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	01/09/2026

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 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. Based on interview and record review, the facility failed to develop a comprehensive care plan for two of four sampled residents (Resident 1 and Resident 2) following a change of condition when: 1. Mucus was found in the stool of Resident 1 on 12/20/25; and, 2. Blood was found in Resident 2's urine (hematuria) on 1/2/26. These failures placed Resident 1 and Resident 2 at risk of not receiving appropriate and individualized care to meet their needs. 1. Review of Resident 1's medical record titled admission RECORD, indicated Resident 1 was admitted to the facility in late 2024 with diagnoses that included mild chronic kidney disease (long term condition when the kidneys are damaged and cannot filter waste and extra fluid from the blood), Parkinson's disease (a movement disorder of the nervous system) and dementia (a progressive state of decline in mental abilities). Review of Resident 1's medical record titled eINTERACT Change in Condition Evaluation - V 5.1, dated 12/20/25, indicated .Resident noted with loose mucus like stool. During a concurrent interview and record review on 1/7/26, at 2:30 p.m., with Licensed Nurse (LN) 1, LN 1 stated if a resident had a change in condition the nurse would need to complete reports which included updating the resident's care plans to include the new issue. LN 1 reviewed Resident 1's care plans and confirmed Resident 1 did not have a care plan initiated following the change of condition for the mucus in her stool on 12/20/25. LN 1 stated there should have been a care plan initiated for Resident 1's change of condition. LN 1 stated it was important to have initiated a care plan in order for the staff to be aware and to follow-up on health issues, and if the issue happened again, then the care plan would be used as a reference on what interventions were needed or if it was resolved. 2. Review of Resident 2's medical record titled admission RECORD, indicated Resident 2 was admitted to the facility in 2025 with diagnoses that included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland). Review of Resident 2's medical record titled eINTERACT Change in Condition Evaluation - V 5.1, dated1/2/26, indicated .Resident c/o [complained] that he is not feeling good.CNA [Certified Nurse Assistant] mentioned dark-colored urine on urinal [a plastic container designed to collect urine for individuals with limited mobility] and hematuria.During a concurrent interview and record review on 1/8/26, at 1:38 p.m., with LN 3, LN 3 stated Resident 2 had a change of condition on 1/2/26 because he complained he was not feeling good, urine had a foul odor, and had blood in the urine. LN 3 stated if a resident had a change of condition then a care plan should have been created by the nurse. LN 3 reviewed Resident 2's care plans and confirmed there was no care plan created for the change of condition on 1/2/26 for the hematuria. During a concurrent interview and record review on 1/9/26, at 3:00 p.m., with the Director of Nursing (DON), the DON confirmed both Resident 1 and Resident 2 did not have care plans created for their changes in condition. The DON stated it was her expectation for a care plan to have been created for every change of condition for each resident. The DON stated it was important to have created a care plan because it was specific, (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident centered, and individualized to the resident's care needed for the change of condition. Review of facility's policy titled Charting and Documentation, revised 7/2017, indicated .Policy Statement.All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.Policy Interpretation and Implementation.2. The following information is to be documented in the resident medical record: .d. Changes in the resident's condition; .f. Progress toward or changes in the care plan goals and objectives.