not be left at bedside, and the nurse should be present when the resident took all the medication. The DON further stated the risk of leaving medications unattended was ineffective medications if the resident did not take them, or a risk of another resident taking them. The DON explained if another resident took the medications it could affect their health and safety.A review of the facility policy and procedure (P&P) titled, Administering Medications, revised April 2019, indicated, .Medications are to be administered in a safe and timely manner.A review of the facility P&P titled, Administering Oral Medications, revised, October 2010, indicated, .22. Remain with the resident until all medications have been taken.A review of the facility P&P titled, PREPARATION AND GENERAL GUIDELINES IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES, effective, October 2017, indicated, .15) The resident is always observed after administration to ensure that the dose was completely ingested.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to ensure safe monitoring and assessment of blood pressure (BP -the force of your blood pushing against the walls of your arteries as your heart pumps blood and was measured as two numbers: systolic [when the heart beats] and diastolic [when the heart rests between beats]) and heart rate (HR -frequently of your heart beats per minute) for a medication used to treat low (hypotension) BP for two of six sampled residents (Resident 17 and Resident 80), when:1. Resident 17's physician prescribed hold parameters (a set of numbers that guide the nursing staff when to not give [hold] a medication) for Midodrine (a medication used to treat low blood pressure) were not followed 13 times between 8/15/25 and 10/1/25; and,2. Resident 80's physician prescribed hold parameters for Midodrine were not followed 13 times between 8/1/25 and 9/30/25.This failure had the potential to put Resident 17 and Resident 80 at risk of adverse drug effects including hypertension (HTN - high blood pressure) and increased Resident 17 and Resident 80's risk of having a severe medical emergency.Findings:1. A review of Resident 17's Order Details, dated 8/2025, indicated Midodrine was ordered by a physician with parameters (a measurable blood pressure value used to assess a patient's condition and guide treatment) to .Hold if SBP [SBP - systolic blood pressure] > [greater than] 100.During a concurrent interview and record review on 10/2/25, at 11:13 AM, with the Director of Nursing (DON), Resident 17's, Medication Administration Record, (MAR - a document used in healthcare setting to track and record medication given to residents) dated 8/1/25 through 10/1/25 was reviewed. The DON confirmed that Midodrine was given in error, outside of doctor ordered parameters, 13 times on the following dates:8/15/25, 8/19/25, 8/26/25, 8/27/25, 8/30/25, 9/2/25, 9/4/25, 9/6/25, 9/9/25, 9/13/25, 9/14/25, 9/28/25, and 10/1/25.2. A review of Resident 80's Order Details, dated 8/16/24, indicated Midodrine was ordered by a physician with parameters to, .HOLD FOR SBP [systolic blood pressure] GREATER THAN 100.During a concurrent interview and record review on 10/2/25, at 11:13 AM, with the DON, Resident 80's MAR dated 8/1/25 through 9/30/25 was reviewed. The DON confirmed that Midodrine was given in error, outside of doctor ordered parameters, 13 times on the following dates:8/1/25, 8/2/25, 8/5/25, 8/14/25 at 6 AM, 8/14/25 at 1 PM, 8/14/25 at 6PM, 8/17/25, 8/18/25, 8/28/25, 9/11/25, 9/19/25, 9/28/25, and 9/30/25.During an interview on 10/2/25, at 11:05 AM, with Licensed Nurse (LN) 14, LN 14 stated that Midodrine was used for Hypotension (low blood pressure). LN 14 further stated that they had parameters given by the physician that if the SBP was above 100, the nurses were expected to not give the medication to the residents. LN 14 explained it was important to not give the medication because it might make the resident's blood pressure high causing hypertension, (HTN - high blood pressure) and put the resident at risk for a stroke (a sudden interruption of blood flow to part of the brain causing brain cells to die) and other medical complications.During an interview on 10/2/25, at 11:18 AM, with the DON, the DON stated her expectation was for the LN to give the medication as ordered and that expectation included not to give the Midodrine if it did not meet the physician ordered hold parameters. The DON further stated the risk to the residents when the medication was given in error, would increase the residents blood pressure more and could affect their health status. The DON stated it could create additional medical problems for the residents.A review of the facility policy and procedure (P&P) titled, Administering Medications, revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders.The following information is checked/verified for reach resident prior to administering medications.Vital signs [VS -include checking the residents heart rate and blood pressure].

