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	03/10/2026

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 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 report an allegation of potential sexual abuse to the state survey agency within two hours as required by law for one 1 of two 2 sampled residents (Resident 1) when Housekeeper (HK) 1 observed Resident 1 being touched inappropriately by Resident 2 on 2/20/26 in the facility's dining room but did not report the incident to the administration staff until 2/27/26. This failure resulted in a delay of the state survey agency and facility administrative staff from investigating an allegation of potential sexual abuse which had the potential to put Resident 1 and other residents within the facility at risk for ongoing abuse.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in late 2024 with admitting diagnoses including but not limited to Sequelae of Cerebral Infarction (the lasting, long-term physical, cognitive, and psychological impairments occurring after blood to the brain is blocked) and dementia (a progressive, umbrella term for cognitive decline-including memory loss, language difficulties, and poor judgment-that interferes with daily life).Review of Resident 1's Minimum Data Set (MDS- an assessment tool), dated 12/12/25, indicated, Resident 1 scored 7 out of 15 in a Brief Interview for Mental Status which indicated severe cognitive impairment (a significant, often irreversible decline in cognitive functioning, including memory, reasoning, and awareness, that makes independent living impossible).A review of the SOC-341 form (a form used to report abuse in long term care facilities) submitted to the state survey agency by the facility, dated 2/27/26, the document indicated, .On 2/27/26 [ADM] received report from [HK 1] that on 2/20/26 when she was clocking out, she witnessed [Resident 2] sitting next to [Resident 1] while in the dining room reach his right arm into the left sleeve of [Resident 1] shirt and put his hand on her chest . During an interview on 3/10/26, at 1:31 p.m., HK 1 stated on 2/20/26 at around 4 pm, when she was going home for the day, she saw Resident 2 with his right hand inside Resident 1's left arm shirt sleeve, touching near her shoulder and underarm, in the social dining room. HK 1 further stated she went home and did not report the incident to anybody. HK 1 continued, she came back to work the next day and following days after the incident but did not report the incident to anyone until 2/27/26 after she was given regularly scheduled abuse training by the facility. HK 1 further added, she had received abuse trainings by the facility before and knew that she had to report any kind of abuse but she did not realize that she needed to report this incident until the day she received another abuse training on 2/27/26.During an interview on 3/10/26, at 2:05 p.m., the administrator (ADM) stated, the alleged incident between Resident 1 and Resident 2, was reported to him on 2/27/26 in the afternoon around 1 p.m., which he then reported to the state agency, law enforcement, and the ombudsman (a resident advocate) at around 2:30 p.m. The ADM confirmed that HK 1 should have reported the incident right away.During an interview on 3/10/26, at 4:40 p.m., the Director of Nursing (DON) confirmed the incident between Resident 1 and Resident 2 was witnessed by HK 1 on 2/20/26, but HK 1 did not report it to the facility administration until 2/27/26. The DON stated this was not acceptable and should have been reported immediately or within 2 hours. The DON stated this delay put the residents' at risk of experiencing emotional, physical, and psychosocial harm and it was very important to report on time to ensure the safety of the residents.Review of a facility policy and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure (P&P) titled Abuse prohibition, revised 10/24, the P&P indicated, .Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor.Review of an undated facility P&P titled Abuse Investigation and Reporting, the P&P indicated, .An alleged violation of abuse, neglect, exploitation our mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury.