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	07/11/2025

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 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)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to provide adequate monitoring and supervision in accordance with accepted professional standards for one of three sampled residents (Resident 1) when: Resident 1 had an instance of elopement (a patient who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected) from the facility on 6/23/25 and staff did not redirect him back in a timely manner; and, 2. Three of six fire alarms were found to be set on a timer as opposed to being in continuous mode.These failures had the potential to cause injury to Resident 1 and other at-risk residents residing within the facility. Findings:1. A review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility in 2024, with a diagnosis of, but not limited to, unspecified dementia, moderate, with other Behavioral Disturbance (an umbrella term for a decline in mental abilities severe enough to interfere with daily life. It affects memory, thinking, and behavior, and is not a normal part of aging).During a review of Resident 1's Elopement Evaluation, dated 5/12/25, the record indicated that Resident 1 had a history of wandering. Further review indicated that Resident 1 has verbally expressed the desire to go home, packed belongings to go home and stayed near an exit door.During a review of Resident 1's Care Plan Report, dated 5/12/25, the Care Plan Report, under the section, Interventions, indicated, . Monitor the resident's location with visual checks during routine care and as needed.During a review of Resident 1's Care Plan Report, dated 6/23/25, the Care Plan Report, under the section, Focus, indicated, . Resident wandered off from the facility due to confusion.During an interview on 7/3/25, at 9:50 AM, with the Director of Nursing (DON), the DON stated Resident 1 was able to walk and had a good ambulatory status (the act or process of walking or moving from place to place). The DON further stated the Housekeeper (HSK) 1 was by the door where Resident 1 eloped from and she did not notify anyone. The DON stated that HSK 1 no longer worked at the facility. The DON further stated Resident 1 was found about two blocks away from the facility.During an interview on 7/3/25, at 11:05 AM, with Licensed Nurse (LN) 1, LN 1 stated Resident 1 was not alert and oriented (a medical term describing a person's level of consciousness and cognitive function). LN 1 further stated Resident 1 would not be safe by himself outside the facility.During an interview on 7/3/25, at 11:29 AM, with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 was usually confused all the time.During a concurrent observation and interview on 7/3/25, at 12:44 PM, with the Director of Staff Development (DSD) and the Infection Preventionist (IP), the location where Resident 1 was found was observed. The approximate distance was 0.1 miles (unit of distance) or about 4 to 5 minutes walking distance from the facility. The IP stated she brought Resident 1 in her car once the DSD located him. During an interview on 7/3/25, at 1:32 PM, with the DSD, the DSD stated that HSK 1 was by Door 6 at the [NAME] Station. The DSD further stated the HSK 1 saw Resident 1 leave and did not tell anyone until the DSD approached her. The DSD explained that it was not safe for residents with a dementia diagnosis to leave the facility unattended.During an interview on 7/3/25, at 2:01 PM, with Resident 2, Resident 2 stated that he saw Resident 1 attempting to leave through Door 6 on 6/23/25, as his room was right next to Door 6 at the [NAME] Station. Resident 2 further stated that he was able to convince Resident 1 to turn around the first time he was by the door but was unsuccessful when Resident 1 came back later. Resident 2 stated he also pressed his call light (a communication tool used in healthcare settings to allow patients to request assistance from nurses or other staff) to get assistance for Resident 1, but no one came to assist in a timely manner.During an interview on 7/3/25, at 2:20 PM, with the DON, the DON stated residents with dementia should not leave the building as they could disappear and would not be able to help themselves. The DON further stated that it was a dangerous situation for Resident 1 to be in.During an interview on 7/11/25, at 1:05 PM, with the Administrator (ADM), the ADM stated HSK 1 was cleaning a room in the area and did not report to anyone that Resident 1 had left the building. The ADM further stated that when HSK 1 was questioned about the incident, she stated that she was a housekeeping staff member and was not part of the nursing staff. The ADM explained that HSK 1 and the Maintenance Director (MD) were no longer working at the facility. The ADM stated that he did not want residents with dementia to leave the building unattended as it posed a safety risk to them.During a review of the facility's policy and procedure (P&P) titled, Safety of Residents, dated 6/27/22, the P&P indicated, .Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Implementing interventions to reduce accident risks and hazards shall include the following. Communicating specific interventions to all relevant staff Ensuring that interventions are implemented

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of three sampled residents (Resident 1) when:1. The Elopement Assessment (a process to identify individuals at risk of leaving a supervised environment [like a care facility or school] without permission or supervision, potentially putting themselves in danger) was not completed after Resident 1 had eloped from the building; and,2. The Treatment Administration Record ([TAR] a document used in healthcare settings to keep track of the medications and treatments administered to patients) was not accurately completed for the months of June and July.These deficient practices had the potential to result in confusion in the care and services for Resident 1 and placed the resident at risk of not receiving appropriate care due to inaccurate and incomplete documentation. Findings:1. A review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility in 2024, with a diagnosis of, but not limited to, unspecified dementia, moderate, with other Behavioral Disturbance (an umbrella term for a decline in mental abilities severe enough to interfere with daily life. It affects memory, thinking, and behavior, and is not a normal part of aging).During a review of the facility reported 5-day summary report titled, Unusual occurrence, dated 6/24/25, the report indicated that the facility would conduct an updated elopement assessment for Resident 1.During a review of Resident 1's electronic health record (EHR), Resident 1's previous Elopement Evaluations, were reviewed. The EHR indicated that Resident 1 had previous Elopement Evaluations conducted on 5/1/24 and 5/12/25. No Elopement Evaluations were conducted after 6/23/25.During an interview on 7/11/25, at 1:05 PM, with the Administrator (ADM), the ADM confirmed that the elopement assessment was not completed for Resident 1. The ADM stated if the facility did not do the elopement assessments, high risk factors could be overlooked. The ADM further stated that the facility could not be proactive in preventing elopement instances if the assessments were not completed.During a concurrent interview and record review on 7/11/25, at 1:42 PM, Resident 1's Elopement Evaluations were reviewed with the Director of Nursing (DON). The DON confirmed that the facility did not complete an Elopement Evaluation at any time after 6/23/25 for Resident 1.During a review of the facility's policy and procedure (P&P) titled, Elopements, revised 2/21/25, the P&P indicated, .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.Documentation in the medical record will include: findings from nursing and social service assessments.During a review of the facility's P&P titled, Tab Alarms, Bed Alarms, Wanderguard System, revised 12/12/24, the P&P indicated, .Nursing Assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement.2. During a review of Resident 1's Care Plan Report, dated 7/3/25, the Care Plan Report under the section Interventions, indicated, .monitor wander guard q (every) shift for functioning.During a review of Resident 1's June TAR, dated 7/3/25, two instances of the Wander Guard system (a system designed to detect, track and alert staff when a patient or resident attempts to exit a designated area or enters an unauthorized zone checks) were not documented. The scheduled dates included 6/4/25 and 6/14/25.During a review of Resident 1's July TAR, dated 7/11/25, three instances of the Wander Guard system checks were not documented. The scheduled dates included 7/2/25, 7/6/25, and 7/9/25.During an interview on 7/11/25 at 1:05 PM with the ADM, the ADM stated that it was important for the staff to document daily if the Wander Guard devices were working properly. The ADM further stated that the facility may not know if the devices were functioning effectively if the documentation was incomplete.During a concurrent interview and record review on 7/11/25, at 1:42 PM, Resident 1's June TAR), dated 7/3/25 was reviewed with the DON. The DON confirmed that the TAR indicated, on 6/4/25 and 6/14/25, the administration dates for the following treatment were left blank without any licensed staff initials: Wander Guard/Wander Elopement Device #8077 to Right Ankle check Placement and function every shift check function.During a concurrent interview and record review on 7/11/25 at 1:44 PM, Resident 1's July TAR), dated 7/11/25 was reviewed with the DON. The DON confirmed that the TAR indicated, 7/2/25, 7/6/25, and 7/9/25, the administration dates for the following treatment were left blank without any licensed staff initials: -Wander Guard/Wander Elopement Device #8076 to Right Ankle check Placement and function every shift check function.The DON stated that it was important for the nurses to check placement of the Wander Guard devices to determine if the devices are working properly or