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (% percentage - number or ratio expressed as a fraction of 100) with a resident census of 104. Medication administration observations were conducted over multiple days, in random locations throughout the facility. The facility had a total of 2 errors out of 32 opportunities which resulted in a facility wide medication error rate of 6.25% for 2 of 6 residents (Resident 68 and Resident 17) observed for medication administration.These failures had the potential to result in unsafe medication use and medication errors affecting the resident's health and well-being. Findings:a. During a medication administration observation on 9/29/25, at 9:15 AM, with Licensed Nurse (LN) 4, the following medication was observed given to Resident 68:LN 4 was observed administering 4 units of Insulin Lispro (a human-made rapid acting insulin analog to treat high blood sugar levels) subcutaneously (applied under the skin) in the upper right arm to Resident 68 on 9/29/25, at 9:15 AM.A review of Resident 68's order for, Insulin Lispro injection solution.Inject 4 units [measure of dosage] subcutaneously [applied under the skin].3 x [times] a day before meals. dated, 1/29/25, was documented as given on Resident 68's medication administration record (MAR -a legal document that serves as a detailed log of all medications given to a patient by healthcare professionals) on 9/29/25, at 8 AM.During an interview on 9/30/25, at 7:55 AM, with LN 4, LN 4 stated that Resident 68 had breakfast at 8 AM on 9/29/25 and that it was around the normal time for trays to be delivered to the rooms. LN 4 confirmed the order for Resident 68's insulin was supposed to be given before meals and that she gave it late on 9/29/25, at 9:15 AM. LN 4 stated the insulin should be given before meals and if given late the risk to the resident was that the insulin would not be as effective. b. During a medication administration observation on 10/1/25, at 8:18 AM, LN 5 administered a total of 8 medications to Resident 17, including 1 drop of Visine Dry Eye Relief, in each eye.During a record review of Resident 17's MAR, dated 10/2025, the following order indicated, Visine Dry Eye Relief Ophthalmic [an eye drop medication used to treat dry eyes].Instill 2 drop in both eyes two times a day for dry eye.During a concurrent interview and record review, on 10/1/25, at 8:45 AM, with LN 4, LN 4 reviewed Resident 17's MAR, dated 10/1/25, Visine Dry Eye Relief, order. LN 4 confirmed he was supposed to put 2 drops in each eye but only administered 1 drop in each eye. LN 4 stated he made the medication error because he had never seen an order for more than one drop in each eye before. LN 4 further stated the risk to the resident for not receiving the prescribed dose was continued dry eyes and the medication not being as effective or therapeutic. During an interview on 10/2/25, at 11:25 AM, with the Director of Nursing (DON), the DON stated her expectation was for the nurses to double check the orders and follow the rights of medication administration including, right order, right resident, right time, right dose, right route, and right documentation. The DON further stated it was important to follow the doctor's order and directions for giving insulin before meals. The DON explained the risk to the resident when insulin was given at the wrong time is that the insulin would not be as effective and it could also cause a blood glucose drop (the amount of glucose a simple sugar in the bloodstream). The DON stated it was her expectation to give the medication as ordered, for example, giving the wrong dosage of a medication like eye drops was a medication error and expected the doctor to be notified.A review of facility policy and procedure (P&P) titled, Administering Medications, revised, April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed. Medication are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders.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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices in two out of three medication rooms and four out of five medication carts when:1. An external air-conditioning (ac) unit that had a filter with grayish colored dust and debris, was placed on top of a medication refrigerator in Medication Storage room [ROOM NUMBER],2. Two bottles of Drug Buster (an eco-friendly, liquid solution designed for safe and effective disposal of unwanted or expired medications. It dissolves pills, tablets, capsules, and other forms of medication on contact, rendering them non-toxic and safe for disposal in regular trash) were found soiled and in active use in two different medication carts,3. Four pill cutters (a device used to safely and accurately divide medication tablets, vitamins, and supplements) were found with white and grayish residue in three different medication carts,4. Medications were opened in a medication cart and medication room without being labeled with an open date; and,5. A Topical medication was opened and not labeled with date opened, and sterile single use wound care supplies were opened and available for use in a treatment cart.These failures had the potential for unsafe medication use in the facility.Findings: 1. During a concurrent interview and inspection of the facility's medication storage room at Station 1, on 9/29/25, at 8:35 AM, accompanied by the Infection Preventionist (IP), an ac unit that takes air from the facility and removes it to the outside environment had a vent filter with grayish colored dust and debris placed on top of a medication refrigerator. The IP confirmed that the vent filter was dirty and had dust and debris build-up. The IP stated that the debris could get inside the medication refrigerator and that the filter should have been clean. During an interview on 10/1/25, at 9:10 AM, with the Director of Staff Development (DSD), the DSD stated that dust bunnies and spores could get inside of the medication refrigerator if the ac vent filter was dirty. The DSD further stated dirt and debris could get on the medications that were in the refrigerator. During an interview on 10/1/25 at 9:25 AM with the Director of Nursing (DON), the DON stated that the ac filter vents needed to be maintained and kept clean. The DON also stated that it could be a environmental hazard having the medication refrigerator being exposed to various dust and debris. The DON further stated that the medications could have been damaged, and that the efficacy of the medications could also be impacted. During a review of the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, dated 04/08, the P&P indicated, .Medication storage areas are kept clean. 2. During a concurrent interview and inspection of the facility's medication cart at Station 1, on 9/29/25, at 10:24 AM, accompanied by Licensed Nurse (LN) 3, a bottle of Drug Buster solution was observed to be soiled and dirty. LN 3 confirmed that the bottle of Drug Buster was soiled and making the medication cart dirty. LN 3 stated that it was an issue having a dirty Drug Buster available for use in the medication cart. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and inspection of the facility's medication cart at Station 3, on 9/29/25, at 10:36 AM, accompanied by LN 4, a bottle of Drug Buster solution was observed to be soiled and dirty. LN 4 confirmed that the bottle of Drug Buster was soiled and making the medication cart dirty. LN 4 stated that the Drug Buster solution should have been clean, and it posed a cross-contamination risk for the medications stored in the medication cart. During an interview on 10/1/25, at 9:10 AM, with the DSD, the DSD stated that the chemical solution could mix with other medications and cause unwanted drug-to-drug interactions (occur when the effect of one drug is changed by the presence of another drug. This interaction can result in the drug being less effective, more effective, or causing new, unexpected side effects to occur. During an interview on 10/1/25, at 9:25 AM, with the DON, the DON stated that having a dirty Drug Buster solution available in the medication cart would make the cart sticky and hard to clean. The DON further stated that the solution could seep into other medications and damage the cart. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 9/18/23, the P&P indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 3. During a concurrent interview and inspection of the facility's medication cart at Station 2, on 9/29/25, at 10:18 AM, accompanied by LN 2, two pill cutters were observed to have a whitish and grayish colored residue on them. LN 2 confirmed that the two pill cutters were dirty and should have been cleaned. LN 2 stated that cross-contamination of other medications could occur with the residue being on the pill cutters. During a concurrent interview and inspection of the facility's medication cart at Station 1, on 9/29/25, at 10:24 AM, accompanied by LN 3, a pill cutter was observed to have a whitish and grayish colored residue on it. LN 3 confirmed that the pill cutter was dirty. During a concurrent interview and inspection of the facility's medication cart at Station 3, on 9/29/25, at 10:36 AM, accompanied by LN 4, a pill cutter was observed to have a whitish and grayish colored residue on it. LN 4 confirmed that the pill cutter was dirty. LN 4 stated that previous medications that were cut using the pill cutter could interact with other medications. LN 4 further stated that it was a cross-contamination risk and that the pill cutter should have been clean. During an interview on 10/1/25, at 9:25 AM, with the DON, the DON stated that pill cutters should have been kept clean while in use. The DON also stated that having dirty pill cutters could increase the chances of unwanted drug-to-drug interactions. 4a. During a concurrent medication storage observation and interview on 10/1/25, at 7:59 AM accompanied by LN 5, the Sub-Acute Medication Cart 1 had one opened and undated bottle floor stock supply (supply of commonly used medications kept on hand and available for use) of Miralax (laxative powder mixed into water to help relieve constipation) available for use in the cart. LN 5 stated it was the facility stock bottle and used for multiple residents. LN 5 further stated it was facility policy to label the medication bottles with the date opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a concurrent medication storage observation and interview on 10/1/25, at 8:04 AM, accompanied by LN 5, the medication storage room located on the Sub-Acute Unit (a specialized unit for patients who require more specialized treatment than a standard skilled nursing unit) in the refrigerator, an opened and used box of Bisacodyl suppositories (a laxative used to insert into the rectum to relieve constipation) was not labeled with the date opened. LN 5 stated it was important to label medications with the date opened because some medications have a different expiration date once opened. LN 5 further stated the risk to the resident for taking expired medication was the medication would not be as effective. 5a. During a concurrent medication storage and treatment cart (a mobile, wheeled unit in a healthcare setting used to store and transport medical supplies, equipment and medications for patient care and wounds) observation and interview on 10/1/25, at 7:32 AM, accompanied by LN 6, the medication storage top drawer of the treatment care on the Sub-Acute unit, contained an opened bottle of prescription Clobetasol Propionate Topical Solution (a high-potency corticosteroid medication) that was unlabeled with the opened date. LN 6 stated it was important to label the medication with the opened date because it was only good for 28 days once opened. b. An opened single use, Suresite Transparent Film Dressing, (waterproof, breathable, comfortable dressing that protects skin and wounds) was observed opened and available for use in the treatment cart. The package instructions indicated, .Sterile (free from living microorganisms