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	06/13/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on interviews and record reviews the facility failed to ensure that the nutritional needs were met for one out of nine sampled residents (Resident 4) on a pureed diet (food that is ground, pressed and/or strained to a soft, smooth consistency like a pudding) when Resident 4 was served potato chunks mixed in with mashed potatoes during the dinner meal service on 4/30/25. This failure had the potential for Resident 4 to aspirate (to have trouble swallowing normally when food enters the resident's airways or lungs causing coughing, difficulty breathing, discomfort, and sometimes choking) and could have also resulted in decreased meal intake. Findings: A review of Resident 4's admission Record indicated that Resident 4 was admitted to the facility in 2020 with diagnoses which included Alzheimer's Disease (the most common cause of dementia - a gradual decline in memory, thinking, behavior and social skills which causes the brain to shrink and brain cells to eventually die. These changes affect a person's ability to function), and Traumatic Subdural Hemorrhage (bleeding between the skull and the brain caused by injury). A review of Resident 4's Physician Order Summary , dated 7/18/24, indicated, .Order summary .Regular diet puree texture, Nectar/Mildly Thick Liquids (same consistency as eggnog or fruit nectar which provides extra time for a resident with dysphagia [difficulty swallowing] to swallow without choking) consistency, related to DYSPHAGIA .*Double portion per family's request* .Start Date: 7/18/2024 .End Date: Indefinite . A review of Resident 4's Care Plan Report dated 3/9/25, indicated, .Focus .nutrition risk secondary to . dysphagia, therapeutic diet .Aspiration/choking risk such as coughing while eating, shortness of breath .Goal . Resident will be free of aspiration/choking episodes .Interventions .Assist with meals as needed .Diet as ordered .Observe for signs of aspiration . A review of Resident 4's Social Service Progress Notes , dated 6/13/25 16:49, indicated, .Note: Care conference held in conference room on 6/13 @ 11:15 a.m. Participants .daughter .ombudsman (an independent advocate who assists residents with issues related to health, safety, and rights) .Dietary .DON . SSA (Social Services Assistant) .Dietary team reviewed the resident's dietary profile, which currently includes a regular pureed diet with double portions . (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant 1 (CNA) 1 on 6/13/25 at 11:55 a.m., CNA 1 stated that the Licensed Nurses (LNs) checked the residents' food trays before they were given to the residents to make sure that the correct diets were on the trays. CNA 1 stated that after the LNs confirmed that the diets were correct, the CNAs passed out the meal trays and did hand hygiene between each tray pass. CNA 1 stated that staff offered hand hygiene to the residents before they ate. CNA 1 stated that staff assisted residents with their meals as needed. CNA 1 stated that if residents needed to be fed, the CNAs fed the residents. CNA 1 stated that if the diet on the tray was not correct, the LNs called the kitchen to get the correct diet tray for the residents. During an interview with LN 1 on 6/13/25 at 12:00 p.m., LN 1 stated that the LNs checked the residents diet trays before the meals were given to the residents. LN 1 stated that the CNAs passed out the meal trays to the residents after the LNs confirmed that the meal trays were correct. LN 1 stated that if there was a meal that was not correct, the LN called the kitchen to get the correct meal tray for the resident. LN 1 stated that residents that ate their meals in the Activity Dining Room were assisted by CNAs and Restorative Nursing Assistants (RNAs, nursing aides that help residents to maintain their function and joint mobility), and if the residents ate in their rooms they were assisted by CNAs if family members were not here to assist. During an interview with LN 2 on 6/13/25 at 2:30 p.m., LN 2 confirmed that the LNs checked the meal trays before the CNAs passed out the meals to the residents. LN 2 stated that she remembered the incident where Resident 4 had large chunks of potatoes in her mashed potatoes on her dinner tray on 4/30/25. LN 2 stated that the potato chunks were mixed in with the mashed potatoes. LN 2 stated that she had to help remove the large chunks of potatoes from Resident 4's mouth so that she would not choke on them. LN 2 stated that she told the Dietary Manager and the Assistant Director of Nursing about the incident that day and ordered the correct meal tray for Resident 4. LN 2 stated that the Assistant Director of Nursing no longer worked at the facility. LN 2 stated that the correct meal tray was brought out by the Dietary Manager. During an interview with the Dietary Manager (DM) on 6/13/25 at 2:42 p.m., the DM stated that in-services were provided for the kitchen staff on diets and food textures. The DM stated that she was notified that Resident 4 received mashed potatoes on her dinner tray that had chunks of potatoes in it on 4/30/25 when she was at home. The DM stated that she came back to the facility when staff notified her. The DM stated that she saw Resident 4's food tray with the mashed potatoes with large hard chunks of potatoes in it. The DM stated that she interviewed the cook on duty that day to find out what happened. The DM stated that she asked the cook if she knew that Resident 4 was on a pureed diet. The DM stated that the cook on duty stated that she did not know where Resident 4's meal tray ticket was. The DM confirmed that Resident 4 was on a pureed diet. The DM stated that the cook that prepared the meal tray for Resident 4 was terminated that day. The DM stated that the risk for Resident 4 was choking. The DM confirmed that the facility policy was not followed. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of the facility menu for the week of 4/27/25 and the pureed diet menu for Resident 4 for the week of 4/27/25 with the DM and the Registered Dietitian Consultant (RD) in the RD office on 6/16/25 at 1:30 p.m., the RD stated that she was notified about the incident with Resident 4's meal tray on 4/30/25. The DM and the RD confirmed that the menu for dinner on 4/30/25 was citrus glazed grilled fish, rice pilaf, tomato cucumber salad, roll/margarine, seasonal fresh fruit, and beverage and/or water. The DM and the RD confirmed that the pureed diet dinner menu items for Resident 4 on 4/30/25 were pureed citrus glazed grilled fish, seasoned cream of rice, pureed cooked vegetable, pureed bread with margarine, pureed seasonal fresh fruit, nectar/mildly thick beverage, and nectar/mildly thick water. The RD stated that Resident 4 should have received a pureed diet for dinner on 4/30/25. The RD stated that in-service education was provided to the staff on pureed and textured diets. The RD stated that the risk of serving Resident 4 a meal tray with chunks of potato was choking. The RD stated that the cook who prepared Resident 4's pureed dinner was terminated. The RD confirmed that the facility policy was not followed. During an interview with CNA 2 on 6/16/25 at 3:02 p.m., CNA 2 stated that he knew Resident 4. CNA 2 stated that Resident 4 was one of his assigned residents. CNA 2 stated that he fed Resident 4 dinner unless her family was here. CNA 2 stated that he remembered that he fed Resident 4 on 4/30/25. CNA 2 stated that he began feeding Resident 4, then Resident 4's family came and finished feeding Resident 4. CNA 2 stated that he did not notice chunks of potatoes in the mashed potatoes. CNA 2 stated that Resident 4 had double portions during her meals. CNA 2 stated that he had not started feeding Resident 4 the mashed potatoes when the family came and took over feeding her. During an interview with the facility Administrator (ADM) on 6/16/25 at 4:05 p.m., the ADM stated that he was notified that Resident 4 had received mashed potatoes with hard chunks of potatoes on her dinner tray on 4/30/25. The ADM stated that he moved immediately to remove the cook after the incident on 4/30/25 since the cook had received in-service education on pureed diets and diet consistency. The ADM confirmed that Resident 4 was not served the diet prescribed by her physician. The ADM stated that the risk to Resident 4 if she ate chunks of potatoes was choking. The ADM confirmed that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Therapeutic Diets , revised October 2017, the P&P indicated, .Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences .4. A therapeutic diet is considered a diet ordered by a physician .as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet .5. If a mechanically altered diet is ordered, the provider will specify the texture modification .