

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Hampton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) for one of four sampled residents (Resident 1), when Resident 1's showers were not provided as scheduled.</p> <p>This failure had the potential to negatively impact Resident 1's personal hygiene and psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 1's medical record titled admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), convulsions (a type of seizure characterized by involuntary and rhythmic muscle contractions and relaxations) and generalized muscle weakness.</p> <p>A review of Resident 1's Minimum Data Set (MDS- an assessment tool), dated 4/20/25, under Section C, indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (a BIMS score of 15 means a resident's cognitive function is intact and considered to be functioning normally in terms of their thinking and memory abilities).</p> <p>During an interview on 5/30/25, at 12:19 p.m., with Resident 1, Resident 1 stated he never had a shower since the day he got admitted to this facility until after he complained yesterday. Resident 1 stated he felt fresh and felt good after his shower. Resident 1 stated that he did not know when his showers were scheduled and there was no discussion about it with the facility staff. Resident 1 stated the staff did not give him options of when to shower or offered alternatives to showering.</p> <p>A review of the facility's shower schedule indicated Resident 1 was scheduled to receive showers on Tuesdays and Fridays during the afternoon shift.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/30/25, at 1:39 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated she gave Resident 1 a shower yesterday. CNA 1 stated that all residents are scheduled to have showers at least twice a week. CNA 1 reviewed the facility's shower schedule and confirmed Resident 1 was scheduled for showers every Tuesday and Friday. CNA 1 stated Resident 1 was not scheduled for his shower yesterday, but since he requested for a shower she added him to the schedule. CNA 1 further stated that Resident 1 gets up on his wheelchair so he likes to go into the shower room instead of having bed baths. CNA 1 stated that the CNA staff are responsible to document when showers were given in Resident 1's medical record. CNA 1 stated that it was important for residents to get their showers because they can get skin issues like bed sores (injuries to the skin and underlying tissue) that could lead to possible infection.</p> <p>During an interview on 5/30/25, at 1:57 p.m., with CNA 2, CNA 2 stated if a resident refused the scheduled shower the nurse would be notified, and a shower sheet would be filled out. CNA 2 stated the CNA staff will document on both the resident's chart and on the shower sheets when showers were done or when residents would refuse the showers. CNA 2 stated it was important for residents to receive their scheduled showers for them to feel better, feel clean, and to prevent them from having skin issues.</p> <p>During an interview on 6/4/25, at 8:45 a.m., with CNA 3, CNA 3 stated Resident 1 was alert and was able to make his needs known. CNA 3 stated that residents should get showered at least twice a week. CNA 3 stated she had never given Resident 1 a shower or a bed bath, and he had never asked her for one since she worked during the morning shift and his showers were scheduled for the evening shift. CNA 3 stated when she gave residents a shower or bed bath, she would document it in the resident's chart and fill out a shower sheet. CNA 3 stated it was important to document resident's showers because it would be considered proof that the shower was done. CNA 3 stated it was important for residents to have their showers to maintain good health and to not smell bad. CNA 3 stated if residents did not get their showers, they could feel irritated or develop rashes and skin issues.</p> <p>During a concurrent interview and record review on 5/30/25, at 3:49 p.m., with Licensed Nurse (LN) 1, LN 1 verified Resident 1 had a bed bath done on 5/7/25, 5/11/25, 5/14/25, and 5/19/25 according to his bathing task report for the month of May 2025. LN 1 verified that based on Resident 1's shower schedule, his scheduled shower dates of 5/2/25, 5/6/25, 5/9/25, 5/13/25, 5/16/25 and 5/20/25 showed no evidence showers were given. LN 1 confirmed Resident 1 should have received a shower twice a week and his shower schedule was not followed. LN 1 verified Resident 1 did not have any documented showers for the month of May 2025 and was not able to access the bathing task report for the month of April 2025. LN 1 reviewed Resident 1's chart further and stated Resident 1 did not have any shower refusals under progress notes for May 2025. LN 1 stated that the CNA should have documented if Resident 1 refused any showers and should have notified the nurse. LN 1 stated she was not aware of any shower refusals by Resident 1 and verified that Resident 1 did not have any care plans regarding shower refusal behavior. LN 1 stated it was important for residents to have their showers to provide personal care, maintain good hygiene, and to preserve their dignity. LN 1 further stated body checks were also needed to be done during showers and having missed showers meant missed opportunities to assess the resident for any skin issues.</p> <p>A review of Resident 1's bathing task report for the month of May 2025, indicated .Task: BATHING Tuesday Friday. Repeat 1 weeks. QShift [every shift]: *3p-11p . Bed bath/sponge were marked with a check for dates 5/7/25, 5/11/25, 5/14/25 and 5/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/30/25 at 4:31 p.m., with LN 2, LN 2 stated that residents should be getting their showers two or three times a week. LN 2 stated he was not aware of any shower refusals or preferences for Resident 1. LN 2 stated that the CNA staff were the ones documenting showers in the resident's chart and they would also fill out the shower sheets. LN 2 further stated that the resident's shower sheets were given to the nurse for any refusals or issues and then eventually submitted to the Director of Staff Development (DSD). LN 2 stated it was important for the resident to have their showers to prevent infections and pressure ulcers (injuries to the skin and underlying tissue).