including bacteria, viruses, and fungi) in unopened, undamaged package. Single use only. LN 6 confirmed the finding and stated it the rest of the package should have been thrown away and not be available for use. LN 6 further stated the risk to the residents if was used, was that the package was opened and no longer sterile. c. An opened single use, Bordered Gauze, (three-layered wound dressing with an absorbent pad) was observed opened and available for use in the treatment cart. The package instructions reviewed with LN 6, indicated, .Single use only.Sterile in unopened undamaged package. LN 6 confirmed the finding and stated it should not be opened and available for use in the treatment cart. d. An opened single use, Gentac Silicone Island Dressing, (a medical wound dressing with a central absorbent and gentle skin-safe silicone adhesive border) was observed opened and available for use in the treatment cart. The package instruction reviewed with LN 6, indicated, .Sterile wound dressings. LN 6 confirmed the finding and stated that should have been throw out, once opened it was no longer sterile. LN 6 further stated any product that was single use only and labeled as sterile should not be opened. LN 6 explained once opened the contents were no longer sterile and the risk to the resident was infection. During an interview on 10/2/25, at 11:25 AM, the Director of Nursing (DON) stated that it was important to label all opened medications in the medication carts. The DON further stated it was important because some medications have different expiration dates once opened. The DON explained the risk to the residents for using expired medications was that the medication could not be effective. The DON stated that sterile dressings should not be opened up and put back into the treatment carts because they were no longer sterile once opened. The DON further stated once sterile supplies were opened they were exposed to the environment and the risk to the resident was delayed wound healing or could cause infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an undated facility policy and procedure titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, indicated, .Floor stock medications are labeled.label should include.Expiration date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store, prepare, and serve food per safety standards when:1. Three tomatoes were found with mold and a discolored, flattened, and mushy apple were in the walk-in refrigerator,2. Frozen fish fillets, beef patties, meatballs, and veggie patties were left open to the environment in the reach in meat freezer,3. Small wares (three bowls and a cutting board) were not replaced when worn,4. The cool down log was not followed; and,5. The two-compartment sink did not have an air gap (a break in the plumbing to prevent unsanitary water from flowing back into the sink). These failures had the potential to lead to cross-contamination and food borne illness for the 85 residents eating facility prepared meals.Findings:1. During the initial kitchen tour on 9/29/25, at 8:30 a.m., a discolored, flattened, and mushy apple was found in the walk-in refrigerator.During a concurrent observation and interview on 10/1/25, at 8:52 a.m., with the Certified Dietary Manager (CDM) 1. CDM 1 verified three moldy tomatoes with a receive date of 9/25/25 were in the walk-in refrigerator. CDM 1 stated the moldy tomatoes should not have been there, if served to residents they would be at risk of getting sick from food born illness. During an interview on 10/1/25, at 9:45 a.m., with the Registered Dietitian (RD), the RD stated it was her expectation kitchen staff check food for quality daily. The RD further stated if the moldy tomatoes or apple were served would be a risk for food borne illness.2. During the initial kitchen tour on 9/29/25, at 9:15 a.m., frozen fish fillets and frozen beef patties were left open to the environment in the reach in meat freezer. During a concurrent observation and interview on 9/30/25, at 12:30 p.m., with the District Dietary Manager (DDM), frozen meatballs and frozen veggie patties were left open to the environment in the reach in meat freezer. The DDM stated the frozen meatballs and frozen veggie patties should have been completely covered to prevent food being covered in frost. DDM further stated food open to the environment in the reach in freezer could potentially affect the quality and nutritional value of the food.During an interview on 10/1/25, at 9:45 a.m., with the RD, the RD stated it was her expectation food stored in the reach in freezer should be tightly closed and not exposed to open air. The RD further stated food left open to air in the freezer could potentially affect palatability of the food stored.3. During the initial kitchen tour on 9/29/25, at 9 a.m., three bowls were worn, chipped, and without glaze on the ready to use shelves.During the initial kitchen tour on 9/29/25, at 9:05 a.m., a green cutting board stored ready for use was visibly worn with deep gouges.During an interview on 10/1/25, at 9:30 a.m., with CDM 2, CDM 2 stated bowls that were worn, chipped, and without glaze should have been thrown away because they cannot be cleaned properly. CDM 2 further stated the cutting board should have been thrown away and stated the bowls and cutting boards that were worn are at risk of bacterial growth potentially leading to food borne illness.During a review of the facility's policy and procedure (P&P) titled, Equipment, dated 9/2017, the P&P indicated, .All foodservice equipment will be clean, sanitary, and in proper working order.Review of the US Food and Drug Administration's (FDA) Food Code Section 