

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 02/27/2026
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 observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was provided with reasonable accommodation of needs when Resident 1's call light (system/device used by residents to call staff for assistance) was not answered in a timely manner. This failure resulted in Resident 1's needs not being met and had the potential to affect Resident 1's psychosocial well-being. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including spinal stenosis (narrowing of the open spaces within the spine resulting in pain, numbness, or weakness in the back, neck, arms, or legs), difficulty walking, and generalized muscle weakness. During an observation on 2/27/26, at 11:37 AM, the call light was noted to be already on for Resident 1 and Resident 2's room. During a subsequent observation on 2/27/26, at 11:40 AM, the call light was not answered. Staff were noted at the nurses' station including licensed nurse (LN) 1 who did not respond to the call light for Resident 1 and Resident 2's room. During an observation on 2/27/26, at 11:44 AM, the call light for Resident 1 and Resident 2's room remained unanswered. During a joint concurrent observation and interview on 2/27/26, at 11:46 AM, with Resident 1 and Resident 2, inside their room, the call light for Resident 1 remained unanswered. Resident 2 stated staff did not come to answer the call light. Resident 2 further stated they (Resident 1 and Resident 2) did not get the attention they needed. Resident 2 stated his roommate (Resident 1) wore incontinent briefs (an absorbent undergarment designed for adults to manage moderate to heavy leakage of urine or feces) that would get wet and needed changing. Resident 2 further stated when his roommate (Resident 1) would ask staff to be change him; staff would tell him they would come back but never did. Resident 2 stated staff would only come to their room during shift change. Resident 1 stated he had not been changed since last night. Resident 1 further stated he needed help with changing and would sometimes wait for 30 minutes for his call light to be answered. Resident 2 stated staff had not come to change his roommate's brief since last night. Resident 2 further stated he did not know the name of the certified nursing assistant (CNA) who was assigned to care for him and his roommate. During an observation on 2/27/26, at 11:54 AM, CNA 2 passed by the hallway in front of Resident 1 and Resident 2's room while wheeling a resident on the wheelchair and did not respond to the call light. During an observation on 2/27/26, at 12:01 PM, the Administrator (ADM) responded to the call light in Resident 1 and Resident 2's room. The ADM looked for assistance from staff and called LN 1. During an interview on 2/27/26, at 12:07 PM, with the Director of Staff Development (DSD), the DSD stated she expected call lights to be answered by staff in 2-3 minutes or at least answer within 5 minutes. The DSD further stated anyone could answer the call light. The DSD explained CNAs needed to check if a resident had to be changed every 2 hours and as needed. The DSD stated a 24 minute wait time for the call light response was not acceptable. The DSD further stated if staff were in the hallway they should have answered the call light for Resident 1. The DSD stated that this incident was avoidable. The DSD further stated staff should have answered the call light even if it was not their</p> <p>(continued on next page)</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assigned resident. The DSD stated the risk for not answering the call light would be lack of patient care and patient safety. The DSD further stated Resident 1 was incontinent and he would be at risk for skin breakdown. The DSD explained Resident 1's dignity could also be affected. During an interview on 2/27/26, at 1:46 PM, with LN 1, LN 1 confirmed that she did not answer Resident 1's call light. LN 1 stated she should have answered it or at least asked the CNAs to answer the call light and see what the resident needed. During an interview on 2/27/26, at 2:35 PM, with the Administrator (ADM), the ADM stated his expectation on call lights was for staff to answer as quickly as possible. The ADM further stated the staff needed to prioritize because sometimes multiple call lights would be on at the same time. The ADM explained that staff needed to stop what they were doing and attend to the call light. The ADM stated LN 1 should have answered the call light for Resident 1. The ADM further stated that staff should be doing rounds in the beginning of the shift and be changing or checking on residents every few hours. The ADM stated that failing to answer the call light promptly could delay a resident's needs. A review of Resident 1's Care Plan Report, dated 5/29/25, indicated, .The resident has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Impaired balance, Limited Mobility, Musculoskeletal impairment. Interventions. Encourage the resident to use bell to call for assistance. A review of Resident 1's Care Plan Report, dated 5/29/25, indicated, .Resident is at risk for bowel incontinence episodes r/t musculoskeletal changes. Interventions. Assist resident with cleansing after bowel movement. Discuss and plan toileting schedule with resident. Inform resident of next scheduled toileting. Encourage resident to call for assistance if need to defecate before next scheduled time. Respond promptly to the residents request to toilet. A review of Resident 1's Care Plan Report, dated 1/7/26, indicated, .Impaired Urinary Elimination related to urinary tract infection [infection caused by bacteria entering the bladder or kidneys]. Interventions. Assist with toileting and maintain proper perineal hygiene. A review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised 10/24/24, indicated, .The purpose of this procedure is to ensure timely response to the resident's requests and needs. Answer the resident call system. If the resident needs assistance, indicate the approximate time it will take for you to respond. If the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. When answering a visual request for assistance (light above the room door), knock on the room door. A review of an undated facility P&P titled, Dignity, indicated, .Residents are treated with dignity and respect at all times .Each resident is care 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. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example, promptly responding to a resident's request for toileting assistance.</p>		