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the timeliness of laboratory services ordered by the physician for four of four sampled residents (Resident 1, Resident 2, Resident 3 and Resident 4) when:1. Resident 1's stool sample testing result was delayed following a change of condition on 12/20/25; and, 2. Resident 2's STAT order (a physician's order that needs to be done immediately) results for a CBC (Complete Blood Count - a common blood test to check for an infection), BMP (Basic Metabolic Panel - a common blood test to measure fluid balance, blood sugar and certain electrolytes in the blood), and urinalysis with C&S (Culture and Sensitivity - urine testing to check for urinary tract infection and which germs are causing the infection) were delayed following a change of condition on 1/2/26; and,3. Resident 3's PT/INR (Prothrombin Time/International Normalized Ratio - a blood test to determine if the blood is clotting normally) ordered blood draws for December 2025 had delays in draw time (when the blood is ordered to be taken for a sample) and processing results; and, 4. Resident 4's PT/INR blood tests ordered in December 2025 had delayed draw times and delayed results. These failures risked delayed treatment and serious health issues for Resident 1, Resident 2, Resident 3, and Resident 4. Findings:1. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in late 2024 with diagnoses that included mild chronic kidney disease (long term condition when the kidneys are damaged and cannot filter waste and extra fluid from the blood), Parkinson's disease (a movement disorder of the nervous system) and dementia (a progressive state of decline in mental abilities). Review of Resident 1's medical record titled, .Change in Condition Evaluation ., dated 12/20/25, indicated .Resident noted with loose mucus like stool.MD ordered for stool sample to be collected. Review of Resident 1's medical record titled, Order Summary Report, indicated the following laboratory orders: a.Collect stool sample to test for C. Diff [Clostridium difficile - a bacteria that causes an infection of the intestine] one time only for mucus like stool.Order Date: 12/22/25.b.Collect stool sample to test for C. Diff one time only for mucus like stool.Order Date: 12/28/25.Review of Resident 1's Progress Notes indicated the following: c. 12/22/25 at 1218 (12:18 p.m.) - .Monitoring resident for mucus in stool.Stool collection pending. Resident has not had a BM at this time. d. 12/26/25 at 2318 (11:18 p.m.) - .Called [LABORATORY COMPANY NAME] to follow up on lab result at 2000 [8:00 p.m.] and 2300 [11:00 p.m.] no answer, left a message to call facility back. e. 12/27/25 at 2309 (11:09 p.m.) - .Lab called back on 12/27 at approx. 2305 [11:05 p.m.] , writer explained to lab rep that stool was picked up on 12/22, sample was picked up that same day. No result as of now. DON [Director of nursing] made aware. f. 12/28/25 at 2324 (11:24 p.m.) - .Per [LABORATORY STAFF NAME 1] with [LABORATORY COMPANY NAME], sample is no longer viable [good]. Writer explained that it was picked up after writer called lab and why facility wasn't notified ahead of time. [LABORATORY STAFF NAME 1] with [LABORATORY COMPANY NAME] is unaware of what is going on. MD [medical doctor] and DON was notified. g. 12/31/25 at 2101 (9:01 p.m.)- .Stool sample to be collected for C. Diff one time only.Spoke with [LABORATORY STAFF NAME 2] regarding specimen pick up for STAT [to be processed emergently/quickly] C. Diff lab order. h. 1/1/26 at 0443 (4:43 a.m.) - .Stool specimen been pick up by phlebotomist to be taken to laboratory for analysis. i. 1/3/26 at 2159 (9:59 p.m.) - .Writer called lab 3x [three times] to check on STAT lab result, no answer, left a message instead. RP made aware. j. 1/5/26 at 0006 (12:06 p.m.) - .Stool for C-diff result dated 1/4/26 was faxed to MD. During an interview on 1/7/26, at 3:20 p.m., with Licensed Nurse (LN) 2, LN 2 stated Resident 1 was reported to have mucus in her stool and was very smelly but did not have any other symptoms, so a change of condition report was completed on 12/20/25. LN 2 further stated Resident 1's doctor ordered a stool sample (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	test as routine since she did not have any other symptoms. LN 2 stated she called the laboratory right away on 12/22/25 and in less than 5 minutes they came to collect the sample. LN 2 further stated there was a delay in getting Resident 1's stool sample result and she had called the laboratory to follow-up. LN 2 explained the delays to the MD and LN 2 received a second order that was STAT on 12/29/25. LN 2 stated there was no alternative laboratory company to send specimens to if there was an issue with the current company. LN 2 further stated the risk of delayed test results would be the potential for Resident 1's roommate to have been exposed if she had an active infection. LN 2 confirmed there was a delay in Resident 1's stool sample results since the change in condition happened on 12/20/25 and the final test result was received on 1/4/26. LN 2 stated the importance of getting laboratory tests done on time was for the resident to receive the care needed and to prevent worsening of a health condition. During a concurrent interview and record review on 1/9/26, at 3 p.m., with the DON, Resident 1's medical record was reviewed. The DON stated stool sample orders were usually a one-time only order or could be STAT due to a resident's change of condition. The DON further stated the stool sample timeframe would depend on when the sample was obtained and the expectation was for the laboratory to collect the sample within 24 hours or less. The DON stated specimen laboratory results for stool samples would usually take 24 to 72 hours. The DON confirmed Resident 1 had a change of condition for the mucus in the stool on 12/20/25 and the stool specimen was picked up on 12/22/25. The DON further confirmed several attempts were made to follow up with Resident 1's stool sample results. The DON stated this was not her expectation from the laboratory company because they should have followed the timeframes. The DON confirmed there was a delay with Resident 1's stool sample testing. The DON stated the risk to Resident 1 due to the delay of the stool sample was worsening of her condition.2. Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility in 2025 with diagnoses that included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland).Review of Resident 2's medical record titled, .Change in Condition Evaluation ., dated 1/2/26, indicated, .Resident c/o [complained of] that he is not feeling good.CNA [Certified Nurse Assistant] mentioned dark-colored urine on urinal [a portable container designed to collect urine for individuals with limited mobility] and hematuria [blood in the urine].MD made aware via fax .Review of Resident 2's physician orders indicated the following: a. 1/3/26 - .STAT CBC with differential, BMP, UA with C&S .b. 1/3/26 - .Please follow up with the lab if blood draw is not completed yet or call for the STAT result .c. 1/6/26 - .Send to ED [Emergency Department] for further evaluation .Review of Resident 2's Progress Notes indicated the following: a. 1/3/26 at 2344 (11:44 p.m.) - .[HOSPITAL NAME 1] MD order: STAT CBC with differential, BMP, UA & CS.b. 1/3/26 at 2011 (8:11 p.m.) - .Writer called lab on 1/3/26 at 12:01 [no answer] answer. Faxed order instead requesting for STAT order. No one came. Writer called again and spoke with [LABORATORY STAFF NAME 3] requesting for another STAT order.c. 1/3/26 at 2315 (11:15 p.m.) - .Writer called lab to follow up on STAT blood work. Per [LABORATORY STAFF NAME 3], they will send someone in the facility asap [as soon as possible].Writer endorsed to NOC [night shift] nurse about following up STAT lab if no one came to draw blood.d. 1/4/26 at 1509 (3:09 p.m.) - .Urine sample collected and picked up by [LABORATORY COMPANY NAME] phlebotomist [professional who draws blood]. e. 1/5/26 at 0619 (6:19 a.m.) - .Resident wanted to know when he will be put on atb [antibiotic]. Explained MD needs urine and culture results to start him on atb.f. 1/6/26 at 1611 (4:11 p.m.) - .Pending labs [waiting for] UA C&S. g. 1/6/26 at 2309 (11:09 p.m.) - .At approx 1600 [4 p.m.], resident was seen by [MD NAME]. MD asked writer if UA/CS result came back, no STAT UA/CS result as of yet. Upon MD's assessment, pt looks flushed [a (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sudden temporary reddening of the skin].Due to resident not having UA/CS result yet, MD requested resident to be sent to ED [emergency department].h. 1/7/26 at 0032 (12:32 a.m.) - .Back from ED.Resident was sent to ED due to painful urination.hematuria as per reported by resident to MD.Per ED discharge diagnosis of Urinary Tract Infection with ABT therapy. During an interview on 1/7/25, at 3:20 p.m., with LN 2, LN 2 stated Resident 2 had a change of condition for having UTI symptoms and hematuria on 1/2/26. LN 2 further stated Resident 2's doctor ordered STAT UA with C&S, CBC and BMP and was not drawn until 1/4/26. LN 2 stated Resident 2's urine sample was collected on 1/4/26 and by 1/6/26 the results were still not received from the laboratory. LN 2 further stated on 1/6/26, Resident 2's MD ordered for Resident 2 to be sent out to the ER because of no results still. LN 2 stated Resident 2 came back the same day of going to the ER and it was confirmed he had a UTI at the hospital. LN 2 further stated it was important to receive laboratory results on time to prevent delays for a resident's care and to get the treatment needed right away. LN 2 stated the risk of delayed laboratory results would be septic shock [a serious life-threatening emergency condition], worsening of the resident's condition, and the need to be sent to the hospital. During a concurrent interview and record review on 1/9/26, at 9:55 a.m., with LN 3, LN 3 reviewed Resident 2's chart for his