4-501.12 of the 2022 Food Code on Cutting Surfaces indicated Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.4. During the initial kitchen tour on 9/29/25, at 9:13 a.m., the food cool down log was reviewed. The cool down log for egg salad dated 9/27/25, did not indicate when the egg salad reached 40 degrees Fahrenheit (F, a unit of measurement for temperature) or less.During an interview on 10/1/25, at 9:30 a.m., with CDM 2, CDM 2 stated it was important to follow the cool down log to ensure food that is being logged is safe for consumption. CDM 2 stated when the cool down log was not followed there is a risk the food that should have been logged could cause a food born illness.During an interview 10/1/25, at 9:45 a.m., with the RD, the RD stated following the cool down log process was important, not following the cool down log process risks bacteria growth on foods. Review of US FDA 2022 Food Code section 3-501.14 on Cooling indicated (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from.135 degrees Fahrenheit (F, a unit of measurement) to.70 degrees F: and (2) Within a total of 6 hours from.135 degrees F to 41 degrees F or less. (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna. It further indicated that Safe cooling requires removing heat from food quickly enough to prevent microbial growth. Excessive time for cooling of time/temperature control for safety foods has been consistently identified as one of the leading contributing factors to foodborne illness.5. During the initial

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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 104, when:Urinals were found inside the trash can instead of being placed in the provided urinal receptacle and were not replaced with a clean urinal for Resident 62; and,Flying pests were found inside Resident 65's room; and,Licensed Nurse (LN) 4 did not clean, sanitize, and disinfect a glucometer (device used to measure blood sugar) per manufacturer guidelines.These failures had the potential to spread infections to residents residing in the facility, negatively impacting their health and well-being.1. Review of Resident 62's admission Record, indicated Resident 62 was admitted with multiple diagnoses which included but not limited to cerebral infarction (when part of the brain doesn't get enough blood causing brain cells in that area to die), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), and chronic kidney disease (kidneys are slowly losing their ability to clean your blood and remove waste from your body). During a concurrent observation and interview on 9/29/25 at 9:15 AM, in Resident 62's room, there was three labeled urinals hooked by the urinal handle onto the inside of the trash can. The urinals, all marked with the resident's name and room number, all contained small amounts of yellow urine, and the urinal lids had dark stains. Only one urinal had a date written on the urinal and was dated 9/15/25. The trash can also contain used tissue paper, gloves, and an empty medicine cup, while the blue-colored urinal holder attached to Resident 62's bed frame remained empty. Resident 62 stated, I'm using a urinal. Staff don't have time to replace my urinal. Staff were not consistent in replacing my urinal. I need to press my call button for someone to come and replace it. I wish they would do it routinely. It's not my preference to put it inside the trash can. During a concurrent observation and interview on 9/29/25, at 9:30 AM, in Resident 62's room, Certified Nursing Assistant (CNA) 2 confirmed Resident 62 had three urinals located in the garbage can. CNA 2 stated Resident 62 required only one urinal at a time, and the urinal should not be placed in the garbage can as this was not acceptable and did not follow standard procedures. CNA 2 stated the urinal needed to be placed in the designated urinal holder located at the side of the bed that was within reach. CNA 2 stated urinals placed inside a trash can, posing an infection control risk that could impact Resident 62's safety and physical condition. During an interview on 10/1/25 at 12:48 PM with Infection Preventionist (IP), the IP stated that she expected the CNAs and nurses to store one urinal at the bedside using the designated blue-colored urinal holder attached to the bedframe. The IP stated staff should properly dump the contents into the toilet and return the urinal to the designated holder. The IP stated the urinals needed to label with the resident's name and room number. The IP stated if the urinal was dirty, the staff must replace the urinal. The IP stated each resident should have only one labeled urinal. The IP explained it was unacceptable to have urinals inside the garbage can. The IP stated that using a urinal placed inside the trash could result in germ contamination, which may pose a risk to Resident 62. The IP stated that proper storage of clean urinals was essential for preventing infection and maintaining cleanliness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/25 at 1:17 PM with Director of Staff Development (DSD), the DSD stated CNAs needed to label the urinal with the resident's name and room number and place it in the blue-colored urinal holder. The DSD stated each resident should ideally have only one urinal unless they preferred more. The DSD stated nurses should not allow urinals to be placed inside the trash can. The DSD stated further that germs in the trash could spread and pose an infection risk to Resident 62. During an interview on 10/2/25 at 9:36 AM with Director of Nursing (DON), the DON stated CNAs must clean the urinal after each use and place it back in the designated urinal holder. The DON stated if the urinal was dirty, it should be thrown away and replaced with a new one. The DON stated throwing away dirty urinals and replacing the urinal with a new one would reduce the risk of infection and potential cross contamination. Review of the facility's Policy and Procedure (P&P) titled Bedpan/Urinal, Offering/Removing dated 2/18, the P&P indicated, . Policy Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. General Guidelines: 3. If the resident prefers to keep a urinal at his bedside, check it frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside. After Assisting the Resident: 8. Clean the bedpan or urinal. Wipe dry with a clean paper towel. Store the bedpan or urinal per facility policy. 