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	05/12/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure psychotropic medication (a medication capable of affecting the mind, emotions, and behavior) was administered with consent of the resident or authorized representative for one of seven sampled residents (Resident 1) when an informed consent (process in which a patient is educated on the risks, benefits, and alternatives to obtain agreement and permission for care) was not obtained from Resident 1's Responsible Party (Health Care Decision Maker) prior to administration of an anti-psychotic medication (used to treat and manage symptoms for several psychiatric disorders) prescribed on 3/6/26.This failure had the potential for not honoring resident right to be informed about Resident 1's medical treatment including risks, benefits, and other alternatives to treatment.Findings:During a review of Resident 1's clinical record titled, admission RECORD, dated 5/12/26, the record indicated Resident 1 was admitted to the facility in the middle of 2024 with diagnoses including unspecified dementia (a decline in mental abilities such as memory, thinking, and reasoning that could interfere with daily living) with behavioral disturbance and during her stay in the facility a diagnosis of delusional disorder (an illness characterized by at least 1 month of delusions but no other psychotic symptoms) was added early of 2026. During a review of Resident 1's clinical record titled, MDS Section C-Cognitive Patterns (MDS, Minimum Data Set-an assessment tool), dated 3/31/26, the record indicated Resident 1 had a BIMS (Brief Interview for Mental Status) score of 11 out of 15 suggesting Resident 1 had moderate cognitive impairment (a decline in cognitive abilities that is severe enough to interfere with a person's independence and basic daily activities).During a concurrent interview and record review on 5/8/26, at 2:24 p.m. with Licensed Nurse (LN) 1, Resident 1's electronic file for psychotropic medication use was reviewed. LN 1 confirmed the order summary report of Resident 1's electronic file indicated an anti-psychotic medication was prescribed for Resident 1. LN 1 stated Resident 1 was prescribed risperidone (a prescription medication used to treat several mental health conditions) 0.25 mg (mg, milligram-a unit of measurement) one tablet by mouth at bedtime for paranoia (excessive mistrust or suspicion of people). LN 1 stated the medication was prescribed on 3/6/26 at 9 p.m. LN 1 confirmed the Medication Administration Report (MAR, a document used to track what medication was given, when it was given, and by whom) of Resident 1's electronic file indicated the risperidone was administered starting on 3/6/26 till present. LN 1 also confirmed that the informed consent for risperidone use was not found in Resident 1's electronic file. LN 1 stated that she could not find the informed consent and she went on to say that there should be consent when risperidone was prescribed.During a review of Resident 1's clinical record titled, Order Summary Report, orders active as of 5/12/26, the report indicated, .Risperidone Tablet 0.25 MG Give 1 tablet by mouth at bedtime for Paranoia.During a review of Resident 1's clinical record titled, Care Plan Report, review date 4/7/26, the report indicated, .The resident is on (Risperidone) (Anti-psychotic Medications) r/t [related to] (Paranoia).Administer medications as ordered.During a review of Resident 1's clinical record titled, Medication Administration Record, dated 3/1/26 through 3/21/26, the record indicated Resident 1 received risperidone starting on 3/6/26 at 9 p.m. through 3/31/26. The record also indicated Resident 1 received risperidone from 4/1/26 through 4/30/26 and from 5/1/26 through 5/10/26 and continuing to present date.During a concurrent interview and record review on 5/8/26, at 3:34 p.m. with the (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing (ADON), Resident 1's electronic file was reviewed. The ADON stated the informed consent for risperidone use was not found. The ADON stated that the consent might not have been uploaded in Resident 1's electronic file and would inquire into it.During a concurrent interview and record review on 5/12/26, at 4:11 p.m. with the ADON, Resident 1's informed consent form titled, PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE (Anti-Psychotic) was signed by the attending physician dated 5/9/26 and the responsible party gave verbal consent on 5/11/26. The ADON confirmed the consent was obtained after the risperidone was prescribed and was administered for the months of March, April, and in May 2026 without consent. The ADON stated there were no other consent forms obtained prior to 5/11/26. The ADON also stated consent must be obtained when anti-psychotic medication was prescribed and before administration. The ADON explained that without consent the anti-psychotic medication when administered could become a chemical restraint (when a drug or a combination of drugs is used to restrict or sedate a patient to make them easier to manage) and be used as a convenience for the staff. The ADON also explained the importance of obtaining consent for residents was to be informed about the risks and benefits for anti-psychotic medication use and would have the choice to accept or decline the use of the medication.During a review of the facility's undated policy titled, Psychotropic Medication Use, this policy indicated, .Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives; b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representative's right to accept or decline the treatment.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure psychotropic medication (a medication capable of affecting the mind, emotions, and behavior) was administered with adequate clinical indication for one of seven sampled residents (Resident 1) when the healthcare nurse practitioner's (who has advanced clinical education and training and share many of the same duties as doctors) progress notes were not readily accessible in Resident 1's electronic file for an anti-psychotic medication (used to treat and manage symptoms for several psychiatric disorders) prescribed on 3/6/26.This failure had the potential for Resident 1 at risk for unnecessary anti-psychotic medication use.Findings:During a review of Resident 1's clinical record titled, admission RECORD, dated 5/12/26, the record indicated Resident 1 was admitted to the facility in the middle of 2024 with diagnoses including unspecified dementia (a decline in mental abilities such as memory, thinking, and reasoning that could interfere with daily living) with behavioral disturbance and during her stay in the facility a diagnosis of delusional disorder (an illness characterized by at least 1 month of delusions but no other psychotic symptoms) was added early of 2026. During a review of Resident 1's clinical record titled, MDS Section C-Cognitive Patterns (MDS, Minimum Data Set-an assessment tool), dated 3/31/26, the record indicated Resident 1 had a BIMS (Brief Interview for Mental Status) score of 11 out of 15 suggesting Resident 1 had moderate cognitive impairment (a decline in cognitive abilities that is severe enough to interfere with a person's independence and basic daily activities).During a review of Resident 1's clinical record titled, Order Summary Report, orders active as of 5/12/26, the report indicated, .Risperidone [a prescription medication used to treat several mental health conditions] Tablet 0.25 MG [MG, milligram-a unit of measurement] Give 1 tablet by mouth at bedtime for Paranoia [excessive mistrust or suspicion of people] .During a review of Resident 1's clinical record titled, Care Plan Report, review date 4/7/26, the report indicated, .The resident is on (Risperidone) (Anti-psychotic Medications) r/t [related to] (Paranoia).Administer medications as ordered.During a review of Resident 1's clinical record titled, Medication Administration Record, [MAR, a document used to track what medication was given, when it was given, and by whom] dated 3/1/26 through 3/21/26, the record indicated Resident 1 received risperidone starting on 3/6/26 at 9 p.m. through 3/31/26. The record also indicated Resident 1 received risperidone from 4/1/26 through 4/30/26 and from 5/1/26 through 5/10/26 and continuing to present date.During a concurrent interview and record review on 5/8/26, at 2:24 p.m. with Licensed Nurse (LN) 1, Resident 1's electronic file for psychotropic medication use was reviewed. LN 1 confirmed Resident 1 was prescribed a risperidone, an anti-psychotic medication with an order date of 3/6/26. LN 1 also confirmed the medication was administered starting on 3/6/26 at 9 p.m. through 3/31/26, all of April from 4/1/26 through 4/30/26, and the beginning of May from 5/1/26 through review date. LN 1 stated the indicated diagnosis of paranoia for the risperidone use was not among the list of diagnoses Resident was admitted for . LN 1 also stated the paranoia diagnosis was not added on the list during her stay in the facility. LN 1 further stated she could not locate documentation in Resident 1's electronic file the justification or rationale for risperidone use, who was the healthcare professional who diagnosed paranoia, and an assessment for the need of anti-psychotic medication. LN 1 confirmed the care plan report of Resident 1's electronic file revealed a black box warning for the use of risperidone which indicated that risperidone is not approved for the treatment of patients with dementia-related psychosis due to increased risk of death in elderly patients. LN 1 stated Resident 1 received an anti-psychotic medication without proper or adequate indication of use.During a concurrent interview and record review on 5/8/26, at 5 p.m. with the Assistant Director of Nursing (ADON), Resident 1's electronic file was reviewed. The ADON confirmed there was no documented evidence of justification or rationale for risperidone use. The ADON stated a healthcare professional was at the facility to evaluate Resident 1 for a need for anti-psychotic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. The ADON stated the healthcare professional's progress notes (a clinical document written after each