

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 02/11/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on interview and record review the facility failed to ensure reasonable accommodation of needs were met for one of three sampled residents (Resident 2) when Resident 2's call light (device used to communicate a need for assistance) was tampered with making in nonfunctional. This failure had the potential risk for Resident 2 to have unmet needs and to suffer physical and psychosocial harm due to the inability to call for assistance. Findings: A review of Resident 2's admission RECORD, indicated she was admitted to the facility with diagnoses which included dementia (condition that causes a decline in cognitive abilities such as memory, thinking, reasoning, and problem solving) and blindness (inability to see). During an interview on 2/11/26 at 1:00 PM with Certified Nurse Assistant (CNA) 4, CNA 4 stated when she delivered snacks to Resident 2, during the middle of the PM shift (3:00 PM through 11:00 PM) on 2/4/26, she noticed there was a plastic item between the call light plug and the outlet. CNA 4 stated she notified the licensed nurse (LN) right away. During an interview on 2/11/26 at 1:39 PM with LN 3, LN 3 stated she had noticed Resident 2's call light was not on as much as usual during the PM shift on 2/4/26. LN 3 further stated when she assessed the call light, she noticed there was a plastic tube between the call light plug and the outlet. LN 3 stated she removed the plastic tube and verified Resident 2 was okay. LN 3 stated she plugged the call light into the outlet without the plastic tube and the light worked. LN 3 further stated she reported the call light concern to her supervisor on 2/9/26 when she again saw a plastic tube in Resident 2's room. During an interview on 2/11/26 at 3:38 PM with the Director of Nurses (DON), the DON stated LN 3 reported Resident 2's call light concern on 2/9/26 when she observed another plastic tube on Resident 2's bedside table. The DON stated it was her expectation that staff would report the tampered call light when they noticed it. During a review of the facility policy and procedure titled, Answering the Call light, revised 1/024/24, the policy indicated, .The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Be sure the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056324	If continuation sheet Page 1 of 4

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure they had an effective system in place to investigate and compensate residents for missing items when one of three sampled residents (Resident 1) reported missing items on 12/19/25 and the allegation was not investigated until 2/11/26. This failure caused Resident 1's missing items to not be returned or replaced and had the potential to negatively affect her psychosocial wellbeing. Findings: A review of Resident 1's admission RECORD, indicated she was admitted to the facility with diagnoses which included adjustment disorder with anxiety (a condition that causes a person to feel worried, anxious, and overwhelmed). During a review of Resident 1's clinical progress note titled, Social Service Progress Note, dated 12/19/25 at 10:48 AM, the progress note indicated, .spoke with [Resident 1's] son.who called about missing clothes 5 pairs of sweat [sic] some shirts and blue [NAME] jacket.SSD [social services director] will follow up with Resident 1. During an interview on 2/11/26 at 12:14 AM with Resident 4 in the room shared by Resident 1 and Resident 4, Resident 4 stated Resident 1 had been transferred to the hospital and was not able to be interviewed. Resident 4 further stated Resident 1's clothes were noted lost and the facility could not find them. During an interview on 2/11/26 at 4:15 PM with the Administrator in Training (AIT), the AIT stated when Resident 1's items were reported as missing on 12/19/25, the facility staff should have searched the facility for the items. The AIT further stated if the items were not located, a theft and loss report should have been filed to begin the investigation process. The AIT confirmed the theft and loss process was not initiated for Resident 1's belongings prior to 2/11/26. The AIT stated residents in the facility had a limited number of belongings and it was their right to retain those items. The AIT further stated it was the facility's responsibility to make sure their theft and loss protocol was followed due to the negative effect the loss could have on the psychosocial wellbeing of Resident 1. During an interview on 2/12/26 at 1030 AM with the Dialysis Social Worker (DSW), the DSW stated Resident 1's family member reported that Resident 1 was so upset about her missing clothes that she wanted to call the police. The DSW further stated the facility told the family they would reimburse Resident 1 two hundred dollars (\$200), but the facility had not provided the reimbursement. During a review of the facility's policy titled, Investigating Incidents of Theft and Loss, revised 4/17, the policy indicated, .All reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated.Residents have the right to be free from theft and loss.When an incident of theft and/or misappropriation of resident property is reported, the administrator will appoint a staff member to investigate the incident. During a review of the facility's undated policy titled, Dignity, the policy indicated, Residents are treated with dignity and respect at all times.Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem.Residents' private space and property are respected at all times.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to ensure professional standards of quality care were met for one of three sampled residents (Resident 2) when Resident 2's blood sugar was not monitored before meals and Resident 2's scheduled medications to control blood sugar were not administered in a timely manner. These failures had the potential to negatively affect the therapeutic benefits of the medications prescribed to Resident 2 and had the potential for Resident 2 to receive unnecessary doses of insulin (injectable medication used to manage blood sugar levels). Findings: A review of Resident 2's admission RECORD, indicated she was admitted to the facility with diagnoses which included type 2 diabetes mellitus (a chronic condition in which the body has trouble controlling blood sugar levels). During an interview on 2/11/26 at 11:34 AM with Resident 2, Resident 2 stated she had to wait a long time to receive her medications. Resident 2 further stated sometimes when she requested a medication the staff and said OKAY and then Resident 2 stated, the thought was wiped from their minds when they left the room. During a review of Resident 2's clinical document titled, Care Plan Report, dated 9/29/25, the report indicated, .Focus.The resident is at risk for hyperglycemia [elevated blood sugar] r/t [related to] Disease process Diabetes Mellitus Type 2 (DM 2). Interventions. Educate regarding medications and importance of compliance. Finger Stick Blood Sugar (FSBS) [test in which a finger is pricked with a small needle to obtain a drop of blood to determine the blood sugar level] as ordered with regular insulin [medication used to regulate and lower blood sugar levels]. Follow MD orders with new insulin regimen/sliding scale [insulin dose adjustment based on blood sugar level]. During a concurrent interview and record review on 2/11/26 at 3:16 PM with the Director of Nurses (DON), Resident 1's MAR (Medication Administration Record, a document that contains information of ordered medications and when the medications were given or held) dated 2/1/26 through 2/28/26, was reviewed. The MAR indicated, .Insulin/Lispro [rapid acting insulin] .Inject as per sliding scale.if 70- [through] 249 [range of blood sugar level] = [equals] 0 units [no insulin given]; 250-300 = 2 units; 301-350 = 4 units.The MAR further indicated Resident 1's blood sugar levels and insulin administration were scheduled at 7:30 AM and 5:00 PM daily.The MAR indicated Resident 1 received insulin for elevated blood sugar levels on three dates between 2/1/26 and 2/11/26 as follows:2/5/26 = blood sugar 324; 4 units of insulin were administered at 9:37 AM2/8/26 = blood sugar 280; 2 units of insulin were administered at 9:18 AMThe DON stated it was her expectation that medications would have been administered within one hour before or after they were scheduled. The DON further stated there was the potential for Resident 2 to have experienced hypoglycemia (blood sugar below the standard range, can be life threatening) or hyperglycemia (high blood sugar, can lead to nerve damage, eye and kidney disease) if her insulin was not administered timely. The DON stated breakfast was provided to Resident 2 at 7:30 daily. During a review of the facility's undated policy titled, Insulin Administration Purpose, the policy indicated, .To provide guidelines for the safe administration of insulin.key characteristics of insulin are.Onset of action- how quickly the insulin reaches the blood stream and begins to lower blood glucose.Rapid-acting.Insulin lispro.Onset within 15 minutes. During a review of the facility's policy titled, Administering Medications, revised 4/19, the policy indicated, .Medications are administered in a safe and timely manner, and as prescribed.Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include.Enhancing optimal therapeutic effect of the medication.Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals) . During a review of an online article from DAILYMED, accessed on 2/12/26 at 12:44 PM titled INSULIN LISPRO - insulin injection, solution, revised 9/2023, the article</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>indicated, . Administration Instructions for the Approved Routes of Administration.Subcutaneous Injection.Administer the dose of Insulin Lispro within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks.https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=97d5e596-aae1-42c9-ae89-c37809:</p>