2. Review of Resident 65's admission Record, indicated Resident 65 was admitted with multiple diagnoses which included but not limited to chronic obstructive pulmonary disease (COPD - a common lung disease causing restricted airflow and breathing problems), adult failure to thrive (someone is not eating well, losing weight and feeling weak), and generalized muscle weakness. During a concurrent observation and interview on 9/29/25 at 11:53 AM with Licensed Nurse (LN) 2, LN 2 confirmed the presence of an uncollected empty fruit cup containing used tissue paper and a spoon, a dark blue plastic mug with a small amount of coffee, an empty glass, and another plastic cup with a small amount of water, all of which had insects present. LN 2 stated that this situation was unsanitary, unacceptable, and presented an infection control concern that required immediate cleaning. LN 2 stated that the presence of multiple gnats in Resident 65's room should prompt CNAs to report the unclean environment to licensed nurses, who would then inform housekeeping to ensure proper cleaning. During an interview on 10/1/25 at 8:08 AM, in Resident 65's room, Resident 65 stated that staff were not cleaning his room regularly, and it was dirty. Resident 65 stated that he was not receiving consistent assistance from the staff and noted that his meal tray was not being picked up once he had finished. Resident 65 confirmed the presence of multiple flying insects in his room on 9/29/25 and expressed concern that this could attract more gnats, which might affect his health, particularly his breathing. Resident 65 stated that he did not decline the staff's assistance in cleaning his room. During an interview on 10/1/25 at 8:21 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated that she prepared Resident 65 for meals, served the meal tray, and collected it once Resident 65 finished eating. CNA 2 stated Resident 65 occasionally asked to leave juice or coffee on the bedside table, and she later checked if it was suitable to pick it up. CNA 2 stated that leaving empty fruit cups or glasses of juice on the bedside table can attract insects and increase the risk of infection for Resident 65. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/1/25 at 12:48 PM with Infection Preventionist (IP), the IP confirmed the absence of a non-compliance care plan in Resident 65's records pertaining to staff not being permitted to pick up empty cups and glasses, as well as the refusal to have his room cleaned. The IP stated the presence of gnats in the environment could increase the risk of infection. During an interview on 10/1/25 at 1:17 PM with the Director of Staff Development (DSD), the DSD stated that CNAs must remove the meal tray as soon as Resident 65 finishes eating and if Resident 65 prefers to keep food at the bedside, nurses need to provide education about the associated risks and benefits. The DSD stated leaving food at the bedside may attract bugs, which could present an infection control concern and potentially impact Resident 65's health and safety. The DSD stated that it was her expectation for Resident 65's refusal of meal tray removal or room cleaning to be care planned and communicated during shift reports however, she confirmed that this did not occur with Resident 65. During an interview on 10/2/25 at 9:36 AM with the Director of Nursing (DON), the DON stated that old food remaining at the bedside can lead to bacterial growth and food poisoning. The DON stated there should be no old food or meal trays left at the bedside. The DON stated leaving moldy old food at the bedside posed risks, including gastrointestinal (includes the stomach and intestines) issues like diarrhea, nausea, and vomiting. Review of the facility's P&P titled Assistance with Meals dated 3/22, the P&P indicated, . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Resident Confined to Bed: 3. The nursing staff . will take food trays into resident's rooms. 4. Nursing services . will pick up resident's food trays after each meal . Review of the facility's P&P titled Pest Control dated 5/08, the P&P indicated, . Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 5. Garbage and trash are not permitted to accumulate and removed from the facility daily. 