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	06/24/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse by another resident for two of three sampled residents (Resident 9 and Resident 13) when:1 Resident 12 yelled and hit Resident 13 on the back of his head on 1/29/2025; and,2 Resident 12 and Resident 9 yelled and swung at each other on 5/9/25.These failures had the potential to cause physical and psychosocial harm to Resident 9 and Resident 13. Findings:1.A review of Resident 12's clinical record titled, admission RECORD, indicated that Resident 12 was admitted to the facility with diagnoses that included stimulant abuse (consumption of a drug that caused a state of alertness, attention, and energy) and unspecified dementia (a group of symptoms that negatively affected memory, thinking, and social abilities). A review of Resident 13's clinical record titled, admission RECORD, indicated that Resident 13's diagnoses included mild cognitive disorder with behavioral disturbance (a condition characterized by a slight decline in cognitive abilities, such as memory, language, or problem-solving skills) and unspecified mood disorder (symptoms are characteristic of a depressive disorder and caused clinically significant distress or impairment in social, occupational, or other important areas of functioning).A review of Resident 12's clinical record titled, Brief Interview of Mental Status (BIMS) Evaluation, (BIMS-an assessment tool facilities used to screen and identify memory, orientation, and judgement status of the resident) dated 5/26/25, indicated that Resident 12 had a score of 13 (Resident 12 was cognitively intact).A review of Resident 13's clinical record titled, Brief Interview of Mental Status (BIMS) Evaluation, dated 5/21/25, indicated Resident 13 had a score of 10 (Resident 13 had moderate cognitive impairment). A review of Resident 12's clinical record titled, eInteract Change of Condition Evaluation, dated 1/29/25, indicated, .Per CNA (Certified Nursing Assistant) witness, PT [patient] roommate [Resident 13] was trying to move by him [Resident 12] in their room, when PT [Resident 12] stated, 'Get the [expletive] out of my way' and was seen physically hitting his roommate [Resident 13] and pushing his wheelchair aggressively.During a concurrent observation and interview on 6/24/25, at 9:25 a.m., with Resident 12, Resident 12 acknowledged that he had been involved in a resident-to-resident altercation with Resident 13 on 1/29/25. Resident 12 became verbally aggressive during the interview and stated, It was a long time ago, now get the [expletive] out and stop bothering me with that [expletive]! Resident 12 refused to answer any more questions regarding the prior events. During an interview on 6/24/25, at 9:45 a.m., with Resident 13, Resident 13 stated that he recalled when Resident 12 hit him in January 2025. During a phone interview on 6/25/25, at 1:29 p.m., with CNA 6, CNA 6 stated that she was in the hall when she heard yelling coming from Resident 12 and Resident 13's room. CNA 6 stated she went to see what was going on and noted that Resident 13 was trying to get out of the room and asked Resident 12 to move out of the way. CNA 6 stated that Resident 12 became angry and yelled and swore at Resident 13. CNA 6 stated that she stepped into the room and spoke with both residents and then started to help Resident 13 move past Resident 12 to exit the room. CNA 6 stated it was at that time that Resident 12 stood from his wheelchair and struck Resident 13 on the back of the head. CNA 6 stated that Resident 12 had a history of verbal aggression towards residents and staff.During an interview on 6/24/25, at 2:17 p.m., with CNA 3, CNA 3 stated that she heard noises coming from Resident 12 and Resident 13's room. CNA 3 stated that she assisted CNA 6 in separating Resident 12 and Resident 13, but when CNA 6 assisted Resident 13 out of the way, Resident 12 stood from his wheelchair, reached out and hit Resident 13 on the back of his head. CNA 3 stated that Resident 12 had been aggressive towards other residents and staff.During a concurrent interview and record review on 6/24/25, at 11:42 a.m., with Licensed Nurse (LN) 5, Resident 12's care plans were reviewed. LN 5 stated a verbal report had been received on 1/29/25 from CNA 6 that Resident 12 struck Resident 13 on the back of the head. LN 5 stated that Resident 12 had a history of verbal aggression towards staff and residents. LN 5 confirmed that Resident 12 had a history of aggressive behaviors towards staff and residents, but a care plan had not been developed to address the aggressive behavior. LN 5 stated it was important for staff to have guidance on how to address Resident 12's aggression so that they could prevent a recurrence of the altercations. 2. A review of Resident 9's clinical record titled, admission RECORD', indicated that Resident 9's diagnoses included Cerebral Infarction (a medical condition that occurred when the blood flow to the brain was disrupted) and Encephalopathy (a group of conditions that causes confusion, memory loss, and personality changes).A record review of Resident 9's clinical record titled, Brief Interview of Mental Status [BIMS] Evaluation, completed on 5/9/25, indicated Resident 9's BIMS score was 14 (Resident 9 was cognitively intact) During

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to submit their investigation results of a resident-to-resident altercation that occurred on 5/9/25 involving two residents (Resident 9 and Resident 12) to the State Survey Agency within 5 working days .This failure had the potential to affect the staff and the residents' safety and had the potential to continue to endanger the wellbeing of the residents.Findings:During a concurrent interview and record review on 6/24/25 at 11:30am a facility provided undated document was reviewed with the Director of Nurses (DON). The document indicated that it was the 5 day follow up investigation regarding the altercation between Resident 9 and Resident 12. The DON confirmed the report indicated the incident had occurred on 5/8/25 and that there was no physical contact between the two men. The DON stated that the altercation actually happened on 5/9/25 and that Resident 9 and Resident 12 swung at each other. The DON was unable to confirm if the 5-day follow-up investigation had been sent to the State Survey Agency within the 5 working days. The DON stated the report was inaccurate and she would review it with the Administrator.During a phone conversation with the Administrator on 6/27/25 at 1:46pm, the Administrator was unable to confirm that the 5-day follow-up investigation report for the resident-to-resident abuse incident that occurred on 5/9/25 had been sent into CDPH. The Administrator stated that the 5-day follow-up investigation report should have been sent to the Survey agency.A review of facility provided policy titled Abuse Prohibition date 10/25/24 the policy indicated .The CED [Center Executive Director] or designee will: Report findings of all completed investigations within five (5) working days to the Licensing District Office.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to develop and implement person-centered comprehensive care plans (a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive) for two of three sampled residents (Resident 12 and Resident 13) when, 1. Resident 12's comprehensive care plan did not include the verbal and physically aggressive behaviors that Resident 12 displayed towards other residents and staff or personalized interventions to prevent or mitigate those behaviors from escalating including when Resident 12 yelled and hit Resident 13 on the back of his head on 1/29/2025, and when Resident 12 and Resident 9 yelled and swung at each other on 5/9/25; and, 2. Resident 13's comprehensive care plan did not reflect the risk of psychosocial harm Resident 13 may have experienced after a verbal and physical altercation with Resident 12 on 1/29/25; and, 3. Resident 12 was not referred to psychiatric services (a broad range of medical and therapeutic interventions designed to diagnose, treat, and prevent mental, emotional, and behavioral disorders) as care planned on 5/13/25.These failure's placed other facility residents at risk for being verbally and physically assaulted by Resident 12 and placed Resident 13 at risk for not receiving the care and interventions needed to address any psychosocial adverse outcomes from the assault by Resident 12.Findings:1.A review of Resident 12's clinical record titled, admission RECORD, indicated that Resident 12 was admitted to the facility with diagnoses that included stimulant abuse (consumption of a drug that caused a state of alertness, attention, and energy) and unspecified dementia (a group of symptoms that negatively affected memory, thinking, and social abilities). A review of Resident 12's clinical record titled, Brief Interview of Mental Status (BIMS) Evaluation, (BIMS-an assessment tool facilities used to screen and identify memory, orientation, and judgement status of the resident) dated 5/26/25, indicated that Resident 12 had a score of 13 (Resident 12 was cognitively intact).During a concurrent interview and record review on 6/24/25 at 2:08 p.m., with the Certified Nursing Assistant (CNA) 5, CNA 5 stated that on 5/9/25 she saw Resident 9 and Resident 12 yell at one another, told each other to get out of the way, and then Resident 9 and Resident 12 swung at each other. CNA 5 stated that the Director of Staff Development (DSD) had intervened and separated the two residents. CNA 5 further stated Resident 12 had displayed behaviors that consisted of verbal aggression towards residents and staff and physical behaviors that included pushing and shoving other residents. CNA 5 stated Resident 12's behaviors and interventions should have been reflected on the CNA Kardex (a summary of Resident 12's plan of care) or in Resident 12's Electronic Health Record (EHR) for the CNAs to review. CNA 5 confirmed that there were no behaviors or interventions listed on Resident 12's Kardex or in CNA tasks.During a concurrent interview and record review on 6/24/25, at 11:42 a.m., with the Licensed Nurse (LN) 5, LN 5 confirmed that Resident 12 had a tendency to become verbally and physically aggressive towards other residents when they were not getting out of his way fast enough. LN 5 stated that the care plan for Resident 12 should have been updated after the altercation with Resident 13 on 1/29/25 and after Resident 12 and Resident 9 yelled and swung at each other on 5/9/25. LN 5 confirmed Resident 12's care plan was never updated but should have included interventions that the staff could implement to prevent Resident 12 from becoming verbally and physically aggressive towards residents and staff. LN 5 stated that it was possible that had the care plan and interventions been developed, the resident-to-resident altercations may have been prevented.2. A review of Resident 13's medical record admission RECORD' indicated that Resident 13 had diagnoses that included a mild neurocognitive disorder with behavioral disturbance (a condition with a decline in memory, language, or problem-solving skills) and unspecified mood disorder (depressive disorder that can cause impairment in social, occupational, or other important areas of functioning).A review of Resident 13's BIMS evaluation completed on 5/21/25 had a score of 10 indicating that Resident 13 had moderate impairment for cognitive functioning.During a concurrent interview and record review on 6/24/25 at 11:42 with LN 5, LN 5 stated that a care plan was not developed for Resident 13 for the incident that occurred with Resident 12 on 1/29/25. LN 5 further stated a care plan should have been developed for Resident 13 to address any potential psychosocial adverse reactions.3. During a concurrent interview and record review on 6/26/25 at 3:38pm the SSD confirmed that Resident 12's care plan, initiated on 5/13/25 included an intervention for referral to the facility's psychiatric services provider. The SSD confirmed that Resident 12 was not referred to psychiatric services as care planned.During a concurrent interview and record review of Resident 12's and Resident 13's EHR on 6/24/25 at 2:37pm with the Director of Nurses (DON), the DON confirmed that Resident 12's care plan was not an accurate reflection of the

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice for one of 14 sampled residents (Resident 7), when required neurological checks (neurochecks - vital signs [heart and respiratory rate per minute, blood pressure, and temperature] and assessments done following a head injury) were not completed per policy. This failure resulted in Resident 7 not receiving the required neurochecks and had the potential to result in neurological issues going unrecognized, which could have negatively impacting Resident 7's health and well-being.Findings:A review of Resident 7's clinical record titled, admission RECORD, (contains clinical and demographic data) indicated Resident 7 was admitted to the facility with a diagnosis which included aphasia (a language disorder that affects a person's ability to communicate).A review of Resident 7's clinical record titled, Change in Condition Evaluation, dated 5/5/25, indicated, .Signs & Symptoms Identified . Other change in condition . Resident to resident altercation . 05/05/25 . Review Findings and Provider Notification . Per staff witness, PT (Resident 7) was seen getting physically stricked [sic] by another resident in the activity room . PT was noted with new bruising to facial area after incident . Neurological Status Evaluation . Is a neurological assessment relevant to the change in condition been reported . Not clinically applicable to the change in conditions being reported . During an interview with the licensed nurse (LN) 5, on 6/26/25, at 10:59 a.m., LN 5 stated that he did not recall if he did any neurochecks for Resident 7. LN 5 explained neurochecks were supposed to be taken for any kind of head injury. LN 5 stated the importance of the neurochecks was to assess if there were any new changes after head trauma. A review of Resident 7's clinical document titled, NEUROLOGICAL RECORD, dated 5/5/25, indicated vital signs and assessments (right and left pupil reaction to light) were supposed to be completed at 10:45 a.m., 11:00 a.m., 11:15 a.m., 11:30 a.m., 11:45 a.m., 12:15 p.m., 12:45 p.m.,1:15 p.m.,1:45 p.m., 2:15 p.m., and 2:45 p.m. The document indicated the vital signs were initiated at 3:15 p.m., approximately 4 hours after Resident 7 received a blow to the head. During an interview with the Director of Nursing (DON), on 6/24/25, at 4:15 p.m., the DON stated Resident 7's neurochecks should have been completed immediately after the head injury. The DON explained the importance of the neurochecks was to check if Resident 7 had or any physical or mental changes after the head injury. During an interview with the DON, on 7/3/25, at 1:20 p.m., the DON stated the altercation with Resident 7 occurred around 11 a.m., on 5/5/25.A review of the facility policy titled, NEUROLOGICAL ASSESSMENT (NEURO-CHECKS), revised 11/2012, indicated, .Neuro checks will be completed by a licensed nurse after a fall involving a blow or injury to the head .Collect neurological signs data as follows . Every 15 minutes for the first hour . Every 30 minutes for the next 4 hours . Every hour for the next 2 hours . Every shift for a total of 72 hours . Record findings on Neurological Signs Form .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 adequate supervision and implement preventative measures to reduce the risk of elopement (when a resident leaves the facility without supervision) for one of the three sampled residents who were at risk for elopement (Resident 1), when Resident 1 left the facility unsupervised on 1/1/25 and on 1/4/25. These failures had the potential for Resident 1 to experience serious harm or injury during an elopement.Findings:A review of Resident 1's clinical record titled, admission RECORD, indicated, she was admitted to the facility in late 2024, with diagnoses which included dementia (condition characterized by memory disorders, personality changes and impaired reasoning) and falls. A review of Resident 1's clinical record titled, Progress Notes, dated 12/31/24, at 3:14 PM, indicated .Social Services Progress Note .Met with resident in the front lobby, who was attempting to leave and return home. Resident insisted on leaving .Explained that it would not be safe to leave the facility without proper procedures .Resident was escorted .back to her room with belongings .A review of Resident 1's clinical record titled, .Change in Condition Evaluation ., dated 1/1/25, at 1:30 PM, indicated, .Pt [patient] left facility without notifying staff .At approximately 1320 [1:20 PM], daughter came to visit and noted that pt was not in her room and neither at the facility. Staff searched for pt .confirmed that pt is at the hospital brought by herself .Resident also has a history of trying to leave AMA [against medical advice] .A review of Resident 1's clinical record titled, Care Plan Report, initiated 1/1/25, indicated, .Focus .Resident has a history of leaving the facility without letting staff know .Goal .Resident will not leave the facility without an escort . The interventions dated for 1/1/25, indicated, .Interventions .Encourage resident to engage in services and establishment of an appropriate discharge plan .encourage resident participation in activity preferences . Allow time for expression of feelings .Personalize resident's room with familiar objects .A review of Resident 1's Progress Notes, dated 1/2/25, at 10:39 AM, indicated, Nurse has requested an order from the MD [medical doctor] for a wander Guard [device worn by a resident to activate exit door alarms and alert staff when the resident exits the facility] .Waiting for response .A review of Resident 1's Progress Notes, dated 1/4/25, at 1:35 PM, indicated, . Interdisciplinary Care Conference (meeting of facility healthcare professionals who assess and coordinate care) .Around 8:20 this morning staff observed the resident walking by the corner of [NAME] St and California St During interview resident said she wanted to go to [specific address] . consented to wearing a wander guard device .A review of Resident 1's Order Summary Report, indicated, . Wander Guard/Wander Elopement Device .Order Date 1/4/25 .During an interview on 6/24/25, at 1:34 PM, with Licensed Nurse (LN) 2, LN 2 stated Resident 1 frequently went outside and would not come back in. LN 2 stated residents who were at risk of, or had a history of, elopement were provided with wander guard devices. LN 2 further stated a physician's order was required before a wander guard was placed on a resident. LN 2 stated when a wander guard was ordered the care plan was updated to indicate its use. LN 2 further stated he did not remember if Resident 1 had a wander guard device.During an interview on 6/24/25, at 3:26 PM, with the Director of Nurses (DON), the DON confirmed Resident 1 had no interventions in place, after the elopement on 1/1/25, to prevent her from leaving the facility unattended. The DON stated it was her expectation that a wander guard device would have been ordered right away and placed on Resident 1 on 1/1/25. The DON further stated it was her expectation that a 1-1 staff member would have been assigned to Resident 1 until the wander guard order was received. The DON stated Resident 1 was at risk of injury or harm when she eloped.A review of a facility policy titled, Elopements, revised 2/21/25, indicated, .The residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering .implementing interventions to reduce hazards and risks .