Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

| 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 04/07/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hampton Post Acute | 442 Hampton Street<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures (evidence-based practices designed to prevent the spread of infections) for 1 of 3 sampled residents (Resident 1), when Certified Nursing Assistant (CNA) 2 did not properly wear the required personal protective equipment (PPE, equipment such as protective clothing, gloves, masks or other garments used to prevent or minimize exposure to hazards) while providing high-contact care to Resident 1 who was on Enhanced Barrier Precautions (EBP, infection control steps used in a healthcare setting to prevent the transmission of multidrug-resistant organisms (MDRO, are bacteria often called superbugs, that are resistant to germs that are difficult to treat and spread rapidly in healthcare settings) that are passed by direct contact with a patient or their environment). This failure had the potential to increase the risk of cross-contamination and spread infection to staff and other residents in the facility.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including gastrostomy status (the presence of a surgically created opening in the stomach wall, used for a feeding tube to deliver nutrition, hydration, or medication directly to the stomach. The status implies that the patient requires ongoing care to manage the tube, prevent infection, and ensure proper nutritional intake).Review of the facility provided undated care plan for Resident 1, in the section titled, Focus, indicated, . [Resident 1] is at risk for MDRO colonization/infection due to: presence of g-tube. In the section titled, Interventions, indicated, . required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing. changing linens.During an interview on 4/7/26, at 11:43 AM, CNA 1 stated an EBP sign was posted on residents' doorways as a guide to alert staff to wear appropriate PPE when providing direct care. CNA 1 further stated the purpose of the sign was to reduce the risk of infection transmission to other residents within the facility.During an interview on 4/7/26, at 12:58 PM, Licensed Nurse (LN) 1 stated that purpose of EBP signs was to provide directions to staff to ensure the use of appropriate PPE when delivering high-contact care to residents on EBP. LN 1 added the EBP signs outlined proper PPE use, and staff were expected to follow those instructions to reduce the risk of introducing infections to themselves, other staff, and residents. LN 1 further stated that failure to use appropriate PPE increased the risk of infection transmission throughout the facility.During a concurrent observation and interview on 4/7/26, at 2:12 PM in Resident 1's room, an EBP sign was observed posted on the wall at the doorway. CNA 2 was observed inside the room changing Resident 1's bed linens while Resident 1 was in bed. CNA 2 was not wearing a gown, as required by the EBP sign posted outside of Resident 1's room. Upon exiting the room, CNA 2 confirmed she had not worn the appropriate PPE and acknowledged that she should have worn a gown prior to entering the room to change Resident 1's bed linens, as the resident was on EBP. CNA 2 further stated that failure to wear the required PPE while providing direct care placed her at risk of acquiring infection and contributing to the transmission of infection to other residents within the facility. During an interview on 4/7/26, at 2:43 PM, the Director of Staff Development (DSD) stated that when staff were providing direct care to residents under EBP, they were expected to wear appropriate PPE prior to entering the resident's<br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | room. The DSD explained that an EBP sign posted near the doorway served as a guide to inform staff of the required PPE. The DSD further stated that during the provision of direct care, staff should ensure they were wearing the proper PPE to prevent the transmission of infection, thereby protecting other residents from potential cross-contamination.During an interview on 4/7/26, at 3:02 PM, the Infection Preventionist (IP) stated Resident 1 was placed on EBP due to having a surgically inserted feeding tube, which increased the risk for MDRO colonization. The IP stated that high-contact care activities, including changing Resident 1's bed linens, required the use of PPE. The IP further stated staff were expected to wear a gown and gloves while changing Resident 1's bed linens to prevent the possibility of the spread of infection within the facility.During a concurrent interview, and record review, on 4/7/26, at 4:23 PM, with the Assistant Director of Nursing (ADON), the facility Policy and Procedure (P&P) titled, Enhanced Standard/Barrier Precautions, revised on 2/21/25, was reviewed. The review indicated, . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 4. High-contact resident care activities include. e. Changing linens. 8. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until. discontinuation of the indwelling medical device that placed them at higher risk. The ADON stated staff were expected to wear appropriate PPE when providing direct and high-contact care, including changing bed linens for Resident 1 while on EBP. The ADON stated Resident 1's condition increased the risk of infection transmission to other residents and staff when proper PPE was not utilized. The ADON further stated failure to wear appropriate PPE could result in the spread of infection throughout the facility and lead to noncompliance with infection prevention requirements. The ADON acknowledged that the facility P&P was not followed, and also confirmed that nursing staff did not meet the expected infection prevention requirements. |