STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056324	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Post Acute	442 Hampton Street Stockton, CA 95204

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the contracted (an agency hired by the facility to provide a service) radiological (x-ray) services were available for a census of 116 when an x-ray ordered ASAP (urgent, stat, as soon as possible) was not performed for one resident (Resident 4). This failure resulted in a delay in care and treatment for Resident 4 with a potential risk for unmanaged pain. Findings: A review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility in 2023 with diagnoses which included cerebral infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke). During an interview on 4/11/25, at 1:10 p.m., with Resident 4 in his room, Resident 4 stated that in June 2024, he had a dream and when he woke up his left thigh was hurting. Resident 4 stated that he reported the pain to one of the nurses, but he did not remember who he reported it to. Resident 4 further stated about one month prior to being hospitalized at the acute care facility, he heard his left thigh pop. Resident 4 stated that he told one of the nurses, but did not remember who it was that he told. Resident 4 further stated he was sent to the acute care facility for an x-ray for his left thigh last June, and afterwards he returned to the facility. Resident 4 stated the x-ray showed a broken bone in his left thigh. During a review of Resident 4's Progress Notes, indicated, .6/24/24 15:40 [3:40 PM] .SBAR [a communication tool used to structure conversations in high-risk situations like healthcare, by organizing information into four key areas: Situation, Background, Assessment, and Recommendations. It helps ensure clear and concise communication, promoting efficiency, and reducing errors] Summary for Providers . Situation: The Change in Condition/s [CIC, a sudden, clinically important (a deviation that, without intervention, may result in complications or death) deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains] reported on this CIC evaluation are/were: Pain (uncontrolled) .Primary Diagnosis: Cerebral Infarction .Nursing observations, evaluation, and recommendations are: Resident complain of 6/10 pain [Pain scale, a method of rating level of pain numerically with 0 meaning no pain and 10 meaning worst pain] on his left thigh .pain meds given with relief .Primary Care Provider (physician) Feedback: x-ray of the left thigh, femur . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056324	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Post Acute	442 Hampton Street Stockton, CA 95204

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Progress Notes, indicated, .General Progress Note .6/24/24 23:33 .X-ray Tech did not come to give pt [Resident 4] x-ray. Order is still in the binder and the MAR [Medication Administration Record, a document listing medications and monitoring parameters] . During a review of Resident 4's Progress Notes, indicated, .SNF/NF [skilled nursing facility/ nursing facility] To Hospital Transfer Form .sent to [acute care facility] .Date of Transfer: 6/25/24 14:53 . During a review of Resident 4's X-ray Left Hip, dated 6/25/24, indicated, .6/25/24 16:25 .X-ray evaluation hip, 2 views .Findings: [AGE] year-old patient. Left hip pain .oblique fracture of the proximal left femoral shaft, slightly distracted [a thigh bone broken at a diagonal angle across the length of the bone that is slightly shifted out of alignment] . During a review of Resident 4's Progress Notes, indicated, .General Progress Note .6/25/24 23:14 [11:14 PM] .Pt admitted to [acute care hospital] admitting dx [diagnosis]: femur fx [fracture] . During a concurrent interview and record review on 4/11/25, at 1:16 p.m., with a Licensed Nurse (LN) 1, Resident 4's electronic medical record (EMR) was reviewed. LN 1 stated that a stat x-ray was ordered to be done by a contracted x-ray service at the facility for Resident 4's left femur (thigh bone) and hip on 6/24/24, at 3:40 p.m., because he complained of pain in his left thigh. LN 1 further stated the Progress Notes, dated 6/24/24, at 11:33 p.m., indicated the stat x-ray was not done. LN confirmed that Resident 4 was sent to the acute care facility to have the x-ray done on 6/25/24. LN 1 acknowledged it was a delay in care for the resident. LN 1 stated that if the x-ray technician from the contracted x-ray service had not arrived at the facility to do the x-ray on 6/24/24, she would have called the x-ray technician to see how long it would take for them to arrive because Resident 4 complained of pain. LN 1 further stated that if the x-ray technician stated that they couldn't come to the facility to do the x-ray, she would have called Resident 4's physician to notify him and to request that Resident 4 be sent to the acute care facility to have the x-ray done. During a phone interview on 4/11/25, at 2:15 p.m., with X-ray Technician (TECH) from the facility's contracted x-ray services, TECH stated that when an x-ray was ordered ASAP or stat by the facility, the x-ray was done within six hours depending on the volume of stat orders received by the contracted services. During a concurrent interview and record review on 4/11/25, at 3:35 p.m., with the Assistant Director of Nursing (ADON), Resident 4's EMR was reviewed. The ADON confirmed there was a Change In Condition (CIC) form documented on 6/24/24, at 3:40 p.m., that indicated Resident 4 complained of 6 out of 10 pain in his left thigh, and indicated that there was a physician order for an x-ray of the left hip and femur ordered stat on 6/24/24. The ADON further confirmed that a progress note documented on 6/24/24, at 11:33 p.m., indicated that the x-ray had not been done. The ADON confirmed that a transfer form documented on 6/25/24, at 11:49 a.m., indicated that Resident 4 had 7 out of 10 pain in his left thigh and was sent to the acute care emergency department for assessment and care. The ADON further confirmed that a progress note documented on 6/25/24, at 11:14 p.m., indicated Resident 4 was admitted to the acute care facility with an acute left femur fracture. The ADON stated there was a delay in care. The ADON further stated the risk was that the resident was not safe and experienced more pain. The ADON confirmed that the facility policy was not followed.