3. During a concurrent observation and interview on 10/1/25 at 9:23 AM, (LN) 7 was observed cleaning the glucometer after use. LN 7 took one (name brand pre-moistened disinfectant) towelette and cleansed the glucometer for 10 seconds and then placed the glucometer on top of the medication cart (a mobile unit used in healthcare settings to store and transport medications for patient delivery). LN 7 stated she cleansed the glucometer for about 10 seconds and did not realize she needed to cleanse it longer or with a second disinfectant towelette for a wet-contact time (how long a disinfectant needs to stay wet on a surface to be effective) of two minutes. A review of the side of the disinfectant towelette label with LN 7 indicated, . Disinfects in 2 minutes.Allow surface to remain visibly wet for contact time(s) listed on the label. LN 7 stated the risk to the residents for not cleaning the glucometer per instructions was the spread of infection. During an interview on 10/2/25 at 9:50 AM, the IP stated the expectation for glucometer cleaning was for it to be cleansed with one towelette first, and then a second towelette to disinfect, with the pre-moistened facility provided purple wipes for a total wet contact time of 2 minutes. The IP further stated the cleaning process was as directed on the glucometer manufacturer's instructions. The IP explained the risk to the residents if it was not cleansed properly was the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/24 at 11:24 AM, the Director of Nursing (DON) stated the glucometers should be cleansed with the, .purple wipes. with 2 separate disinfectant wipes for a set time of 2 minutes. The DON further stated it was important to prevent cross contamination (the process where bacteria or other microorganisms (undetectable to the eye organisms) that can cause disease are transferred from one substance or object to another, with harmful effect). A review of an undated facility provided document titled, GUIDELINES FOR CLEANING AND DISINFECTING THE ASSURE PLATINUM METER, the document indicated, .To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below.The meter should be cleaned and disinfected after use on each patient.Clean and disinfect the meter following step-by-step instructions.CLEANING.Step 1 Wear appropriate protective gear.Step 2.pull out 1 towelette.Step 3 Wipe surface of the meter to clean blood and other body fluids.Step 4.Dispose of used towelette.The meter should be cleaned prior to each disinfection step. DISINFECTING.Step 5 Pull out 1 new towelette and wipe entire surface.Step 6 Treated surface must remain wet for recommended contact time.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer, obtain informed consent and provide education to a resident or resident representative (RP) about influenza (or the flu, is a contagious viral infection of the respiratory system that can range from mild to severe, causing symptoms like fever, cough, sore throat, muscle aches, and fatigue) vaccine and pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccine for two out of five sampled residents (Resident 13 and Resident 65) when:1. Resident 13 was not offered the flu vaccine for 2 years.2. Resident 65 was not offered the pneumococcal vaccine within 30 days of admission.These failures had the potential for Resident 13, Resident 65, and resident's responsible parties to not be fully informed about the risks and benefits, and potential side-effects of the pneumococcal vaccine and flu vaccine prior to receiving or declining the vaccination and it violated Resident's right to make an informed choice.1. During a concurrent interview and record review on 10/1/25, at 12:49 PM, with the Infection Preventionist (IP), the IP stated they have an upcoming influenza, COVID-19, and pneumococcal vaccination clinic on 10/14/25. The IP stated they offer the flu vaccine annually to residents during the flu season (typically begins in October and ends in May). The IP stated that either her or the Licensed Nurse (LN) will obtain signed consents from the resident or the RP. The IP explained that they inform the resident or the RP about the availability of the vaccine being offered and if they agree, they are asked to sign the consent form. The IP stated if the resident or the RP were not interested in getting the vaccine, the risks of not receiving the vaccine and the benefits of getting it would be explained to them and if they still refused, they were asked to sign the refusal form. The IP stated they still offer the flu vaccine after their scheduled vaccination clinic if it is still Flu season. The IP stated when a resident gets admitted to the facility during the off season of the flu, they wait until October for the next flu season and offer the vaccine to the residents. Resident 13's medical record was reviewed with the IP and the IP stated Resident 13's last flu vaccine was given on 9/20/22. The IP confirmed there was no refusal form signed for Resident 13's flu vaccine during the 23/14 and 24/25 flu season. The IP stated the flu vaccine should have been offered to Resident 13 during the 23/24 and 24/25 flu season. During an interview on 10/2/25, at 9:11 AM, with the Sub-acute Director (SAD), the SAD stated they always offer the flu vaccine upon admission. The SAD stated the flu vaccine was offered yearly and if they offered it, they should educate the RP or the resident if and it should be documented that education was provided and indicate if the vaccine was refused or accepted. During a concurrent interview and record review on 10/2/25, at 10:04 AM, with the Director of Nursing (DON), the DON stated they offered the flu vaccine every year and upon admission even if it was not the flu season. Resident 13's medical record was reviewed with the DON, and the DON stated Resident 13's last flu vaccine was in 2022. The DON stated Resident 13 is nonverbal, and Resident 13's mother was the RP and if the RP refused the vaccine, it should have been documented. The DON confirmed that there was no documentation that the flu vaccine was offered for Resident 13. The DON stated they usually have the consent form, and she expected the nurses to document that the resident or the RP was educated with the risk and benefits of the vaccine and put it on the consent form and progress notes. The DON stated if the flu vaccine was not offered annually, there would be a chance of getting a respiratory infection or flu and that would deteriorate the resident's condition.A review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, revision date 8/25, the P&P indicated, .Between October 1st and March 31st each year, the influenza vaccine is offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.The resident (or representative) has the right to refuse vaccines. If refused, the date of and state reason for the refusal of the vaccine are documented in the resident's medical record. 