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	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Post Acute	442 Hampton Street Stockton, CA 95204

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of 2 out of 38 sampled residents (Resident 45 and Resident 56) when:1. Resident 45's call light (a device used in healthcare settings to allow patients to remotely request assistance from nurses or staff) was not working and was not within reach; and,2. Resident 56's call light was hanging on the wall behind the bed and was not within reach.These failures had the potential to increase the risk of falls and unmet needs for Resident 45 and Resident 56 due to their inability to request assistance from staff.Findings:1. During a concurrent observation and interview on 7/21/25 at 3:23 PM, Certified Nursing Assistant (CNA) 4 confirmed that Resident 45's call light was on the floor and not within reach. CNA 4 stated it was important for Resident 45 to have the call light within reach in case he needed anything.During a concurrent observation and interview on 7/21/25 at 3:23 PM in Resident 45's room, Licensed Nurse (LN) 6 also confirmed Resident 45's call light was on the floor and not within reach. LN 4 stated that it was important for residents to have call lights within reach in case they were thirsty or needed assistance from staff.A review of Resident 45's Care Plan Report, dated 5/29/25, indicated, . [Resident 45] is a moderate risk for falls r/t [related to] Confusion, Unaware of safety needs.Be sure the resident's call light is within reach.needs prompt response to all requests for assistance.2. During a concurrent observation and interview on 7/21/25 at 9:50 AM in Resident 56's room, CNA 3 confirmed that Resident 56's call light was hanging on the wall behind Resident 56's bed and not within reach. CNA 3 stated that it was important for the call light to be within reach in case of a fall or if Resident 56 needed anything to reach us fast.During an interview on 7/24/25 at 12:46 PM, the Director of Nursing (DON) explained it was her expectation that each resident had a working call light, and that it was within reach of the residents. The DON further explained she expected the CNAs to round the rooms, check on the residents throughout the shifts, and make sure call lights were within reach. The DON stated when a call light was not within reach of the residents, the risk to the residents was unmet needs.A review of facility policy and procedure titled Answering the Call Light, revised 10/2024, indicated, .The purpose of this procedure is to ensure timely responses to the residents' requests and needs.Ensure that the call light is accessible to the resident when in bed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide required notices to one of three residents (Resident 4) reviewed for the beneficiary protection notification (residents who received Medicare Part A Services have specific rights and protections related to financial liability and appeal rights which are communicated to beneficiaries through notices given by providers), when Resident 4 was not issued a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN: CMS 10055 a form which gives the choice to continue services under private pay if Medicare does not provide payment) and Notice of Medicare Non Coverage (NOMNC: CMS 10123 a form that Medicare providers must give to beneficiaries when their Medicare-covered services are ending) notices upon changes in his Medicare Part A service coverage.This failure had the potential for Resident 4 and his representatives not being informed of their specific rights and protections related to financial liability for medical expenses incurred as well as the right to appeal. Findings:Review of an undated form filled out by the facility titled, BENEFICIARY NOTICE - RESIDENTS discharged WITHIN THE LAST SIX MONTHS/MEDICARE PART A, indicated Resident 4 was discharged from Medicare Part A services on 5/23/25 with remaining skilled benefit days but continued to remain at the facility.During a concurrent interview and record review on 7/24/25, at 2:47 p.m., the Director of Nursing (DON) verified Resident 4 was discharged from Medicare Part A services with remaining skilled benefit days on 5/23/25 but continued to stay at the facility. The DON verified there was no evidence that Resident 4 was issued a SNF ABN and a NOMNC form. The DON stated that anytime a resident stayed in the facility after they were discharged from Medicare Part A with remaining skilled benefit days, they should be issued a NOMNC and SNF ABN notice so that they were made aware of changes and could make mindful financial decisions.Review of an undated facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, indicated, .The facility will issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN CMS form 10055) to any Medicare (Fee for Service) resident prior to providing care that Medicare usually covers, but may not pay.If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before Medicare covered services end.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) were provided to maintain good hygiene for 1 of 38 sampled residents (Resident 45) when:1. Resident 45's fingernails were long and sharp with a brown substance caked underneath them; and,2. Resident 45 had no documented bathing for the month of 7/2025.These failures resulted in Resident 45 not having had a documented bath or shower in 7/2025, with Resident 45's nails being long, sharp, and dirty with a brown substance underneath, hands and nails not being cleansed prior to eating meals, the potential for injury due to long sharp nails, and infection from the nails harboring microorganisms (bacteria, virus, or fungus).Findings:During a concurrent observation and interview on 7/23/25 at 9:43 AM, in Resident 45's room, Resident 45 was observed sitting up in bed wearing a yellow hospital gown. When asked, Resident 45 stated yes, he wanted to be cleaned and have his nails cut.During a concurrent observation, interview, and record review, on 7/23/25 at 9:46 AM, in Resident 45's room, Licensed Nurse (LN) 4 confirmed Resident 45 was dependent on staff for care and ADLs. LN 4 further confirmed Resident 45's nails were long and dirty with a brown substance under them. LN 4 explained it was expected that Resident 45's nails would be cleaned multiple times daily prior to each meal, and nails cleaned and trimmed with bathing. LN 4 further explained the risk to Resident 45 was self-injury on his skin, and that touching food with his dirty nails could cause an infection. LN 4 completed a review of Resident 45's electronic health record (EHR - a digital collection of a resident's medical history and other health information) and stated she could not find any documented record of Resident 45 receiving a bath or shower for the month of July, and added Resident 45's bathing/showering days were Tuesday and Friday. LN 4 confirmed Resident 45 did not appear to have any recent nail care or hand hygiene performed. During a concurrent observation and interview on 7/22/25 at 10:14 AM, in Resident 45's room, CNA 5 explained Resident 45 needed assistance with ADLs. CNA 5 stated she gave Resident 45 a bed bath the day before on 7/21/25. CNA 5 further stated she did not do hand hygiene or trim Resident 45's nails. CNA 5 stated she did Resident 45's hand hygiene prior to assisting him with meals on 7/21/25. CNA 5 reviewed Resident 45's EHR and could not find documentation that indicated she completed the tasks. CNA 5 confirmed Resident 45's nails were untrimmed and dirty. CNA 5 explained the risk to Resident 45 for having long dirty nails was infection and scratching himself and cutting himself with them. CNA 5 further explained it was important to stick to Resident 45's bathing and nail cleaning and trimming schedule to prevent infection and to maintain good hygiene.During an interview on 7/24/25 at 12:53 PM, the Director of Nursing (DON) stated it was her expectation for staff to be providing ADL care to residents who required assistance like Resident 45. The DON further stated they should be providing showers, hygiene, nail care, and that it was important for personal hygiene and dignity. The DON explained she expected staff to accurately document in the resident's EHR when they received bathing/showering and all hand hygiene prior to meals/snacks. The DON reviewed Resident 45's EHR and confirmed Resident 45 had no documented baths/showers for the month of 7/2025. The DON explained that Resident 45's long dirty nails, and lack of bathing documentation did not meet her expectation for resident cleanliness or hygiene.A review of Resident 45's, Care Plan Report, dated 5/29/25, indicated, . [Resident 45] has Skin Tear/potential for skin tear r/t [related to] lack of safety awareness.Identify causative factors and eliminate/resolve.Keep skin clean and dry.A review of Resident 45's, Care Plan Report, dated 6/3/25, indicated, .Self-care Deficit (hygiene) r/t cognitive impairment [a decline in one or more functions such as memory, attention, language, reasoning, decision-making], poor judgement.Goal Pt [patient] will maintain personal hygiene with staff assistance.Educate pt [patient].the importance of hygiene for infection prevention and skin integrity.Ensure a clean safe environment; promptly remove feces and disinfect.Provide hygiene care. A review of facility Policy and Procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure proper hydration (process of providing fluid to the body) for three of 38 sampled residents (Resident 32, Resident 45, and Resident 112), per facility policy and each resident's comprehensive plan of care, and failed to maintain the usual body weight of 1 of 3 sampled residents (Resident 73) with weight loss when: 1. Resident 32 did not have available fluids to drink at bedside; and,2. Resident 45 did not have available fluids to drink at bedside; and, 3. Resident 112 did not have available fluids to drink at bedside; and,4. Resident 73 had a weight loss of 11. 1% over a 6-month period. These failures had the potential to result in altered hydration status, and complications associated with fluid imbalance (when the body loses or gains too much water/fluids) for Resident 32, Resident 45, and Resident 112; in addition, Resident 73's weight loss could lead to malnutrition (not consuming enough calories) and potentially decrease his functional status, immune function, and muscle mass. Findings: 1. During a concurrent observation and interview in Resident 32’s room on 7/21/25 at 9:22 AM Licensed Nurse (LN) 3 confirmed Resident 32 did not have available fluids at bedside. LN 3 further stated it was important for fluids to be available at bedside so that Resident 32 did not get dehydrated (a harmful reduction in the amount of water in the body). During a concurrent observation and interview in Resident 32’s room on 7/23/25 at 8:42 AM LN 7 confirmed Resident 32 did not have fluids available at bedside. LN 7 further confirmed Resident 32 had cracked and chapped lips. LN 7 explained the risk of Resident 32 not having fluids available to drink at bedside was dehydration, urinary tract infections (UTI -an infection in the bladder or urinary tract), chapped lips and dry skin. LN 7 further explained it was important for fluids to be in reach of Resident 32 so she could drink when she wanted to. LN 7 asked Resident 32 if she was thirsty and Resident 32 shook her head up and down in an affirmative motion. A review of Resident 32’s “Care Plan Report” (a document detailing an individual’s health needs, goals, and the steps needed to achieve those goals) revised 7/15/2025, indicated, “…Interventions…Monitor for s/s [signs and symptoms] of dehydration…Encourage increase fluid intake…” 2. A review of Resident 45’s “admission RECORD” indicated Resident 45 was admitted to the facility with a diagnosis including but not limited to urinary tract infection. During a concurrent observation and interview in Resident 45’s room on 7/21/25 at 3:23 PM LN 6 confirmed Resident 45 did not have fluids available at bedside. LN 3 stated the risk to Resident 45 not having fluids available at bedside was dehydration. LN 3 observed Resident 45’s urinary catheter collection bag (a medical device used to collect urine from a person with a urinary catheter (a flexible tube inserted into the bladder to drain urine)) and confirmed Resident 45’s urine was dark in color. LN 3 further explained the risk to Resident 45 not having fluids available at bedside to drink not only made him at risk for dehydration but could also put him at risk for another UTIDuring a concurrent observation and interview in Resident 45’s room on 7/23/25 at 9:46 AM, LN 4 confirmed Resident 45’s water cup was empty, and Resident 45 requested more water. LN 4 further confirmed resident 45 had chapped, dry lips. LN 4 explained the risk to Resident 45 not having fluids available was dehydration and risk for another UTI. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 45’s “Care Plan Report” revised 6/8/25, indicated, “… [Resident 45] has dehydration or potential fluid deficit r/t [related to] poor intake…Encourage the resident to drink fluids of choice…Ensure [Resident 45] has access to…fluids…cold water…whenever possible…promote additional fluid intake…offer drinks…” A review of Resident 45’s “Care Plan Report” revised 7/23/25 indicated, “… [Resident 45] has indwelling foley catheter…Monitor and document intake…” 3. During a concurrent observation and interview in Resident 112’s room on 7/21/25 at 10:24 AM, Resident 112 stated he was thirsty and had wanted a refill of water. Resident 112 further stated he had needed his cup refilled since 8 AM, and he felt unimportant and frustrated when his needs were not met by the facility. During a concurrent observation and interview in Resident 112’s room on 7/21/2025 at 10:43 AM, LN 3 confirmed Resident 112 did not have fluids available. LN 3 further stated it was important for fluids to be available at bedside so Resident 112 did not get dehydrated. A review of Resident 112’s “Care Plan Report” revised 2/4/2025, indicated, “…[Resident 112] has potential fluid deficit/dehydration r/t Diuretic [a drug that causes the increase passing of urine] use…[Resident 112] needs assistance/encouragement/supervision with fluid intake in order to meet daily requirements…The resident/family need to be instructed on the importance of fluid intake…” During an interview on 7/24/25 at 12:37 PM, the Director of Nursing (DON) stated her expectation was that fluids to drink were available at bedside for all residents. The DON stated the facilities process was for the CNA to provide fluids to the residents at the beginning of each shift, with meals, and at the resident’s request. The DON further stated the risk to the residents was dehydration and hypotension (low blood pressure). The DON explained that residents with foley catheters would be at more risk of UTI’s and expected the nurses to observe for signs of dehydration, hypotension, fever, headache, dry mouth, dry skin and chapped lips. The DON further explained her expectations were not met. A review of the facility’s Policy and Procedure (P&P) titled, “Resident Hydration and Prevention of Dehydration,” revised 3/4/2025, indicated, “…Nurses will assess for signs and symptoms of dehydration during daily care…Nurses’ Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis…” 4. Review of Resident 73’s medical record titled, “admission RECORD,” indicated Resident 73 was admitted to the facility in with diagnoses that included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells) and mild protein-calorie malnutrition (a condition where the body doesn't get enough protein and calories to meet its needs). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/25, at 8:08 a.m., with Resident 73, Resident 73 stated he had lost weight going from 165 pounds (lbs – unit of measurement) to his current weight of 111 lbs. Resident 73 stated that his weight loss was due to his dislike of the food at the facility, and that his likes and dislikes were not always followed. Review of Resident 73’s weight history for 2025 were as follows: 1. 12/8/24 – 125.6 lbs 2. 3/2/25 – 113.8 lbs. 3. 5/7/25 – 110.4 lbs. 4. 6/1/25 – 112 lbs. Review of Resident 73’s progress notes found one documented weight refusal note dated 7/8/25, which indicated “Resident refused to be weighed, offered 3x [times], explain risk and benefits”. No refusal progress notes for the months of January, February and April 2025 were found. Review of Resident 73’s care plans (a form where you can summarize a person's health conditions, specific care needs, and current treatments) did not include his refusal of weight checks. Review of Resident 73’s medical record titled, “Care Plan Report,” initiated on 1/4/22, indicated “…Focus…[Resident 73] is at risk for altered nutrition/hydration status and/or weight fluctuation…Goal…Resident will consume at least 75% meals, maintain adequate hydration status, maintain current weight = +/-5% [plus or minus 5 percent of normal body weight] . Interventions/Tasks…Monitor weight monthly or as indicated…” Review of Resident 73’s Nutritional Assessment, dated 3/25/25, indicated Resident 73’s usual body weight was 125-135 lbs. Goal weight range was gradual weight gain to UBW (usual body weight), recent weight change -11.8 lbs. (loss of 11.8 lbs. or a 9.4% weight change) in 3 months. Review of Resident 73’s Interdisciplinary Care Conference (enabling facility staff to discuss residents' unique situations, develop shared understandings, and integrate care plans with input from the resident) note, dated 3/25/25, verified Resident 73’s weight variance of -11.8 lbs. (9.4%) over the past three months. Dietary review indicated, “…67 y/o [year old] male with diabetes, mild malnutrition, gastritis (irritation of the stomach lining) and anemia noted with weight loss over the past 3 months, now considered underweight…Nutritional Diagnosis: unintended weight loss r/t [related to] predicted inadequate oral intake aeb [as evidenced by] -11.8 lbs (9.4%) x 3m [times three months]…” (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/23/25, at 1:00 p.m., with the Registered Dietitian (RD), the RD stated the facility normally did weekly weights for four weeks when a resident was newly admitted to the facility and if stable would be done monthly. The RD stated weekly interdisciplinary meetings were done to discuss any