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	04/29/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to ensure an environment free of accidents or hazards for one out of three sampled residents (Resident 3) when Resident 3 eloped (when a resident leaves a healthcare facility without notice/authorization) from the facility in a wheelchair and was found at a gas station one quarter mile away from the facility.This failure had the potential to result in injury to Resident 3 during an elopement on 2/18/26.Findings:A review of Resident 3's admission Record, indicated that Resident 3 was admitted to the facility in 2026 with diagnoses which included Closed Fracture Left Radius (broken bone in the forearm near the wrist with no bones poking out of the skin), Closed Fracture Shaft of Left Tibia (a broken bone between the knee and the ankle with no bones poking out of the skin), Basilar Skull Fracture (broken bones around either ear, the eyes, near the spine, and the nasal cavity), and Suicide Attempt (an act in which an individual tries to end their own life but survives).A review of Resident 3's Physician Order Summary, indicated .1:1 staff assistance to enhance safety d/t [due to] suicidal ideation [thoughts or preoccupation with ending one's own life] x 72hrs [hours] one time only for 3 Days.Order Date.01/28/2026.End Date.01/31/2026.A review of Resident 3's Physician Order Summary, indicated, .NOTIFY provider immediately if suicide ideation/attempt recurs. Every shift for suicidal ideation.Order Date.02/04/2026.Start Date.02/04/2026.A review of Resident 3's Medication Administration Record (MAR, a document listing medications and monitoring parameters) February 2026, indicated that facility staff documented Resident 3's behavior each shift daily.A review of Resident 3's Care Plan Report, indicated, .Focus.Risk for leaving the facility without notice related to.suicide attempt.Date Initiated.02/02/2026.Goal.Resident will remain safe within the facility, demonstrate reduced exit-seeking behavior.Interventions.Allow time for expression of feelings.As appropriate redirect Resident if nears exits or doorways.A review of Resident 3's Care Plan Report, indicated, .Focus.Patient [Resident] may smoke with supervision per smoking assessment.Date Initiated.02/04/2026.Goal.Patient will smoke safely x90 days per smoking assessment.Educate Patient.on the facility's smoking policy.Inform and remind Patient of smoking areas and times.Monitor Patient.A review of Resident 3's Progress Notes, indicated .Effective Date.2/18/2026 10:19:00 [10:19 AM].Around 10:19 [AM] patient told staff member that he wanted to sit in the front of the facility in his wheelchair. Nurse was told that the patient was seen going towards the gas station. Nurse walked on foot to get to the patient at the.gas station away from the facility. Nurse accompanied the patient back safely to the facility. Full body assessment completed with no noted injury.Administrator, unit manager, DON [Director of Nursing] and ADON [Assistant Director of Nursing] notified.Educated that patient.Patient stated he was sorry and just wanted donuts from the gas station.A review of Resident 3's Progress Notes, indicated .Effective Date.02/19/2026 11:43 [AM] .Type.Primary Physician.follow up note.Pt [Patient] stated he would like to get a day pass to go out to the store to buy some stuff. Denies any suicidal ideations.Given the patient's history of.prior suicidal ideations, he is not appropriate for an unsupervised day pass at this time due to safety concerns. However, he may be considered for a day pass if accompanied at all times by a responsible adult who is aware of his history and able to provide appropriate supervision and ensure his safety.During an interview on (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/26 at 3:58 p.m. with the Director of Nursing (DON), the DON stated that her expectations were that Licensed Nurses (LNs) rounded on the residents at the start of their shift and made sure that the residents were all accounted for. The DON stated that if a resident left the facility, the staff should check the sign out form at the front desk to see if the resident had a day pass. The DON stated that residents had to get permission from their physicians to leave the facility on the day pass. The DON stated that the staff checked for scheduled appointments and checked with family members to see if the resident was with the family. The DON stated that if a resident had a cell phone, the staff would call the resident's cell phone to see if the resident answered. The DON stated that she expected the staff to look for the resident, to alert the supervisor on duty, and their coworkers on duty to search for the missing resident. The DON stated that if the staff could not find the missing resident in the facility, Code [NAME] (agency code indicating a missing resident) was activated to search for the missing resident. The DON stated that the Certified Nursing Assistants (CNAs), charge nurses, and the medication nurses would tell the unit managers when the resident was last seen. The DON stated that the staff were also expected to notify the DON and the Administrator (ADM), then the police were called. The DON stated that the risk of not following the process was that the missing resident could fall, possibly get into traffic and be injured, possibly be hungry and without their medications, possibly suffer confusion, possibly be cold and tired, or worse.During a concurrent interview and record review on 4/29/26 at 4:28 p.m., with the ADM, the facility policy and procedure, Leave of Absence without [sp] Notice, dated January 2026 was reviewed. The ADM stated that his expectation was that the facility staff followed the elopement policy and procedure in place. The ADM stated that he heard about Resident 3 leaving the facility on 2/18/26. The ADM stated that since facility staff knew the direction Resident 3 went when he left the property on 2/18/26, and staff knew where to go to find Resident 3, that was not considered elopement. The ADM stated that Resident 3 was alert. The ADM stated that Resident 3 was not injured and received education when he returned to the facility. The ADM stated that there were no further incidents of Resident 3 leaving the facility after the education was provided. The ADM confirmed that Resident 3 did not have a day pass to leave the facility alone on 2/18/26. The ADM confirmed that Resident 3 did not have an appointment outside of the facility on 2/18/26 at the time that he left the facility. The ADM acknowledged that based on the definition of elopement listed on the facility policy and procedure, Resident 3 eloped from the facility on 2/18/26. The ADM acknowledged that the facility policy was not