</p> <p>During a concurrent interview and record review on 5/30/25, at 4:46 p.m., with the DSD, the DSD stated that medical records could not pull the bathing task report for April 2025 because their system only allowed them to do the 30-day look back. The DSD provided copies of Resident 1's shower sheets titled Skin Review Form , dated 4/9/25, 4/25/25 and 5/29/25 and monitoring report titled Documentation Survey Report for the bathing task for the month of April and May 2025. The DSD confirmed that Resident 1 only had these three shower sheets and stated it was her expectation for the CNA staff to fill out Resident 1's Skin Review Form every time he received a shower or bed bath.</p> <p>A review of Resident 1's three shower sheets titled SKIN REVIEW FORM, indicated the following: form dated 4/9/25 indicated Resident 1 had a shower, form dated 4/25/25 indicated Resident 1 refused x 3 (refused three times), and form dated 5/29/25 indicated Resident 1 had a shower.</p> <p>A review of Resident 1's bathing task monitoring report for the month of April 2025, indicated codes entered for 4/28/25 as 05 (Setup or Clean-up assistance) during the evening shift, and for 4/29/25 as 02 (Substantial/maximal assistance) during the evening shift. The remainder of the codes noted on the monthly report for the other dates started from the initial admission date of 4/24/25 and ended at 4/30/25, with codes -97 (Not Applicable). The bathing task monitoring report for the month of May 2025 indicated codes entered on 5/7/25 as 04,B (04 - Supervision or touching assistance and B stood for bed bath/sponge), code entered on 5/9/25 as 01 (Dependent - full assist of staff), code entered on 5/11/25 as 02,B (02 - Substantial/maximal assistance and B stood for bed bath/sponge), code entered on 5/14/25 as 04,B (04 - Supervision or touching assistance and B stood for bed bath/sponge), and code entered on 5/19/25 as 04,B (04 - Supervision or touching assistance and B stood for bed bath/sponge). Resident 1 was admitted to the hospital from [DATE] to 5/27/25. The remainder of the codes for the rest of the month were codes -97 (Not Applicable) and -99 (Resident not available) for 5/23/25. Several dates without documentation were noted for dates 4/30/25 during night shift, 5/7/25 during evening shift, 5/9/25 during day shift, 5/10/25 during evening shift, 5/15/25 during evening shift, 5/17/25 during night shift, and 5/18/25 both evening and night shifts.</p> <p>During an interview on 5/30/25, at 4:49 p.m., with LN 3, LN 3 stated she did not know of any issues with Resident 1's showering. LN 3 stated the CNA should notify the nurse if a resident refuses their shower and the nurse would ask the resident three times but if the resident still refused then the nurse would document it in the resident's chart, the MD would be notified and a care plan would be initiated. LN 3 stated that the CNA would document in the resident's chart and would also turn in the skin review form for each shower or bed bath occurrence. LN 3 stated that it was the resident's right to get a shower or be offered alternatives, but sometimes due to staff shortages during the evening shift, some residents would not be able to get their showers on time and would then refuse since it was already too late in the day. LN 3 stated that during showers, it would be an opportunity for the CNA to check on the resident to see if there were any skin issues noted.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/3/25, at 3:02 p.m., with the DSD, the DSD verified Resident 1's shower schedule was on Tuesdays and Fridays. The DSD stated she could only view Resident 1's chart bathing report during the month of May 2025, which indicated a shower/bed bath was done on 5/7/25, 5/9/25, 5/11/25, 5/14/25, 5/19/25, 5/23/25 and 5/29/25. The DSD stated Resident 1 missed two out of the nine scheduled showers for the month of May 2025. When asked what type of bathing Resident 1 received during the dates noted, the DSD stated Resident 1's chart did not show whether these dates documented were a shower or a bed bath. The DSD verified Resident 1 only had three shower sheets dated 4/9/25, 4/25/25 and 5/29/25 and staff should have completed one for every scheduled shower or resident refusal. The DSD stated Resident 1's shower sheet dated 4/9/25 was possibly someone else's sheet or wrong month listed since Resident 1 was admitted to the facility at a much later date. When asked which LN signed off on the 4/9/25 shower sheet, the DSD confirmed she was the LN who signed off on it and stated it might have actually been on 4/29/25, and not 4/9/25. The DSD stated it was important to have the shower sheets and electronic charting completed to keep track and ensure the CNA staff were doing their daily tasks. The DSD stated the importance of providing residents with their showers were to maintain resident's dignity and to maintain cleanliness.</p> <p>During a concurrent interview and record review on 5/30/25, at 4:56 p.m., with the Director of Nursing (DON), the DON stated residents should have their showers a minimum of twice a week and staff were expected to follow the schedule. The DON confirmed Resident 1 only had three shower sheets dated 4/9/25, 4/25/25 and 5/29/25. The DON stated the shower sheet dated 4/9/25 should have been dated 5/9/25, since Resident 1 was admitted to the facility on [DATE] and it was just written wrong. The DON stated it was her expectation to have the shower sheets filled out by the CNA for each scheduled shower day or attempt for a shower with Resident 1. The DON reviewed the monitoring report titled Documentation Survey Report for the task bathing for April and May 2025 with the noted coding and multiple days without documentation and stated this documentation was not accurate. The DON stated the CNA staff were expected to follow the shower schedule and document based on it. The DON stated that it was important for the staff to have documented correctly in Resident 1's chart to ensure that the task was completed or done by the staff. The DON stated it was important for residents to get their showers to provide a home-like environment and to preserve their dignity.</p> <p>A review of facility's policy document titled, Bath, Shower/Tub, revised on 2/18, indicated .The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .Documentation . 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted with the shower/tub bath. 3. All assessment data (e.g.m any redenned areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data .</p>		