lab orders. LN 3 confirmed Resident 2's STAT labs were ordered on 1/3/26 for CBC, BMP and UA with C&S. LN 3 stated on 1/3/26, the staff could not obtain a urine sample in the morning and evening shift. LN 3 further stated on 1/3/26, the nurse called the laboratory, but no one came for the blood draw and finally on 1/4/26 the urine sample was collected by the laboratory. LN 3 stated on 1/6/26, Resident 2's MD ordered him to be sent out to the ER because there were still no results received from the laboratory. During a concurrent interview and record review on 1/9/26, at 3 p.m., with the DON, the DON stated the expected timeframe for STAT orders to be drawn would be between 4 to 8 hours and results within 24 hours or less. The DON further stated the expected timeframe for STAT UA with C&S would be for the laboratory company to have collected the sample within 24 hours or less and the results should have been received within 24 hours. The DON confirmed Resident 2's STAT order results were delayed because the laboratory company did not send the results timely. The DON further stated if Resident 2's samples were taken on 1/4/26, the results should have been received within 24 hours. The DON stated the laboratory should have sent the results sooner because they were STAT orders and Resident 2 ended up going to the ER on [DATE] because of the delay. 3. Review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility in 2021 with diagnoses that included spastic quadriplegic cerebral palsy (a severe form of cerebral palsy caused by early brain damage that results in weakness on all limbs, trunk and face) and developmental disorder of speech and language. Review of Resident 3's medical record titled, MEDICATION ADMINISTRATION RECORD, indicated the following orders for PT/INR testing for December 2025: a. 11/29/25 - .Warfarin Sodium oral tablet 5 mg [blood thinner medication].NEXT PT/INR on 12/01/2025.b. 12/03/25 - .Warfarin Sodium oral tablet 5 mg.NEXT PT/INR on 12/08/2025.c. 12/12/25 - .Warfarin Sodium oral tablet 5 mg.NEXT PT/INR on 12/16/25.d. 12/18/25 - .Warfarin Sodium oral tablet 5 mg.NEXT PT/INR on 12/24/25.Review of Resident 3's medical record titled, Order Summary Report, indicated the following PT/INR orders for December 2025:a. 11/27/25 - .LAB: PT/INR on 12/01/2025. b. 12/11/25 - .PT/INR STAT for COUMADIN [brand name for Warfarin] DOSING.Start Date: 12/11/25.c. 12/12/25 - .STAT PT/INR on 12/16/2025. Pls call lab for STAT PT/INR.d. 12/28/25 - .STAT: PT/INR one time only for 4 days.Start Date: 12/28/2025.e. 12/29/25 - .STAT: PT/INR STAT.Start Date: 12/29/2025.Review of Resident 3's Progress Notes for the month of December 2025, indicated the following: a. 12/11/25 at 2313 (11:13 p.m.) - .Called [LABORATORY COMPANY NAME] about PT/INR results. Confirmed with [LABORATORY STAFF NAME 4] from [LABORATORY STAFF NAME 5] (lab coordinator) that (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PT/INR was drawn on 12/8. Awaiting results. MD aware, continue Warfarin 5 mg dose until next PT/INR. Endorsed to oncoming nurse.b. 12/12/25 at 0444 (4:44 a.m.) - .Phlebotomist in to draw stat pt/inr on resident @0330 [3:30 a.m.]. Made phone call to [LABORATORY COMPANY NAME] @ 0445 [4:45 a.m.] to f/u [follow-up] on pt/inr results. No answer at this time. c. 12/12/25 at 0701 (7:01 a.m.) - .Made phone call to [LABORATORY COMPANY NAME] to f/u on 12/2 pt/inr. No answer. Endorsed to next shift to f/u with results. d. 12/12/25 at 2223 (10:23 p.m.) - .MD reviewed lab results and ordered warfarin 10 mg PO at HS [at bedtime] x 2 days [for two days] and then 5 mg PO in the evening thereafter. Next PT/INR on Tuesday 12/16/25. e. 12/16/25 at 0545 (5:45 a.m.) - .Laboratory work: PT/INR, done today.f. 12/19/25 at 0652 (6:52 a.m.) - .Made lab req [request] for pt/inr draw on 12/24/25. Placed in lab binder.g. 12/24/25 at 0452 (4:52 a.m.) - .Phlebotomists unable to obtain sufficient blood for pt/inr draw.h. 12/26/25 at 2324 (11:24 p.m.) - .LN requested for STAT PT/INR per MD. LN called at 2000 [8 p.m.], 2300 [11 p.m.] and 2324 [12:24 p.m.] no answer, faxed requisition instead. i. 12/27/25 at 2338 (11:38 p.m.) - .Lab called back on 1227 [12:27 a.m.] at approx 2305 [11:05 p.m.], writer explained to lab rep [representative] that it's a STAT order and to call [NAME] when the result is available and fax to facility ASAP. NOC nurse made aware. DON notified. j. 12/28/25 at 0657 (6:57 a.m.) - .Called lab at 0700 [7 a.m.] to f/u on pt/inr results. No answer and phone line cut out. No results on portal in system either.k. 12/28/25 at 2347 (11:47 p.m.) - .Called [LABORATORY COMPANY NAME] and per [LABORATORY STAFF NAME 1], no result