patient encounter that records the services provided, current status, response to treatment, and plan of care) were not found in Resident 1's electronic file and stated the notes should have been uploaded. The ADON stated she will get a copy of the progress notes. The ADON stated Resident 1 received risperidone without adequate indication for use from 3/6/26 through 5/12/26.During an interview on 5/12/26, at 2:33 p.m. with the ADON, the ADON stated that a Nurse Practitioner (NP) was the healthcare professional who evaluated Resident 1 and stated she contacted the NP to send her progress notes to be included in Resident 1's electronic file. The ADON stated the NP notes should have been readily accessible to know what the outcome of the visit was, the reason for prescribing the risperidone, and for the staff to have continuity of care. During a phone interview on 5/12/26, at 3:08 p.m. with the Pharmacy consultant (PC), the PC stated that paranoia was not a diagnosis but part of psychosis such as symptoms related to a psychiatric diagnosis. The PC also stated that risperidone could be used for other diagnosis such as dementia with behavior as long as it is documented adequately including but not limited to the following: use of non-pharmacologic approaches before administration, must be care planned, must have monitoring of specific behavior, monitoring of side-effects, and must have the reason for use. The PC further stated the diagnosis of paranoia must be clarified and the NP's progress notes must have information regarding the indication for use of risperidone.During a concurrent interview and record review on 5/12/26, at 5:30 p.m. with the ADON, Resident 1's NP progress notes titled, CHE Behavioral Health, dated 2/27/26, 3/20/26, and 4/14/26 were reviewed. The ADON confirmed that the NP was in the facility on those dates and confirmed her progress notes were not in Resident 1's electronic file and stated it should have been uploaded for staff to provide continuity of care.During a review of the facility's undated policy titled, Psychotropic Medication Use, this policy indicated, .Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record.Psychotropic medication management is an interdisciplinary process that involves the resident, family, and /or the representative and includes: a. determining adequate indications for use.Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurate and complete records for one of seven sampled residents (Resident 1) when, Resident 1's behavioral health visits progress notes for visit dates of 2/27/26, 3/20/26, and 4/14/26 were not readily available in Resident 1's medical record. This deficient resulted in care and services provided to not be known across all disciplines in order to assist in making medical decisions for Resident 1. Findings:During a review of Resident 1's clinical record titled, Care Plan Report, review date 4/7/26, the report indicated, .The resident is on (Risperidone) (Anti-psychotic Medications) r/t [related to] (Paranoia).Administer medications as ordered.During a review of Resident 1's clinical record titled, Order Summary Report, orders active as of 5/12/26, the report indicated, .Risperidone Tablet 0.25 MG Give 1 tablet by mouth at bedtime for Paranoia.During a review of Resident 1's clinical record titled, Medication Administration Record, dated 3/26 through 5/26, the record indicated Resident 1 received risperidone starting on 3/6/26 at 9 p.m. through 5/10/26 and continuing to present date.During a concurrent interview and record review on 5/8/26, at 5 p.m. with the Assistant Director of Nursing (ADON), Resident 1's electronic file was reviewed. The ADON confirmed there was no documented evidence of justification or rationale for risperidone use. The ADON stated a healthcare professional was at the facility to evaluate Resident 1 for a need for anti-psychotic medication. The ADON stated the healthcare professional's progress notes (a clinical document written after each patient encounter that records the services provided, current status, response to treatment, and plan of care) were not found in Resident 1's electronic file and stated the notes should have been uploaded. The ADON stated she will get a copy of the progress notes.During an interview on 5/12/26, at 2:33 p.m. with the ADON, the ADON stated that a Nurse Practitioner (NP) was the healthcare professional who evaluated Resident 1 and stated she contacted the NP to send her progress notes to be included in Resident 1's electronic file. The ADON stated the NP notes should have been readily accessible to know what the outcome of the visit was, the reason for prescribing the risperidone, and for the staff to have continuity of care. During a concurrent interview and record review on 5/12/26, at 5:30 p.m. with the ADON, Resident 1's NP progress notes titled, CHE Behavioral Health, dated 2/27/26, 3/20/26, and 4/14/26 were reviewed. The ADON confirmed that the NP was in the facility on those dates and confirmed her progress notes were not in Resident 1's electronic file and stated it should have been uploaded for staff to provide continuity of care.