weight changes. The RD reviewed Resident 73’s weights and stated Resident 73 was definitely underweight and no weight was taken for July 2025 yet, which was a concern. The RD stated Resident 73 had a dietary assessment done in March 2025, which indicated he had lost 11 lbs. The RD reviewed Resident 73’s weights for 2025 and verified the missing weights for the months of January, February and April 2025. The RD stated it was expected for the facility to have monthly weights to be completed and should have been documented if the resident refused . The RD also stated that weights would usually increase in frequency after weight loss, which did not seem to happen for Resident 73. During an interview on 7/24/25, at 8:35 a.m., with Resident 73, Resident 73 stated he gets weighed once a month and only refused to be weighed once which was about a month ago. During an interview on 7/24/25, at 8:51 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated residents are weighed by the RNA (Restorative Nursing Assistant) monthly during the 1st week of the month. CNA 6 stated if a resident refused to be weighed, the RNA would have notified the Licensed Nurse (LN) of the refusal. CNA 6 stated she was not sure if Resident 73 had any refusals to be weighed because he was someone who wanted to know how much he weighed. CNA 6 stated it was important to monitor a resident’s weight because it was the facility’s responsibility to determine if he needed supplements or needed more food to eat. CNA 6 stated the risk of not monitoring the weights would be weight loss and the residents’ weight might have already dropped if it was not checked. During a concurrent interview and record review on 7/24/25, at 9:03 a.m., with LN 14, LN 14 stated the residents’ weights were monitored monthly or depending on the doctor’s order. LN 14 stated the RNA was responsible for obtaining the resident’s weights and if a resident refused, the RNA would have notified the LN so the LN could speak with the resident to explain the risks and benefits. LN 14 further stated if a resident still refused after speaking with the LN, the LN would then notify the resident’s doctor. LN 14 reviewed Resident 73’s weight summary for the year 2025 and confirmed weights were missing for the months of January, February and April 2025. LN 14 stated Resident 73 had a drop in weight from 125 lbs. in December 2024 to 113 lbs. in March 2025. LN 14 reviewed Resident 73’s progress notes to verify if there were refusals to obtain weights for the missing months (January, February and April 2025) and confirmed no refusal notes were found. LN 14 stated it would be ideal for the RNA to have notified the LN if Resident 73 refused to be weighed and the LN would have noted it in his chart. LN 14 reviewed Resident 73’s care plans and verified no care plans were found for refusal to obtain weights and found an active care plan intervention to monitor his monthly weight instead. LN 14 stated it was important to monitor a resident’s weight to find out if the resident was refusing to eat or if it was due to a disease process. LN 14 stated the risk of not monitoring weights would be the potential for the residents to lose weight due to an unknown diagnosis and failure to thrive (potentially weight loss, decreased appetite, poor nutrition, and reduced physical activity, often accompanied by depression, and social withdrawal). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/25, at 9:23 a.m., with RNA 1, RNA 1 stated residents’ weights were done during the first week of the month. RNA 1 stated the RNA staff checks the resident’s weight and then submits them to the MDS (Minimum Data Set, an assessment tool) Coordinator to be entered into the resident’s medical record. RNA 1 stated if Resident 73 refused to get his weight checked, she would try again the next day and if he still refused then she would have notified the LN. RNA 1 stated it was important to monitor a resident’s weight to determine if they were losing or gaining weight. RNA 1 stated the risk of not checking a resident’s weight would be the potential for skin breakdown, weight loss, and overall not feeling good. During an interview on 7/24/25, at 11:43 a.m., with RNA 2, RNA 2 stated resident weights were done monthly unless they were new admissions or if there was a specific doctor’s order for weekly weights. RNA 2 stated they used a form to document the weight of the residents, which was then submitted to the DON (Director of Nursing), RD, and MDS coordinator. RNA 2 stated the weights were done on the first weekend of the month, (either the first Friday, Saturday and Sunday of the month). RNA 2 stated if a resident refused to be weighed, she would go back to try again later in the day and would attempt for those three days from Friday to Sunday. RNA 2 further stated if the resident still refused the three attempts, she would have to notify the LN and the LN would make their own attempt and the LN would notify the DON, MDS and RD for discussion in the interdisciplinary meeting with the resident. RNA 2 stated Resident 73 had not had his weight checked at the beginning of the month even though he was on monthly weight checks, and instead noted his weight had been checked yesterday (7/23/25). RNA 2 stated it was important to monitor Resident 73’s weight to know of any significant weight loss or gain. RNA 2 stated the risk of not monitoring a resident’s weight would be weight loss, worsening of conditions, dehydration, depression and even death. During a concurrent interview and record review on 7/24/25, at 9:35 a.m., with the MDS, the MDS stated the facility just started a new process wherein the RNA obtained the resident’s weight and then she would enter the resident’s weight into the resident’s electronic medical record and she would make a list for the IDT (Interdisciplinary Team) to have a discussion about weight variances during the meetings and the RD (Registered Dietician) would keep track of the weights for any weight loss or gain. The MDS stated that it was the expectation for the staff to have documented in the resident’s chart for weight check refusals. The MDS further stated the LN would have to talk to the resident to discuss the risks and benefits of monitoring the weights and then to have notified the doctor and resident’s responsible party of the refusal, especially if they have a weight variance. The MDS reviewed Resident 73’s weights for 2025 and verified no weights were documented for January, February and April 2025 and stated Resident 73 lost weight from his weights back in December 2024 to March 2025. The MDS stated Resident 73’s weights should have been checked monthly and if the weight was checked in January and February, the weight would have already triggered a weight loss in the system. The MDS reviewed and verified Resident 73’s progress notes and care plans did not have any refusal of weights found. The MDS stated it was important to monitor the resident’s weight because they are at high risk of malnutrition, dehydration, skin breakdown and overall decline in health. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/25, at 12:15 p.m., with the Director of Staff Development (DSD), the DSD stated the expectation for was for weights to be done monthly for residents unless they were on specific monitoring or based on their condition. The DSD stated if a resident refused to be weighed, the RNA should notify the LN and they should both document on the resident’s chart of the refusal. The DSD stated both the RNA and LN should make three attempts and if the resident still refused, then a change of condition (COC) report should be made, and the doctor should be notified. The DSD reviewed Resident 73’s weights and confirmed weights were not documented for the months of January, February and April 2025. The DSD further reviewed 73’s progress notes and care plans and verified no documentation was found for weight check refusals. The DSD stated Resident 73’s LN should have been notified of the weight check refusals and a change of condition (COC) should have been done, given how much weight he lost based on his March 2025 weight compared to his December 2025 weight. The DSD stated Resident 73 was at risk of losing weight because he gets picky with his food. The DSD stated it was important to monitor residents’ weights to ensure they are getting all the nutrition they need and to determine if there were any issues, if supplements were needed or lacking. The DSD stated the risk of not monitoring weights would be malnutrition and weight loss. During a concurrent interview and record review on 7/24/25, at 2:26 p.m., with the DON, the DON stated the expectation for weight check frequency for stable residents would be monthly. The DON stated if a resident refused to be weighed, the RNA was supposed to notify the LN to continue checking and following up, and a care plan should be implemented for the resident’s refusal. The DON stated if a resident refused the three attempts to obtain the weight, the doctor should be notified. The DON reviewed Resident 73’s medical record and verified his weights were supposed to be done monthly or as needed. The DON confirmed Resident 73’s weights were not documented for the months