yet. Another STAT PT/INR was requested d/t [due to] no result coming from the lab. MD and DON made aware.l. 12/29/25 at 0455 (4:55 a.m.) - .Stat PT/INR drawn by phlebotomist @0400 [4 a.m.].m. 12/30/25 at 1027 (10:27 a.m.) - .Faxed to MD to review, awaiting any new orders. Nurse aware. n. 1/2/26 at 0649 (6:49 a.m.) - .PT/INR laboratory work, not done, per phlebotomist, she can't draw and another phlebotomist will come and do it at around 10:00 am today.During a concurrent interview and record review on 1/7/26, at 11:42 a.m., with LN 1, LN 1 reviewed the [NAME] station laboratory binder log form for Resident 3. LN 1 stated UTO meant unable to obtain and Resident 3 was known to be a hard stick (unable to obtain blood sample). LN 1 further stated Resident 3 got his PT/INR testing done weekly because he was on the medication Warfarin. LN 1 stated the laboratory results would be faxed over to the facility from the new laboratory company they were using. LN 1 explained the facility used to receive laboratory results online through the resident's chart with the old company. LN 1 stated the new laboratory company took a bit longer to receive PT/INR test results. During an interview on 1/7/26, at 3:20 p.m., with LN 2, LN 2 stated Resident 3's PT/INR testing was done weekly and the turnaround time for PT/INR results were usually received right away. LN 2 further stated there was a change in the laboratory company, and since then the nurses have had to follow-up and results have been taking a while. LN 2 stated they were told that the laboratory results would be integrated into the resident's electronic chart but had not been integrated yet so the lab company has to manually fax the results. LN 2 further stated the nurses had to follow up a couple of times due to the delays in getting the laboratory results. LN 2 stated she did not know of any back-up or alternative laboratory that the facility used. During a concurrent interview and record review on 1/9/26, at 9:55 a.m., with LN 3, Resident 3's medical chart was reviewed. LN 3 stated it was important for Resident 3's PT/INR to be done to ensure he was getting the right dose of his Warfarin medication because the MD would adjust the dose based on the test result. LN 3 further stated on 11/27/25, the MD reviewed Resident 3's PT/INR results and the next test would be on 12/1/25. LN 3 stated there was no documentation found for 12/1/25 until 12/11/25 when the nurse called the laboratory to follow-up on the result for PT/INR drawn on 12/8/25. LN 3 further stated on 12/12/25 a phlebotomist came to draw STAT order for PT/INR at 3:30 a.m. LN 3 further stated at 4:45 a.m., another (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse followed up on the PT/INR results, but no one answered at the laboratory. LN 3 explained the facility received results during the evening shift. LN 3 stated Resident 3 had a scheduled PT/INR order on 12/24/25 and the phlebotomist came and could not obtain a sufficient blood sample. LN 3 further stated on 12/26/25, a STAT PT/INR was requested, and the nurse made three calls to the laboratory with no answer. LN 3 stated on 12/27/25, the laboratory called back and the nurse explained the STAT PT/INR order was sent and the DON was then notified. LN 3 further stated on 12/28/25, the nurse called the laboratory to follow-up and the phone line cut out. LN 3 explained that the facility still did not receive the results during the evening shift and another STAT PT/INR was requested and both MD and DON were made aware. LN 3 stated the risk of not getting the laboratory tests timely would be the resident receiving the wrong dose and would cause complications such as blood clots (blood clots can lead to risks like deep vein thrombosis (DVT, blood clot in an extremity like the leg), pulmonary embolism (blood clot in the lung), stroke (blood clot in the brain), or severe bleeding.During a concurrent interview and record review on 1/9/26, at 3 p.m., with the DON, Resident 3's medical records were reviewed. The DON stated the expectation for routine PT/INR blood to be drawn would be within 24 hours and if the order was STAT then it should have been drawn between 4 to 8 hours. The DON further stated the results should have been received in 24 hours or less. The DON confirmed Resident 3 had weekly testing of PT/INR and the schedule would depend on the test results. The DON further confirmed Resident 3's orders and progress notes indicated there were delays in getting Resident 3's PT/INR results from the laboratory. The DON stated there had been issues with getting test results from the new laboratory company and the alternative plan would be sending the resident out to the ER. The DON further stated there was no alternative laboratory company at the time. 4. Review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility in 2025 with diagnoses that included atrial fibrillation (an irregular heart rhythm condition) and congestive heart failure (a long-term condition when the heart could not pump blood enough). Review of Resident 4's progress notes for the month of December 2025 indicated the following: a. 12/3/25 at 2314 (11:14 p.m.)