STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555186	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, the facility failed to report an allegation of verbal abuse (harsh and insulting language directed at a person; also known as verbal attack, verbal aggression, verbal assault) for one of three sampled residents (Resident 1) when Resident 1 reported that a Licensed Nurse (LN) was rude to him and called him a thief on 1/10/26.This failure had the potential to a delayed investigation by the Department and the risk of negatively affecting Resident 1's psychosocial well-being.Findings:A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility in 2025.During a phone interview on 2/5/26, at 11:52 a.m., with Resident 1, Resident 1 stated on 1/10/26 in the early morning hours, he went to the snack room at the facility to get hot water for coffee, and a licensed nurse (LN) stated to him that he could not go into the snack room to get hot water. Resident 1 further stated the LN accused him of being a thief, and told him that if anything came up missing he would be the number one suspect. Resident 1 stated that the way the LN spoke to him felt like verbal abuse and slander (a false spoken statement about someone that damages their reputation), because she accused him of being a thief. Resident 1 further stated the LN worked the 11 p.m. - 7 a.m. shift at the facility, but the incident happened in the early morning hours of 1/10/26. Resident 1 stated that he was not sure what the LN's name was. Resident 1 further stated that he reported the incident to the Licensed Nurse Supervisor (LN Sup). Resident 1 stated the LN Sup told him that he could enter the snack room at any time to get hot water and that she would take care of it.During a phone interview on 2/5/26, at 3 p.m., with LN 1, LN 1 stated she knew Resident 1 and that she recalled the incident with Resident 1. LN 1 further stated she asked Resident 1 not to go into the snack room at night on the date of the incident. LN 1 stated she asked Resident 1 to put on his call light if he wanted snacks or hot water and that staff would get it for him. LN 1 further stated the night shift staff kept their belongings in the snack room so they would not have to go to the other side of the facility to retrieve their belongings and could stay closer to their assignments because there were less staff at night. LN 1 stated that she did not call Resident 1 a thief, and she never accused Resident 1 of being a thief. LN 1 further stated that she never told Resident 1 that he would be the number one suspect if anything was missing. LN 1 stated that she wrote a progress note in Resident 1's electronic medical record (EMR) regarding the incident. LN 1 further stated she reported the incident to administration. LN 1 confirmed that she did not really report the incident when asked who she specifically reported the incident to. LN 1 stated that she did not see the relevance of reporting it. LN 1 further stated that she simply asked Resident 1 to stay out of the snack room.A review of Resident 1's EMR did not indicate a Progress Note, entry was documented regarding the incident between Resident 1 and LN 1 on 1/10/26.During an interview on 2/5/26, at 3:28 p.m., with the Social Services Director (SSD), the SSD stated the facility had a Grievance (a complaint or strong feeling of being treated unfairly) Binder for resident complaints. A review of the facility's Grievance Binder, indicated that a grievance was filed by LN Sup (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 1 on 1/12/26 regarding an interaction with LN 1. The grievance indicated that Resident 1 told the LN Sup that one of the LNs was rude to him and told him that it was not okay to take food from the snack room at night. The grievance further indicated the LN Sup told Resident 1 that it was okay to get snacks from the snack room at night. The grievance indicated the LN Sup talked with the night shift staff and let them know that the snack room was for everyone.During a concurrent interview and record review on 2/5/26, at 4:10 p.m., with the LN Sup, the facility's Grievance Binder, and the facility's undated policy and procedure titled, Elder/ Dependent Adult Abuse, were reviewed. The LN Sup confirmed that she spoke with Resident 1 regarding his concern on 1/12/26 and completed the grievance form for Resident 1. The LN Sup stated Resident 1 reported that LN 1 was rude to him, and that he felt offended by the way the LN spoke to him that day. The LN Sup further stated that she told Resident 1 that he could not take all of the snacks from the snack room, but that he could take enough for the evening if he wanted. The LN Sup stated she told the night shift staff that the snack room was for residents and staff. The LN Sup further stated she reminded the staff that they needed to check the residents' diets before giving them snacks in case the requested snack was not allowed in the diet ordered by their physician. The LN Sup stated Resident 1 did not mention abuse when she spoke to him on 1/12/26 about the incident. The LN Sup further stated in her judgment, she felt the right thing to do was to file the grievance for Resident 1. The LN Sup stated if Resident 1 had said the word abuse, she would have filed a SOC-341 (Suspected Abuse Report Form) form and reported the incident.During a phone interview on 2/6/26, at 9:19 a.m., with LN 4, LN 4 stated she was Resident 1's transition of care nurse with Resident 1's insurance. LN 4 further stated Resident 1 had called her on 1/27/26 and reported that he was verbally abused by one of the LNs at the facility. LN 4 stated Resident 1 told her that he did not remember the LN's name. LN 4 further stated Resident 1 did not describe the incident to her. LN 4 stated she did a three-way call with Resident 1 and the Ombudsman's office (OMB, an independent advocate that helps residents resolve complaints, understand their rights, and navigate care-related issues), but they connected to the OMB's voicemail, so Resident 1 left a voicemail message for the OMB and stated that he was verbally abused at the facility.During a phone interview on 2/6/26, at 9:33 a.m., with LN 2, LN 2 stated he remembered Resident 1. LN 2 further stated Resident 1 told him that another LN told him that he was not allowed in the snack room. LN 2 confirmed that he and LN 1 were the LNs on duty during the night shift on the date of the incident. LN 2 stated Resident 1 told him that LN 1 called him a thief. LN 2 further stated Resident 1 had said that he felt abused by LN 1. LN 2 stated he calmed Resident 1 down and told Resident 1 that he would talk to LN 1. LN 2 further stated he went to talk to LN 1 and that LN 1 claimed that she did not call Resident 1 a thief. LN 2 stated he reported the incident to the LN Sup and that the LN Sup followed up with Resident 1.During a phone interview on 2/6/26, at 1:24 p.m., with the OMB, the OMB stated she received a message from the OMB's office that Resident 1 had called on 1/26/26. The OMB further stated she called Resident 1 back on 1/26/26, and Resident 1 stated that one of the LNs at the facility verbally assaulted him but did not give the name of the LN. The OMB explained Resident 1 told her that he was at an appointment and did not feel comfortable talking about the matter at that time, then requested that she call him back. The OMB stated that she received a missed call from Resident 1 on 1/27/26. The OMB further stated she went to the facility on 1/29/26 hoping to speak with Resident 1 in person, but Resident 1 was away at an appointment.A review of an undated facility policy and procedure (P&P) titled, Elder/Dependent Adult Abuse, indicated, .Policy.The facility will.Protect residents' privacy and protect from any type of abuse.Guidelines.This facility will protect the rights, safety and wellbeing of each resident regardless of physical or mental condition (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	against any and all forms of abuse.Abuse.Includes.verbal.Procedure.Identification of Possible Incidents or Allegations of Abuse.The person identifying the possible incident or allegation will.Follow the mandated reporting procedure and immediately report same to the Administrator or designee.Reporting.Any mandated reporter (someone who is required to report knowledge or reasonable suspicion of abuse) who, in his or her professional capacity, or within the scope of his or her employment.has knowledge of an incident that reasonably appears to be any type of abuse or is told by an elder.that he or she has experienced behavior.constituting abuse.will report the known or suspected instance of abuse.to facility administrator and to other officials in accordance with State law, including.State Survey Agency, LTC (Long Term Care) Ombudsman, local law enforcement and the adult protective services.immediately but not later than.24 hours.if the alleged violation.does not result in serious bodily injury.