2. During a concurrent interview and record review on 10/1/25, at 12:49 PM, with the Infection Preventionist (IP), the IP stated they offer the pneumococcal vaccine upon admission, but they could still get it during flu season vaccination clinic. The IP stated they offered pneumococcal vaccine for residents [AGE] years old and above, and if the resident is below [AGE] years old, they do not offer the pneumococcal vaccine. The admitting nurse is the one responsible for offering the vaccine and getting consent upon admission. The IP reviewed Resident 65's medical record and confirmed Resident 65 was admitted to the facility on [DATE] and there was no vaccine administration record. The IP stated Resident 65 will be offered the COVID-19, flu, and pneumococcal vaccine next week. The IP stated she did not know what happen and why the pneumococcal vaccine was not offered. The IP stated Resident 65 was admitted

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	10/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide COVID-19 vaccine, for one out of five sampled residents (Resident 65) when:1. Resident 65s' clinical record did not contain documented evidence that the COVID-19 vaccine was administered within 30 days upon admission.2. Resident 65's COVID-19 vaccine information history was not obtained and documented in the medical record.This deficient practice put Resident 65 at risk to be infected with COVID-19 virus that could lead to severe illness, hospitalization, and/or death.During a concurrent interview and record review on 10/1/25, at 12:49 PM, with the Infection Preventionist (IP), the IP stated the facility offered a COVID-19 vaccine to all residents upon admission. The IP stated that the admitting nurse is the one responsible for offering the COVID-19 vaccine and obtaining consent upon admission. The IP stated that once the consent was signed, the nurse would put the order in for the pharmacy to deliver the vaccine. The IP stated when a resident had a COVID-19 vaccine prior to admission to the facility, the facility would obtain the administration record of the COVID-19 vaccine and if the resident or the resident's responsible party (RP) could not provide the documentation of the COVID-19 vaccine administration information, they would just take their word for it. Resident 65's medical record was reviewed with the IP and the IP confirmed Resident 65 was admitted on [DATE], and he would be offered the flu vaccine (protect against infection by influenza viruses), the COVID-19 vaccine, and the pneumococcal vaccine (to prevent certain types of infection) next week. The IP stated the COVID-19 vaccine was offered to Resident 65, and he agreed to have it administered during the flu season vaccination clinic. The IP confirmed that there is no documentation that Resident 65 agreed to get the COVID-19 vaccine during flu season and it should have been documented. The IP stated Resident 65 signed a consent form on the day of his admission to the facility on 8/20/25 to receive the COVID-19 vaccine, but the vaccine had not yet been given to Resident 65. During an interview on 10/2/25, at 9:11 AM, with the Sub-acute Director (SAD), the SAD stated the facility offers the COVID-19 vaccine upon admission, and they can also provide it upon request. The SAD stated if the staff offered the vaccine, they should educate the RP or the resident and document whether they refused or accepted the vaccine.During a concurrent interview and record review on 10/2/25, at 10:04 AM, with the Director of Nursing (DON), Resident 65's medical record was reviewed with the DON. The DON stated they have a signed consent form of Resident 65's COVID-19 vaccine dated 8/20/25. The DON stated she did not see Resident 65's previous COVID-19 vaccine information. The DON stated the COVID-19 vaccine information history should have been documented. The DON stated that the immunization record does not provide evidence of administration, thus it is unclear whether Resident 65 received the vaccine. The DON stated she did not see any completed or active or discontinued doctor orders of the COVID-19 vaccine from Resident 65's order list therefore, the COVID-19 vaccine was not given yet. The DON stated the potential outcome when residents were not provided with the COVID-19 vaccine would be risks of getting COVID-19, respiratory issues, and the possibility of spreading COVID-19 infection to other residents and staff too.A review of Resident 65's admission RECORD, dated October 1, 2025, indicated, Resident 65's COVID Booster Vaccine Status and COVID Vaccine Status was left blank.A review of the undated facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, indicated, .If a resident requests vaccination, but missed earlier opportunities for any reason, the vaccine will be offered to that resident as soon as possible. Efforts to help the resident obtain vaccination are documented .Documentation and Reporting 1. The resident's medical record includes documentation that indicated, at a minimum, the following: .c. Each dose of COVID-19 vaccine that was administered to the resident. 2. If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record .