- .The Change of Condition/s reported on this CIC [change in condition] Evaluation are/were:.Called [HOSPITAL NAME 1] and informed that there is no current doses order for warfarin. Last pt/inr draw was on 12/01/25 .New order carried out to document med error, if coumadin was not put on hold, but coumadin was missed due to med error then give warfarin 2 mg now, rechecked INR @ 6am morning STAT and notify coumadin clinic and SNF [skilled nursing facility] MD and follow coumadin orders.Stat pt/inr blood draw called over to [LABORATORY COMPANY NAME].b. 12/4/25 at 0635 (6:35 a.m) - .On monitoring for med error of missed doses of warfarin.No adverse effects noted.Phlebotomist in @0400 [4 a.m.] to draw stat pt/inr. Pending lab results. Endorsed to AM LN to f/u lab results and send to coumadin clinic once received and f/u with coumadin clinic for next dose.c. 12/4/25 at 2302 (11:02 p.m.) - .Followed up with [LABORATORY COMPANY NAME] 5 x [five times] for the stat pt/inr lab.but per operator [LABORATORY STAFF NAME 3] and [LABORATORY STAFF NAME 2], the result is not out yet. Called [HOSPITAL NAME 1] and also informed what is going on since resident did not [sic] warfarin dose for today x 2. Per RN [registered nurse], she will contact the [HOSPITAL NAME 1] doctor and will fax over whatever the order will be to this facility. Will endorse to oncoming shift to follow up.d. 12/4/25 at 2359 (11:59 p.m.) - .Ordered carried out to continue coumadin 2 mg.report the INR to the coumadin clinic tomorrow 12/05/25, and monitor s/s [signs and symptoms] of bleeding .e. 12/5/25 at 0602 (6:02 a.m.) - .Called [LABORATORY COMPANY NAME] to follow up on the results of the Stat order for PT/INR that was drawn 12/4/2. No results yet at this time,. Will follow up again.f. 12/5/25 at 0632 - .Phlebotomist in @0320 [3:20 a.m.] asking if stat pt/inr was already done. Per report it was done already but unable (continued on next page)

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	056324	A. Building B. Wing	01/09/2026

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to locate the stat pt/inr requisition [labroatory slip] for 12/4/25. Phlebotomist called lab center and lab was drawn for cbc, cmp and pt/inr on 12/4/25 but facility requisition only states cbc and cmp. LN made requisition form for pt/inr. Blood work drawn for pt/inr this am.g. 12/5/25 at 2328 (11:28 p.m.) - .Correction: on 12/04/25 new order from [HOSPITAL NAME 1] to administer warfarin 2 mg and given @ 2200 [10 p.m.]. Per emar [electronic medication administration record], medication was administered around 0115 am. DON and MD notified of medication administration time change. New order carried out for warfarin 2 mg to be administered for 12/05/25. Received another result dated for 12/02/25 @2151 [9:51 p.m.].Review of Resident 4's medical records from [HOSPITAL NAME 1] titled, ANTICOAGULATION-SNF COMMUNICATION FORM, indicated, .Was there a.INR test done since the last INR? .INR Result: 1.2.Date/Time: 12/4.Were there any missed doses of warfarin since the last INR? .Provide dates and details of missed warfarin doses: 12/1, 12/2 and 12/4.During a concurrent interview and record review, on 1/9/26. At 11:07 a.m., with LN 4, LN 4 reviewed Resident 4's chart. LN 4 stated Resident 4 got his PT/INR tested weekly. LN 4 further stated the laboratory results have been taking a while, and the nurses had been calling for the results. LN 4 explained they had to wait for the faxed results and then faxed the results over to the coumadin clinic. LN 4 confirmed on 12/3/25, Resident 4 had a change of condition report that stated medication error for a missed Warfarin dose. LN 4 stated the notes indicated only one missed dose on 12/3/25 and a STAT PT/INR was ordered on 1/4/25. LN 4 further stated she was not aware of what happened, but it was a known fact that there were delays in getting Resident 4's PT/INR results. LN 4 stated on 12/4/25, the phlebotomist came in to draw the STAT PT/INR and a new dose of Warfarin was ordered on 12/5/25. LN 4 further stated the facility should have received a STAT order result on the same day or within 24 hours. LN 4 stated it was important to have timely receipt