of January, February and April 2025 and stated the weights should have been done monthly. The DON stated her expectation was for the RNA and LN to have documented Resident 73’s refusal of weight checks. The DON further stated that a COC should have been initiated for weight loss of at least 5% and a care plan should have been implemented for any refusal of weight to be taken. The DON stated it was important to monitor residents’ weights to monitor their body weight and to keep them healthy. The DON stated the risk of not monitoring the residents’ weights would be weight loss or gain and could lead to complications to their health conditions. Review of facility’s undated policy titled, “Weight Management,” indicated “…Policy Statement…To obtain baseline weight and identify significant weight change. To determine possible causes of significant weight change…To determine possible causes of significant weight change. Each individual’s weight will be obtained and documented upon admission to the facility…Policy Interpretation and Implementation…General Guidelines…1…Initial and subsequent measurements for weight will also be documented on in the weight/Vital tab in PCC [Point Click Care – a healthcare software company] or tracked in the electronic medical record and/or computer database…2.In nursing facilities, weights will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly unless physician’s orders or an individual’s condition warrants more frequent weight measurements…”

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Post Acute	442 Hampton Street Stockton, CA 95204

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were followed in accordance with physician orders for 1 out of 38 sampled residents when nursing staff inserted intravenous lines (IV - a thin tube inserted into a vein for administration of medications, fluids and/or blood products usually in the lower arm or hand for short term use) into Resident 33's arm and then removed the IV's without a physician's order on two occasions.These failures had the potential to expose Resident 33 to unnecessary risks related to IV insertion including developing an infection or other health complications and resulted in Resident 33 receiving services without a physicians order.Findings:During an observation on 7/21/2025 at 9:00 AM, Resident 33 was noted with an IV line on the right upper arm (Peripherally inserted central catheter-PICC- an IV that can be used for a prolonged period inserted into a large vein near the heart) and an IV in the left lower arm.A review of Resident 33's medical record titled, admission RECORD dated 6/23/25, indicated that Resident 33 was diagnosed with an infection in an artificial hip joint caused by Methicillin Resistant Staphylococcus Aureus (germs that are resistant to certain antibiotics). A review of Resident 33's medical record titled, admission Summary, dated 6/27/2025 indicated, . PICC to RUA [right upper arm] dated 6/27.During a concurrent observation, interview, and record review, on 7/22/2025 at 10:02 AM with Licensed Nurse (LN) 4 in Resident 33's room, Resident 33's medical record was reviewed. LN 4 confirmed Resident 33 was admitted to the facility with a PICC line. LN 4 stated Resident 33 pulled out his PICC line on 7/18/2025 and LN 2 inserted an IV on the left lower arm within the same shift. LN 4 stated the PICC line was reinserted on 7/19/2025 by the facility's vendor (a mobile company specializing in PICC line insertions). LN 4 stated the IV on the left lower arm should have been removed immediately after the PICC line was reinserted because they are only using the PICC line on the right upper arm to administer medications. LN 4 stated every IV could potentially cause an infection. LN 4 was then observed removing the IV on the left lower arm of Resident 33.A review of Resident 33's medical record titled, Nurses Progress Note dated 7/7/2025, indicated, Started IV.on the resident's right arm with good blood return. Procedure tolerated well.A review of Resident 33's medical record titled, Nurses Progress Note dated 7/12/2025, indicated, IV.on the right wrist/forearm d/cd (discontinued) with tip intact. No acute bleeding. Resident has another working IV line.A review of Resident 33's medical record titled, Nurses Progress Note dated 7/18/2025, indicated, . resident pulled his PICC line.Inserted.IV line.on the Left arm.Waiting for new orders.A review of Resident 33's medical record titled, Nurses Progress Note dated 7/18/2025, indicated, .LN found resident's PICC line was pulled. LN called RN (Registered Nurse) to check. RN reported that she was able to insert [IV] on resident's Lt (left) arm.A review of Resident 33's medical record titled, Nurses Progress Note dated 7/19/2025, indicated, PICC line was inserted to right upper arm and placement was verified by RN.During a concurrent interview and record review on 7/23/2025 at 10:59 AM with the Infection Preventionist (IP), the IP stated she expected the nurses to insert IV's when the PICC was accidentally removed. The IP stated she expects the nurse to remove the IV when the PICC line has been reinserted. The IP stated that an unused IV could lead to infection. The IP stated she expected the nurses to obtain orders from the doctor before inserting and removing an IV. The IP confirmed upon record review of Resident 33's medical record that there were no physician orders for the insertion and removal of the IV's inserted by facility staff. The IP stated that nursing staff always needed physician orders for patient care and safety.During a telephone interview on 7/23/2025 at 3:25 PM with LN 2, LN 2 stated Resident 33 pulled his PICC line out on the evening of 7/18/2025 and she called the after-hours nurse line to inform them that she inserted an IV. LN 2 confirmed Resident 33 did not have an order for the IV-line insertion. LN 2 agreed that there should have been an order for the IV insertion and doing a procedure without a doctor's order would be a safety risk for the resident.During an interview and record review on 7/24/2025 at 11:24 AM with the Director of Nursing (DON), the DON stated when a PICC line was suddenly dislodged, she expected her staff to do an assessment and notify the doctor, and the responsible party. The DON stated the nurses needed a doctor's order before inserting and removing an IV line because it was not safe practice without an order. The DON stated there would be a potential safety issue for the residents if a procedure were started without a doctor's order. Upon record review, the DON acknowledged facility nursing staff had inserted the IV lines for Resident 33 on 7/7/2025 and 7/18/2025 and removed the IV's on 7/12/25 and 7/22/25 without a physician's order. The DON stated there was a risk for infection and risk for clogging when the IV was left on a resident's arm without proper monitoring. The DON stated this method of practice was not acceptable.A review of facility

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe disposal of medications and reduce the risk of drug diversion (unauthorized drug loss/use) when:1. Medication disposals in pill form and in liquid form were identifiable and retrievable by hand when discarded into pharmaceutical waste containers in both medication rooms; and,2. Staff's personal backpack was stored in the medication room where controlled and prescription medications were stored.These failures had the potential to result in unauthorized use of medication and increased the risk of drug diversion.Findings:1. During a concurrent observation and interview on 7/24/25, at 9:14 a.m. in the East Nurses' Station medication room with Licensed Nurse (LN) 5, a pharmaceutical waste container was noted with medications in pill form and liquid form discarded into the waste container that were identifiable and retrievable by hand. LN 5 confirmed there were pills still in their original packaging and a liquid medication still in the bottle.During a concurrent observation and interview on 7/24/25, at 9:40 a.m. in the [NAME] Nurses' Station medication room with LN 5, an opened pharmaceutical waste container was noted with medications in pill form and liquid form discarded into the waste container that were identifiable and retrievable by hand. LN 5 confirmed there were pills still in plastic packs and a liquid medication still in the bottle. LN 5 stated the pills should be disposed of properly and should not be retrievable by hand. LN 5 also stated the liquid medication should have been dumped and mixed with the pills. LN 5 further stated the medications discarded into the pharmaceutical waste containers should not have been recognizable.During a concurrent observation and interview on 7/24/25, at 9:49 a.m. in the [NAME] Nurses' Station medication room with the Director of Staff Development (DSD), she confirmed medications in pill form and liquid form were discarded into the pharmaceutical waste containers which could be identified and retrieved by hand. The DSD stated the medications should have been disposed of properly. The DSD further stated the pills should not have been recognizable and liquid medications should have been dumped from the bottle.During an interview on 7/24/25, at 11:03 a.m. with the Director of Nursing (DON), the DON stated medications discarded into the pharmaceutical waste container should not be identifiable and retrievable by hand. The DON also stated the medications in pill forms should have been removed from their original packaging and the liquid medications should have been dumped and mixed with the pills. The DON explained there would be a high risk for unauthorized use of the medications thrown in the waste containers if medications were not disposed of properly.A review of the facility's policy and procedure titled, Discarding and Destroying Medications, revised November 2022, indicated, .Non-controlled substances [medications] are disposed of in accordance with state regulations and federal guidelines.EPA [Environmental Protective Agency] recommends destruction and disposal of the substance with other solid waste.take the medication out of the original containers.Mix medication, either liquid or solid, with an undesirable substance.include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage.2. During a concurrent observation and interview on 7/24/25, at 9:40 a.m. in the [NAME] Nurses' Station medication room with LN 5, a sign posted above the sink was observed that read, No personal items in med [medication] room. During further inspection, a black backpack was found under the sink. LN 5 confirmed and verified the black backpack belonged to one of the staff. LN 5 stated personal items should not have been in the medication room due to possible risk of theft, misuse of medications, or drug diversion.During an interview on 7/24/25, at 11:03 a.m. with the Director of Nursing (DON), the DON stated she expected the medication room to be clear of staff personal items due to possible risk of unauthorized use of the medications and potential for drug diversion.During a review of the facility's policy and procedure titled, MEDICATION STORAGE IN THE FACILITY, dated April 2008, indicated, .Medications and biologicals are stored safely, securely, and properly.The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (% or percentage- number or ratio expressed as a fraction of 100) for a census of 118 residents. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of two errors out of 26 opportunities which resulted in a facility wide medication error rate of 7.69 % for two out of seven sampled residents (Resident 24 and Resident 119) observed for medication administration observations as follows: 1. Resident 119 was given a medication (sucralfate - a medication often prescribed to treat ulcers and other stomach conditions) prescribed for Resident 20; and, 2. Resident 24 was given the wrong dose of duloxetine (a prescribed medication used to treat depression and anxiety disorders). These failures resulted in unsafe medication use, medication errors, and not following doctor's orders for Resident 119 and Resident 24.Findings:1. During a medication administration observation on 7/21/25 at 8:23 AM with Licensed Nurse (LN) 11, in the hallway outside Resident 119's room, LN 11 poured sucralfate into a medication cup from a bottle prescribed to Resident 20. LN 11 administered the liquid medication from Resident 20's sucralfate bottle to Resident 119. Review of Resident 119's medical record titled, Medication Administration Record (MAR - a record that records the administration of medications to a patient to ensure patient safety and track medication use), dated 7/1/25 - 7/31/25, indicated the following doctor's order: .Sucralfate Suspension 1GM/10ML (GM or gram - a unit of measurement that represents a specific weight or mass of the active ingredient in a medication; ML or milliliter - a unit of volume to measure a fluid).Give 10 milliliter by mouth four times a day for gastric [stomach] protection.Start Date.03/01/25. During a concurrent interview and record review on 7/21/25 at 1:55 PM with LN 11, Resident 119's MAR dated 7/1/25 - 7/31/25 and the sucralfate bottle's medication label for Resident 20 were reviewed. LN 11 confirmed the medication bottle of sucralfate used for Resident 119 was poured from the prescription bottle of Resident 20. LN 11 stated he used the bottle prescribed to Resident 20 because he did not have that medication on hand for Resident 119. LN 11 verified that the process, if medication was not available for the right resident, would be to order a new bottle by sending a request form to the pharmacy. LN 11 confirmed he did not follow the rights of medication administration (a set of principles designed to prevent medication errors and ensure patient safety by acting as a checklist for healthcare professionals, especially nurses, to confirm that a patient receives the correct medication) when Resident 119 received Resident 20's sucralfate. During a concurrent interview and record review on 7/21/25 at 2:14 PM with the Director of Nursing (DON), Resident 119's MAR dated 7/1/25-7/31/25 and the sucralfate bottle's medication label for Resident 20 were reviewed. The DON confirmed Resident 119 did not have a bottle of sucralfate prescribed to him in the [NAME] Cart 1 (medication cart - a portable cart designed to store, organize, and transport medications) and the cart contained a bottle of sucralfate prescribed for Resident 20. The DON stated, the sucralfate prescribed for Resident 20 should not have been administered to Resident 119.A review of the facility's procedure titled, SPECIFIC MEDICATION ADMINISTRATION PROCEDURES, dated April 2008, indicated, . To administer medications in a safe and effective manner.Read medication label before administering. Identify resident before administering medication.Review of the National Library of Medicine-National Center for Biotechnology Information webpage titled Nursing Rights of Medication Administration, dated 9/4/23, indicated, .It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ‘five rights' or ‘five R's' of medication administration. Right Patient.ascertaining [making sure] that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. (https://www.ncbi.nlm.nih.gov/books/NBK560654/)2. During a medication administration observation on 7/21/25 at 8:58 AM, LN 11 popped one pill from a bubble pack (a type of packaging that organizes and protects individual doses of medication) of Duloxetine HCl (hydrochloride- a type of salt added to medication improving the drug's absorption and effectiveness) DR (delayed release-a type of medication that is designed to release its active ingredients at a slower rate in the gastrointestinal tract) 30 MG Cap (Capsule) and placed the capsule inside a medication cup with six other medications. LN 11 administered the medications in the medication cup to Resident 24.Review of Resident 24's medical record titled, Medication Administration Record, dated 7/1/25 - 7/31/25 indicated, .Duloxetine HCl Oral Capsule Delayed Release Sprinkle 20 MG [Duloxetine HCl 20 MG Cap].Give 1 capsule by mouth two times a day for depression.Start date 7/12/25. The MAR indicated Duloxetine HCl 20 MG was given two times a

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices in one out of two medication rooms and three out of three medication carts when:1. Prescription Patches of medication were available to use in a medication cart and medication storage room without a prescription,2. Three bottles of Drug Buster (an eco-friendly, liquid solution designed for safe and effective disposal of unwanted or expired medications. It dissolves pills, tablets, capsules, and other forms of medication on contact, rendering them non-toxic and safe for disposal in regular trash) were found soiled and in active use in three different medication carts, and 3. An unknown medication was found in a medication cart compartment without packaging. These failed practices could contribute to unsafe medication use, medication errors, and the risk of contaminated products or supplies.Findings:1a. During a concurrent interview and inspection of the facility's medication storage room at East Station, on 7/22/25 at 9:10 AM, accompanied by Licensed Nurse (LN) 12, multiple packages of Lidocaine Patch 5% (a prescription medication that prevents pain by blocking the signals at the nerve endings in the skin) were observed to be stored without a prescription. LN 12 stated that the medication should have had a resident's name and label on it. LN 12 also stated that there was a risk of the medication being given to an unintended resident if there was no label on the packaging.During a concurrent interview and inspection of the facility's medication storage room at East Station, on 7/22/25 at 9:50 AM, accompanied by the Director of Nursing (DON), multiple packages of Lidocaine Patch 5% were observed to be stored without a prescription. The DON confirmed that packages of Lidocaine Patch 5% were stored in the medication storage room without a prescription label.During an interview on 7/22/25 at 3:05 PM with the Director of Staff Development (DSD), the DSD stated the nurses could think that the medication Lidocaine Patch 5% could be a house supply medication (medications that are readily available to use and do not require a prescription). The DSD also stated that Lidocaine Patch 5% should have been prescribed to someone and not be available as house supply. The DSD further stated the risks of not having proper labels on medications could lead to the nurses not knowing the proper directions on how to give the medications.During an interview on 7/22/25 at 3:31 PM with the Infection Preventionist (IP), the IP stated that Lidocaine Patch 5% should have an active doctor's prescription and not be available as house supply. The IP also stated that the staff would not know who the medication belongs to if there was not a prescription label on it. The IP further stated that a doctor's order was needed in order to give Lidocaine Patch 5%.During an interview on 7/25/25 at 5:19 PM with the Pharmacy Consultant (PC), the PC stated that prescription strength Lidocaine Patch 5% should not have been available to use as a house supply medication. The PC further stated he was not sure why the facility ordered that strength of medication when Lidocaine Patch 4% is safe to use without a prescription.During a review of the facility's policy and procedure (P&P) titled, Labeling of Medication Containers revised 04/19, the P&P indicated, .All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy.Labels for individual resident medications include all necessary information, such as: .The prescription number.1b. During a concurrent interview and inspection of facility's medication cart 1 at East Station, on 7/22/25 at 9:37 AM, accompanied by LN 7, a box containing patches of Lidocaine Patch 5% were observed without a prescription. LN 7 stated that Lidocaine Patch 4% was okay to have without a prescription. LN 7 also stated that Lidocaine Patch 5% should have a prescription.2a. During a concurrent interview and inspection of facility's medication cart 2 at East Station, on 7/22/25 at 9:22 AM, accompanied by LN 13, a bottle of Drug Buster solution was observed to be soiled and dirty. LN 13 confirmed that the bottle of Drug Buster was soiled and was touching other medications as well as making the medication cart dirty. LN 13 stated that it was an infection control issue having a dirty Drug Buster available for use in the medication cart.During an interview on 7/22/25 at 3:05 PM with the DSD, the DSD stated that having dirty and soiled bottles of Drug Buster solutions in the medication carts readily available for use was a cross-contamination risk. The DSD also stated that the solution could spill and get onto other medications in the carts. The DSD further stated that having dirty medication carts caused an infection control risk and did not meet her expectations on cleanliness.During an interview on 7/22/25 at 3:31 PM with the IP, the IP stated that the dirty Drug Buster solutions in the medication carts could lead to infection control issues and that medication carts should have been clean. The IP also stated that the solution could spill and cause other medications in the cart to get dirty.During an interview on 7/23/25 at 2:21

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to ensure the Dietary Manager met Federal, California, and facility standards for food service manager. This failure had the potential of leading to food borne illness and malnutrition for the 112 residents eating facility prepared meals.During an interview with the Dietary Manager (DM), on 7/21/25, at 7:54 AM, the DM stated she had not completed the Certified Dietary Manager (CDM) program which had been purchased in January 2025, after starting work as the DM for the facility in December 2024. The DM also stated she was currently working 40 hours a week as the DM. A review of the facility provided job description titled, Certified Dietary Manager, dated October 2020, indicated the following: Education -Must possess, as a minimum, a bachelor's degree in nutrition, dietary management field from an accredited college or university.Specific Requirements-Must be a Certified Dietary Manager (or comparable certification) in the state. During an interview with Registered Dietitian 2 (RD 2) on 7/23/25, at 1:01 pm, RD 2 described her duties at the facility. RD 2 worked primarily with the residents providing clinical nutrition (assessments, reassessments, care planning nutrition issues, etc.). When asked about her involvement in the kitchen, RD 2 stated that she did a monthly inspection of the kitchen, as well as a monthly observation of the meal plating and a monthly taste test of the meal. Review of California Health and Safety Code 1265.4 indicated that licensed health facilities who do not hire a full-time registered dietitian to manage the kitchen, must employ a full-time Dietary Manager. The Code lists seven pathways, such as a bachelor's degree in food and nutrition, dietetics, or food management, or graduation from a dietetic technician, Dietary Services Supervisor, and Certified Dietary Manager program. It also indicated that A graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, must maintain this certification, as well as having received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure the nutritive value of food was maintained when:1. The menu recipe was not followed for the baked ziti with meat sauce and when:2. Resident 30 and Resident 98 did not receive all food ordered on their lunch tray.These failures had the potential of leading to nutrient deficiency for the 112 residents receiving facility prepared meals. 1.During a concurrent observation and interview on 7/22/25, at 9:24 a.m., with Dietary [NAME] (DC) 1 in the food preparation area of the kitchen, DC1 prepared the baked ziti for the lunch meal. After straining the pasta, he split it between two large pans and a quarter size pan and proceed to add meat sauce to the pasta. He added 5 containers to one large steam table pan, 4 containers to a second large steam table pan, and 2 containers to the quarter pan. When asked how many cups were in the container, he stated he was unsure. No markings were listed on the container.During this same observation and interview on 7/22/25, at 9:43 a.m. , DC 1 was asked how the sauce was made and stated a jarred product was used. After mixing the pasta with the sauce, DC 1 finished the ziti by adding cheese. DC1 took two opened cottage cheese containers and spread an unmeasured amount on top of the pasta and then poured an unmeasured amount of shredded cheese from the manufacturer packaging on top of it.Review of facility provided recipe, BAKED ZITI/MEATSAUCE (S) METHOD (Healthcare Providers Services Inc. menu), dated 2025, ingredients indicated, .1 and 1/8 cup of cottage cheese.3 and 1/2 cup of mozzarella cheese.3 and 3/4 cup of mozzarella cheese or provolone cheese.Review of facility provided recipe, BAKED ZITI/MEATSAUCE (S) METHOD (Healthcare Providers Services Inc. menu), dated 2025, sauce ingredients indicated, . 3 and 3/4 can diced tomatoes .1 and 1/8 cup chopped onions .2 tablespoon (tbs) and 1/2 teaspoon (tsp) basil .1 tbs parsley, 1 and 3/8 tsp parsley .1 and 1/8 tsp salt .Review of facility provided recipe, BAKED ZITI/MEATSAUCE (S) METHOD (Healthcare Providers Services Inc. menu), dated 2025, included but not limited to the following directions:-Brown ground beef in a large kettle or stock pot. - Add tomatoes, tomato puree, 1st amount of parsley, onions, and other seasonings. Cover and simmer for 10 min. Turn off heat. Omit salt from sauce for salt free diet.- [NAME] pasta in salted water, (for salt free diets omit salt) according to package, drain well.- Layer as follows in 12 x 20 x 2 baking pans:a) sauceb) cooked zitic) cottage cheeseFor each pan:- Smooth more sauce over the top.- Sprinkle the 2nd amount of parsley over the sauce.- Sprinkle 8oz mozzarella (or provolone) cheese over the parsley. 2. During an observation and interview on 7/22/25, at 2.21 p.m., with the DM, Resident 30's lunch tray was reviewed. The DM verified Resident 30 meal ticket indicated, .pureed garlic bread, and moist iced brownie . The DM verified the garlic bread was missing from the tray and a pureed brownie was served instead of a moist iced brownie. During this same observation and interview, Resident 90's lunch tray was reviewed. The DM verified Resident 90 meal ticket indicated, .pureed garlic bread, and moist iced brownie . The DM verified the garlic bread was missing from the tray and a pureed brownie was served instead of a moist iced brownie.During a concurrent interview and record review on 7/22/25, at 2:05 p.m., with Registered Dietitian (RD) 2, the facility kitchen spreadsheet titled, CYCLE 3 2025 dated 7/22/25 was reviewed. The spreadsheet indicated there were several diets that were suppose to be prepared as salt free. RD 2 stated it was important to follow spreadsheet and meal ticket. Residents will not receive adequate nutrition if meal tickets are not followed. RD 2 further stated it was her expectation food preparation followed the recipe instructions as not following the recipe could, affect quality, taste, nutritional value, and actual intake of calories. RD 2 also stated the jarred sauce product likely contains sodium potentially affecting residents on a salt free diet. During a review of the facility's policy and procedure titled, Menus, dated 10/2022, indicated, .Menus will be served as written unless a substitution is provided in response to preference, unavailability of an item, or a special meal.

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Hampton Post Acute	442 Hampton Street Stockton, CA 95204

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 112 residents who ate facility prepared meals when:1. Food items were not labeled properly in the food preparation area and reach-in refrigerator;2. Reach-in refrigerator temperature log was found with missing data for July 2025;3. Three out of four kitchen fans were found with dust buildup;4. Food preparation area had chipped paint;5. Soft and moldy zucchinis and potatoes were found in the walk-in refrigerator, and spices were found beyond the use by date;6. Food products were not fully covered in two out of three reach-in freezers; and,7. The resident's refrigerator had the following:a. Temperature log had an out-of-range temperature reading that was not addressed;b. Stored foods that were improperly labeled; and,c. Stored food were not in compliance with the facility's policy. These failures had the potential to put residents who ate the facility prepared meals at risk for foodborne illnesses.Findings:1. During a concurrent observation and interview during the initial kitchen tour on 7/21/25, at 8:21 a.m., with the Dietary Manager (DM), the following were confirmed with the DM: a. An opened container of Thyme leaves was found in the food preparation area with a label that lacked an open date. The DM confirmed the container of Thyme leaves did not have an open date and staff would not be able to know when to discard. b. A container of peaches found in the walk-in refrigerator had a label that lacked a use by date. c. A container of strawberry gelatin found in the walk-inrefrigerator had a label that indicated the prepared date of 7-18 and use by date of 7-22. The DM confirmed these two dates were missing the year and that staff wouldn't know if the product was still safe when the date was incomplete. d. A jar of buttermilk ranch found in the walk-in refrigerator had a label that indicated use by date of 7/18/25 and open date of 9/18/25. The DM stated the dates were written backwards which would cause confusion to staff regarding the safety of the product.During an interview on 7/23/25, at 2:26 p.m., with the DM, the DM stated food labeling was usually reviewed by the DM or the assistant DM. During this check, they would ensure that everything was labeled and dated for items in the refrigerator and the food preparation areas. During an interview on 7/23/25, at 1:00 p.m., with the Registered Dietician (RD), the RD stated food items should be labelled with the item's name, open date, made by date, and use by date. The RD stated it would be a problem if the labels were not complete as they help ensure food freshness and safety, and that improperly labeled food should therefore be tossed out. Review of the facility's undated policy titled, LABELING AND DATING OF FOOD, indicated .Policy: All food will be dated, labeled, and prepared for storage to prevent contamination, deterioration, and dehydration.Procedure:.All products must be clearly labeled with the date when the product was opened.Review of facility's undated policy titled, Food Receiving and Storage, indicated .Refrigerated/Frozen Storage.1. All foods stored in the refrigerator or freezer are covered, labeled and dated.7. Refrigerated foods are labeled, dated.2. During the initial kitchen tour on 7/21/25, at 8:28 a.m., with the DM, the walk-in refrigerator was observed with a temperature log posted on the door for the month of July 2025. Review of the kitchen's walk-in refrigerator temperature log for the month of July 2025, titled Refrigerator Temperature Log, indicated missing entries for the following: a. 7/9/25 and 7/10/25 - missing PM temperature and staff initials b. 7/12/25 - missing PM temperature and staff initialsc. 7/13/25 - missing PM temperature and staff initialsd. 7/14/25 - missing AM and PM temperature and staff initialse. 7/15/25 - missing AM and PM temperature and staff initialsf. 7/17/25 - missing AM temperature and staff initialsg. 7/18/25 to 7/20/25 - missing PM temperature and staff initialsReview of the log showed 24 out of 80 entries were not entered and left blank. During an interview with the DM on 7/21/25 at 8:38 a.m., the DM concurred that entries were left blank and stated all kitchen staff were responsible for checking and making sure that the temperature logs were completed.During an interview on 7/23/25, at 1:00 p.m., with the RD, the RD stated that specific staff positions would be assigned the task to of monitoring temperature on and the supervisor should be reviewing to make sure it is being done since temperature control is critical in food safety. The RD verified that sections were not filled out on the walk-in refrigerator temperature log for the month of July 2025. The RD stated it was important that the temperature logs were completed for food safety as food left above 41 degrees F (Fahrenheit, a unit of measure) could lead to food poisoning. Review of facility's undated policy titled, Food Receiving and Storage, indicated .Refrigerated/Frozen Storage.5. Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a complete and accurate clinical record for one of 38 sampled residents (Resident 56) when the resident's Physician Orders for Life-Sustaining Treatment (POLST -outlines a patients end-of-life care and wishes) was not readily accessible in Resident 38's electronic health record (EHR -a digital collection of a patient's medical information that is stored and accessed quickly).This deficient practice had the potential to go against Resident 56's wishes to not be resuscitated (revived from unconsciousness or apparent death) if Resident 56 became unresponsive, which could result in serious physical harm to Resident 56.Findings:During an interview on [DATE] at 8:48 AM in Resident 56's room, Resident 56 stated he had signed a POLST indicating he wanted to be a Do-Not-Resuscitate (DNR -a medical order instructing healthcare professionals not to perform cardiopulmonary resuscitation [CPR] if a person's heart stops or they stop breathing) around the time he was admitted to the facility.During a concurrent interview and record review on [DATE] at 8:53 AM, Licensed Nurse (LN) 7 checked Resident 56's EHR and stated Resident 56 did not have a code status (a patient's pre-determined instructions regarding medical interventions that should be performed in the event of a cardiac [heart] or respiratory [lungs, breathing] arrest [stops]) entered. LN 7 further stated that since Resident 56 did not have a code status readily available in their EHR, Resident 56, would be treated as a full-code (medical term that indicates a patient's wish to receive all possible life-saving measures in the event of cardiac or respiratory arrest) and CPR would be initiated. During a concurrent interview and record review on [DATE] at 9:35 AM, LN 9 checked a binder at the East nurse's station and found the written POLST form signed by Resident 56 and the physician that indicated Resident 56 was a DNR. LN 9 explained they were to assume a resident was a full-code and someone would check the EHR to confirm their code status as they began CPR. LN 9 further stated that the POLST should have been entered in the Residents EHR and entered as a physician's order when the POLST was signed by Resident 56 and the physician on admission, LN 9 confirmed neither was completed. During an interview on [DATE] at 1:16 PM the Director of Nursing DON stated it was her expectation that the resident's code status be readily available when the resident was pulled up in the EHR. The DON further stated if no code status was listed, it was assumed the residents were a full code, and CPR would be initiated.A review of Resident 56's Care Plan Report, dated [DATE], indicated, . [Resident 56] is DNR.Will respect and adhere to [Resident 56] care directives.Do Not Resuscitate. No Life Prolonging Procedure -No Intubation.A review of facility policy titled, Do Not Resuscitate Order, revised [DATE], indicated, .Our facility will not use cardiopulmonary resuscitation [CPR] and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to implement and maintain a comprehensive QAPI (QAPI- a data driven and proactive approach to improvement used to ensure services are meeting quality standards) program and plan when the facility did not implement and maintain a comprehensive QAPI program, and did not provide documentation or evidence of ongoing QAPI activities.These failures had the potential to result in the facility's inability to identify and correct deficiencies which could negatively impact the residents' physical and psychosocial health and well-being. Findings: During a concurrent interview and record review on 7/24/25 at 4:05 PM, the Administrator (ADM) reviewed the QAPI program and confirmed that they did not have appropriate monitoring and documentation portion of the QAPI program. The QAPI program binder was reviewed with the ADM, and the ADM confirmed they should have focused more on documenting the QAPI program. The ADM further stated that the QAPI program was lacking in detail, follow-up and documentation. The ADM explained that the QAPI team did a lot of work behind the scenes, however, they did not have any documentation that showed the results of their monitoring. The ADM stated that the risk of not having a well-documented QAPI program and plan placed the residents at risk of having quality of care issues not reviewed and correction plans not being developed and implemented. A review of the facility's undated policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership Policy Statement indicated, . 1. The Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI Program, and for interpreting its results and findings to the governing body. 2. The governing body is responsible for ensuring that the QAPI program: a. Is implemented and maintained to address identified priorities; b. Is sustained through transitions of leadership and staffing;.Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to use its Quality Assurance Performance Improvement (QAPI- a data driven and proactive approach to improvement used to ensure services are meeting quality standards) program to develop and implement P&Ps for data collection systems, feedback, monitoring, analysis, and action, including adverse event monitoring when the facility did not collect data (information) or identify corrective measures for any issues affecting the facility.These failures had the potential for goals to go unreviewed, issues to go unidentified, and quality care improvement activities not to be evaluated and revised as needed, which could lead to declines in residents' overall quality of care.During a concurrent interview and record review on 7/24/25 at 4:05 PM, the Administrator (ADM) reviewed the QAPI policy and confirmed that data collection, monitoring, analysis and action including adverse event monitoring measures were not added to the QAPI program and were never addressed. The ADM stated that We don't have monitoring and documentation portion of the QAPI plan, it's not compiled and input in our records. I know that it is not up to standards. A review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership Policy Statement indicated, . The Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI Committee, which reports its findings, actions and results to the Administrator and governing body . Is based on data, resident and staff input, and other information that measures performance; and e. Focuses on problems and opportunities that reflect processes, functions and services provided to the residents.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility's Quality Assessment and Assurance (QAA: a proactive process that aims to prevent errors, identify standards of practice that are not being met, and ensure health care services consistently meet or exceed predetermined standards) committee failed to meet quarterly with all required members for a census of 118, when:1. The required quarterly Quality Assurance Performance Improvement (QAPI: a data driven and proactive approach to improve the quality of life, quality of care and services delivered in nursing facilities) meeting was not held in April 2025, and,2. The Director of Nurses (DON) did not attend the January 6, 2025, quarterly meeting and the Administrator did not attend the QAPI meeting held on June 26, 2025.These failures had the potential for goals to go unreviewed, issues to go unidentified, and quality care improvement activities not to be evaluated and revised as needed, which could lead to declines in residents' overall quality of care.Findings:1. During a concurrent interview and record review on 7/24/2025 at 4:05 PM, the Administrator (ADM) stated that the QAA committee should meet frequently but not less than quarterly. Quarterly QAPI meeting minutes were reviewed with the ADM. The ADM confirmed that the committee met on January 1, 2025, and June 26, 2025, to review quality reports, safety concerns, and ensure corrective actions had been implemented but had failed to meet in April 2025. The ADM stated, We don't have monitoring and documentation portion of the QAPI plan, it's not compiled and input in our records. I know that it is not up to standards.2. During a concurrent interview and record review of the QAA Committee attendance sheets on 7/24/2025 at 4:05 PM, the ADM confirmed the DON had not attended the QAPI meeting held on January 1, 2025, and he had not attended the June 26, 2025, QAPI meeting. The ADM stated, I should have focused more on QAPI, I didn't work on it as I should have. The ADM added that all required members of the QAA Committee, which included the ADM and the DON, should attend the QAPI meeting. The ADM stated that the risk of required members of the QAA Committee not attending the QAPI meeting placed residents at risk of having quality of care issues not reviewed and correction plans not being developed and implemented.Review of a facility policy titled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership revised March 2020, indicated, .The following individuals serve on the committee: a. Administrator, or a designee who is in a leadership role; b. Director of Nursing Services; c. Medical Director; d. Infection Preventionist.The committee meets at least quarterly (or more often as necessary).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure their call light system (system/device used by residents to call staff for assistance) was functioning for 5 out of 38 sampled residents (Resident 3, Resident 13, Resident 34, Resident 71, Resident 112) and 1 unsampled resident (Resident 92), per facility policy when:1. Resident 3, Resident 13, Resident 34, and Resident 71 did not have a functioning call light and an alternative means to call for assistance was not provided; and, 2. Resident 112 and unsampled Resident 92 did not have a functioning call light in their room and an alternative means to call for assistance was not provided.These failures resulted in Residents 3, 13, 34, 71, 92, and 112 being unable to call staff for assistance when needed, their physical and emotional needs were not met; and Resident 112 felt frustrated and that his needs were not important. Findings:1. During an observation in the [NAME] side nursing station on 7/21/25 at 9:10 a.m., Resident 34's call light was alarming but there was no visible light outside the resident's room. During a concurrent observation and interview on 7/21/25 at 10:14 a.m. with the Certified Nursing Assistant (CNA) 1, CNA 1 verified that Resident 34's call light was pressed, and no visual alert was observed outside the resident's room. CNA 1 proceeded to test the other resident's room and confirmed that Resident 3, 13, and 71's did not have their lights turned on outside their doors when the call light was pressed. CNA 1 stated that having a working call light was important because it let staff know that residents need assistance. CNA 1 also stated that it put the residents at risk for harm especially in an emergency.During a concurrent observation and interview on 7/21/25 at 11:24 a.m. in the hallway of the [NAME] side nursing station with Licensed Nurse (LN) 1, LN 1 confirmed Resident 3, 13, 34, and 71's call lights were not working when pressed and the residents did not have a bell to use at bedside. LN1 stated that it was important for the residents to have a working call light for their safety, and it also would alert staff when the residents needed help. LN 1 also stated that it could put the residents at risk for harm in emergency situations. 2. During a concurrent observation and interview on 7/21/25 at 10:24 PM, in Resident 112 and Resident 92's room, Resident 112 stated he was thirsty and wanted more water to drink but could not find his call light. Resident 112 was given his call light that was found on the floor and pressed it for assistance. Resident 112 further stated he had tried to use his call light all weekend, and it was not working. Resident 112 explained he and Resident 92 told staff their call lights were not working, and they were not given an alternative way to call for assistance. Resident 112 stated it made him feel not important and frustrated, that he had no way to get help unless Resident 92 yelled for assistance. Resident 92 confirmed the call lights had not been working all weekend and that he yelled each time he or Resident 112 needed assistance. Resident 92 further confirmed they were not given an alternative way to call for assistance. During a concurrent observation and interview on 7/21/25 at 10:38 AM, LN 4 confirmed the call light was not coming on above the door entrance to Resident 112 and Resident 92's room and confirmed the call light was also not sounding at the nurse's station or lighting up at the nurse's station call light board. LN 4 stated functioning call lights were important in case the resident's needed assistance. LN 4 explained the risk to the residents for their call light not working could be a resident falling and getting injured.A review of Resident 112's, Care Plan Report, dated 8/7/2023, indicated, .[Resident 112 is high risk for falls.Be sure resident's call light is within reach.needs prompt response to all requests for assistance.[Resident 112 needs a safe environment.a working and reachable call light.During an interview on 7/23/25 at 2:58 p.m. with the Maintenance Assistant (MA), the MA stated that resident call lights were checked monthly. Staff reports on any broken equipment using the TELS system (program used by staff to report any broken equipment). The MA stated the call lights were manually checked in June 2025 because he did not have access to the TELS system during that time and there were no broken call lights in the facility. The MA added that the call lights were important for the resident's safety. During an interview and record review on 7/22/25 at 10:18 a.m. with the Director of Nursing (DON), the DON stated having a working call light system was important for the residents because staff can provide the needed care and, they could notify staff of any concerns. The DON further stated that having a non-functional call light system placed residents at risk of harm because they were unable to request assistance when needed. The DON explained this could lead to unsafe situations, such as residents attempting to get up without help, which could result in falls and potential injuries. The DON confirmed that the call light policy was not followed. During a follow up interview on 7/24/25 at 12:46 PM, the DON confirmed residents should be given an alternative way to contact staff when assistance was needed and the facility had bells to give to the residents in these circumstances. A review of the facility's