followed.During an interview by phone with LN 2 on 4/29/26 at 5:35 p.m., LN 2 stated that she remembered Resident 3. LN 2 stated that she was in the process of medication administration at the facility on 2/18/26 and could see the front of the facility through the windows. LN 2 stated that during medication administration she noticed Resident 3 in his wheelchair leaving the facility parking lot. LN 2 stated that a staff member came to her and asked if Resident 3 had a day pass to leave the facility. LN 2 stated that the staff member stated that Resident 3 was headed in the direction of the gas station. LN 2 stated that she knew that Resident 3 did not have a day pass. LN 2 stated that she walked to the gas station and Resident 3 was inside the gas station mini market. LN 2 stated that she asked Resident 3 if he was hurt and he stated that he was not hurt. LN 2 stated that she told Resident 3 that she was concerned about his safety. LN 2 stated that Resident 3 stated that he just wanted to get snacks. LN 2 stated that she walked with Resident 3 back to the facility. LN 2 stated that she called the ADON and the DON on duty at that time and notified them of the incident. LN 2 stated that she did not know all the forms that needed to be completed for the elopement. LN 2 stated that the DON and the ADON that were on duty that day no longer worked at the facility. LN 2 stated that she asked the DON and the ADON which forms to fill out, and the DON stated that she should call Resident 3's physician and complete a progress note. LN 2 stated that she educated Resident 3 on leaving the facility against medical advice. LN 2 stated that Resident 3 understood the education. LN 2 stated that she suggested that Resident 3 asked staff, visitors, or other residents who had day passes to get snacks for him, or have snacks delivered since he did not have a day pass. LN 2 stated that besides the progress note on the elopement, she did not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document any assessments (physical/mental) on Resident 3 since the DON and the ADON only said to call Resident 3's physician and write the progress note.During an interview by phone on 4/30/26 at 12:49 p.m. with CNA 3, CNA 3 stated that she remembered Resident 3. CNA 3 stated that she remembered the incident when Resident 3 left the facility and went to the gas station on 2/18/26. CNA 3 confirmed that the incident occurred in the morning on 2/18/26. CNA 3 stated that the staff wondered where Resident 3 was and asked other staff where he was. CNA 3 stated that she thought that one of the CNAs reported the incident to the unit manager. CNA 3 stated that the CNAs and LNs started looking for Resident 3 in the facility, in the smoking area, and in the front patio of the facility, but did not find him. CNA 3 stated that the staff searched for Resident 3 at the facility for about an hour.A review of a facility policy and procedure (P&P) titled, Leave of Absence without [sp] Notice, dated January 2026, the P&P indicated, .Policy.The Interdisciplinary team members (IDT, a team of professional staff or a care team consisting of different disciplines who work together towards the goals of their clients) are recommended to evaluate if a resident is deemed at risk of leaving the facility without notice and identify resident-specific measures in a least restrictive environment.Definitions.Elopement occurs when a resident leaves the premises or a safe area without notice/authorization (i.e., an order of discharge or leave of absence) and/or any necessary supervision to do so.Procedural Guidelines.3. A resident deemed at risk for Leave of Absence without [sp] Notice by IDT are to consider the following measures but not limited to.Initiate/Update plan of care.Procedure for Locating Missing Resident.a. Any staff member becoming aware of the missing resident will alert personnel using facility approved protocol (e.g. internal alert code) .b. The designated facility staff will look for the resident.c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department.d. DON or designee shall notify the physician and family member or legal representative.e. Police will be given a description and information about the resident; include any photos.f. All parties will be notified of the outcome once the resident is located.g. Appropriate reporting requirements to the State Survey agency should be conducted.4. Procedure Post Leave of Absence without Notice.a. A nurse will perform a physical assessment, document, and report findings to physician.e. Documentation in the medical record will include findings from nursing.assessments, physician.notification.as applicable.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on interview and record review, the facility failed to provide written notice at the time of the position change of the Administrator (ADM) and the Director of Nursing (DON) to the State Agency (SA) when:The current DON started the DON position on 4/21/26, and the facility did not report the change of the DON position to the SA.The current ADM started the ADM position in August 2025 and the facility did not report the change of the ADM position to the SA These failures delayed the SA from verifying that the ADM and the DON were qualified to lead clinical services at the skilled nursing facility, which had the potential to compromise resident safety and compliance with federal and state regulation for a census of 109 residents.Findings:1. During an interview on 4/29/26 at 10:22 a.m. with the facility Administrator (ADM), the ADM stated that he did not think that the application to the Centralized Applications Branch (CAB-part of the SA that reviews, analyzes, and evaluates requests for facility licensure and/or certification, as well as processes other license-associated transactions) was completed for the new DON. The ADM stated that the DON was the one responsible for completing the CAB application. During an interview with the DON on 4/29/26 at 3:58 p.m., the DON stated that she started working at the facility eight days ago. The DON confirmed that she had not filed the application with the CAB. The DON stated that the ADM would get the information. The DON stated that she was not informed about the CAB expectations.A review of the SA database revealed no receipt of the DON application was received from the facility.2. During an interview on 4/29/26 at 10:31 a.m. with the ADM, the ADM stated that he had been working at the facility since August 2025. The ADM stated that the change in ADM application should have been completed and sent to the CAB for his new position back in August 2025 by the facility's corporate office.A review of the SA database revealed no receipt of the ADM application was received from the facility.