of laboratory results because if the result was abnormal, then the resident's condition might worsen, and could cause delays in care. LN 4 further stated if Resident 4 missed a dose of Warfarin, then he would need to wait for a new test result to get the medication dosing needed from the coumadin clinic. LN 4 explained the risk to Resident 4 with delays in testing results would be worsening of his condition and blood clots. During a concurrent interview and record review on 1/9/26, at 12:05 p.m., with the DON, Resident 4's medical records were reviewed. The DON stated Resident 4 was under the [HOSPITAL NAME 1] and once his laboratory test results were received, it would be faxed over to the coumadin clinic for the medication orders. The DON further stated she was notified by the nurse that Resident 4's change of condition issue on 12/3/25 was due to the missed Warfarin doses on 12/1/25 and 12/2/25 because his PT/INR draw was not done on 12/1/25. The DON stated she had told the nurse to ask for a STAT PT/INR order and the MD was notified. The DON further stated she was told by the MD to wait for the STAT PT/INR results. The DON explained that she was made aware by the LN that she called the laboratory five times to follow-up. The DON stated the facility had no issues with the old laboratory company because it was established and routine, and due to the changes with the new company it had been a struggle. During a follow-up concurrent interview and record review on 1/9/26, at 3 p.m., with the DON, Resident 4's hospital records were reviewed. The DON confirmed Resident 4's hospital record indicated the missed Warfarin doses on 12/1/25, 12/2/25 and 12/4/25. The DON stated Resident 4's missed Warfarin doses were due to the laboratory issue. The DON further stated the laboratory did not complete Resident 4's PT/INR draw for 12/1/25 and there were no current doses due to the pending result at the time. The DON stated the risk of missed medication doses for Resident 4 was the risk of blood clots. During an interview on 1/9/26, at 5:32 p.m., with the Administrator (ADM), the ADM stated it was his expectation for the laboratory company to have followed their contract for the completion of testing results. The ADM further stated if there were (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delays, the laboratory should have communicated with the facility for any barriers and what their plans were to address the issue. The ADM stated the facility's alternative if the laboratory company could not provide results would be to find a new provider. The ADM further stated it was important to have laboratory results timely so care was not delayed for the residents. During a phone interview on 1/21/26, at 10:05 a.m., with [LABORATORY STAFF NAME 4], [LABORATORY STAFF NAME 4] stated they have a partnered laboratory that caters to the Stockton area facilities. [LABORATORY STAFF NAME 4] stated the facility orders were received from facilities by email or fax. [LABORATORY STAFF NAME 4] stated once an order was received, they would call the facility to confirm the order and would then send a phlebotomist onsite. [LABORATORY STAFF NAME 4] stated the routine PT/INR orders were usually endorsed during the day of the order and the phlebotomist would also go on the same day to the facility to draw blood from the resident. [LABORATORY STAFF NAME 4] explained for STAT orders they had specialized order processing and it would immediately get sent to their manager based on priority. Review of the facility's contract with [LABORATORY COMPANY NAME] titled California Professional Diagnostics Services Agreement, effective date 11/1/25, indicated .2. [LABORATORY COMPANY NAME] Services and Responsibilities.Laboratory send out results will be made available to the facility when received from the reference laboratory and may vary depending on the test ordered.For all STAT orders provided by the physician, [LABORATORY COMPANY NAME] will prioritize and expedite the services and return results to the facility as promptly as possible. The facility will make its best efforts to limit STAT orders for critical conditions, as deemed absolutely necessary by the physician.Review of facility's undated policy titled, Lab and Diagnostic Test Results - Clinical, indicated, .Protocol.Assessment and Recognition.1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Referral of Problems and Concerns About the Process.1. Physicians or nurses who have concerns about how test results have been handled or reported should communicate such concerns to the DON and/or Medical Director.a. Such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation.

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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. Based on interview and record review, the facility failed to ensure two of four sampled residents (Resident 1 and Resident 2) medical record's contained an accurate representation of their progress and/or their decline in health status after a change in condition when:1. Mucus was found in the stool of Resident 1 on 12/20/25 and nursing staff did not assess and document on the progress and/or decline in Resident 1's condition every shift; and, 2. Blood was found in Resident 2's urine (hematuria) on 1/2/26 and nursing staff did not assess and document on the progress and/or decline in Resident 2's condition every shift. These failures risked missing any changes or deterioration in the physical, mental, or psychosocial conditions of Resident 1 and Resident 2 after their change of condition. Findings:1. Review of Resident 1's medical record titled admission RECORD, indicated Resident 1 was admitted to the facility in late 2024 with diagnoses that included mild chronic kidney disease (long term condition when the kidneys are damaged and cannot filter waste and extra fluid from the blood), Parkinson's disease (a movement disorder of the nervous system) and dementia (a progressive state of decline in mental abilities). Review of Resident 1's medical record titled eINTERACT Change in Condition Evaluation - V 5.1, dated 12/20/25 at 1240, indicated .Resident noted with loose mucus like stool. Review of Resident 1's nursing follow-up documentation or monitoring following the change of condition on 12/20/25, indicated the following completed reports: a. 12/20/25 at 2254 - Follow-up Documentation b. 12/21/25 at 2148 - Follow-up Documentation c. 12/22/25 at 1218 - Follow-up Documentation Review of Resident 1's progress notes on monitoring following the change of condition on 12/20/25, indicated one note regarding the change of condition dated 12/21/25 at 0654 .Resident is alert and verbally responsive. On monitoring for mucus in the stool. During a concurrent interview and record review on 1/7/25, at 2:30 p.m., with Licensed Nurse (LN) 1, LN 1 stated a resident should be monitored every shift for 72 hours following a change of condition, and nurses should document on the report called Follow-up documentation. LN 1 reviewed Resident 1's chart and verified a change of condition report was done on 12/20/25 with three Follow-up documentation reports dated 12/20/25 during PM (evening) shift, 12/21/25 during PM shift and 12/22/25 during AM (morning) shift. LN 1 further reviewed Resident 1's chart and verified there were missing monitoring reports for other shifts following the change of condition on 12/20/25 (a total of 6 follow up documentation reports were missing in the 72 hour period). LN 1 stated Resident 1's chart showed a red alert that read the follow-up documentation reports should have been done every 8 hours. LN 1 stated Resident 1's monitoring following a change of condition should have been done every shift for the 72-hour timeframe. LN 1 stated it was important to monitor a resident every shift following a change of condition to be aware of the resident's status and to ensure whether the condition got better or if it had worsened. 2. Review of Resident 2's medical record titled admission RECORD, indicated Resident 2 was admitted to the facility in 2025 with diagnoses that included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland).Review of Resident 2's medical record titled eINTERACT Change in Condition Evaluation - V 5.1, dated1/2/26 at 2201, indicated .Resident c/o [complained] that he is not feeling good.CNA [Certified Nurse Assistant] mentioned dark-colored urine on urinal and hematuria [blood in the urine].Review of Resident 2's follow-up documentation or monitoring following the change of condition on 1/2/26 indicated the following completed reports: a. 1/3/26 at 0713 - Follow-up Documentation b. 1/3/26 at 2315 - Follow-up Documentation c. 1/5/26 at 0619- Follow-up Documentation Review of Resident 2's progress notes on monitoring following the change of condition on 1/2/26, indicated one progress note dated 1/4/26 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 0202 .Alert and responsive.Resident unable to provide urine sample. Resident voided with little amount of urine.Monitored closely.During a concurrent interview and record review on 1/8/26, at 1:38 p.m., with LN 3, LN 3 stated Resident 2 had a change of condition on 1/2/26 because he complained he was not feeling good, had foul smelling urine, and had blood in the urine. LN 3 stated the change of condition process included monitoring the resident every shift for the next three days. LN 3 further stated a resident's condition could change quickly, the resident could be fine in the morning and could have a change by the evening shift. LN 3 reviewed Resident 2's change of condition monitoring and confirmed she only saw two shifts documentation done on 1/3/26, no monitoring report on 1/4/26 and only one report for 1/5/26 (a total of 6 missing follow up documentation reports were missing in the 72 hour period). LN 3 confirmed there should have been at least three follow-up documentation reports for each day of the three-day monitoring period. LN 3 further stated the importance of monitoring Resident 2 every shift for the three days following the change of condition was to have known his status and if the staff were following up on it. During a concurrent interview and record review on 1/9/26, at 3:00 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1 and Resident 2's chart and verified the missing documentation for the 72-hour timeframe, every shift, monitoring period following the change of conditions for both Resident 1 and Resident 2. The DON stated it was her expectation for a resident to have the 72-hour monitoring as part of the change of condition process documented. The DON further stated the staff should have documented on a progress note or completed the Follow-up documentation report every shift for the 72-hour timeframe. The DON stated the risk of not completing the resident monitoring every shift for the 72-hour timeframe would be not catching any subtle changes in the resident and the staff might miss something that could potentially lead to worsening of the resident's condition. Review of facility's policy titled Charting and Documentation, revised 7/2017, indicated .Policy Statement.All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding resident's condition and response to care. Policy Interpretation and Implementation. 2. The following information is to be documented in the resident medical record: .d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident.