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	05/19/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to implement interventions to prevent a recurrence of a pressure injury (sores (ulcers) that happen on areas of the skin that are under pressure) for one of three residents (Resident 1) who had a history of a resolved pressure ulcer in the sacrococcygeal area (lower back/tailbone area), active moisture-associated skin damage (MASD - skin damage caused by prolonged exposure to moisture) to the right buttock, bowel and bladder incontinence, decreased bed mobility, and dependence on staff for repositioning, when Resident 1was not repositioned while in bed, resulting in Resident 1 remaining on her back in the same position for more than two hours despite complaints of back and buttocks pain. These failures placed Resident 1 at risk for recurrence of pressure injury and skin impairment, including MASD.Findings:Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar that has caused damage to the kidneys), rheumatoid arthritis (a disease that causes joint pain, swelling, and stiffness), anxiety disorder, recurrent dislocation of the right shoulder, muscle weakness, chronic pain syndrome (long-lasting pain), pain in the right shoulder, pain in the left shoulder, spondylosis (wear and tear of the spine), primary generalized osteoarthritis (joint damage causing pain and stiffness in multiple joints), gout (a type of arthritis that causes sudden joint pain, often in the big toe), and repeated falls.Review of Resident 1's Skin Observation Tool dated 4/29/26 indicated Resident 1 had right buttock MASD.Review of Resident 1's Care Plan, initiated 10/16/25, in the section titled Focus, indicated .[Resident 1] POTENTIAL ALTERATION IN SKIN INTEGRITY RELATED TO .DECREASED BED MOBILITY .INCONTINENT OF BOWEL AND BLADDER AND HISTORY OF RESOLVED ULCER .Review of Resident 1's Brief Interview for Mental Status (BIMS - to assess a resident's thinking and memory) dated 5/8/26 indicated Resident 1's BIMS score was 14, which reflected intact cognition (13-15 = Intact, 8-12 = Moderate Impairment, 0-7 = Severe Impairment).Review of Resident 1's [Facility Name] Documentation Survey Report v2 [version 2] May-26, for the period 5/1/26 through 5/19/26, in the section titled GG - Roll Left and Right, indicated Resident 1 was mostly dependent (helper does all of the effort) and was never independent with rolling and repositioning during the review period. This indicated Resident 1 was unable to independently reposition herself in bed and relied on staff assistance for pressure relief at the time of the assessment.During a concurrent observation and interview on 5/19/26 at 11:55 AM with Resident 1 in Resident 1's room, Resident 1 was lying on her back in bed with the head of the bed slightly elevated. Resident 1 stated she had wounds on her buttocks and complained of pain in her buttocks and back.During an observation on 5/19/26 at 1:05 PM in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM.During a concurrent observation and interview on 5/19/26 at 1:45 PM with Resident 1 in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM and 1:05 PM. Resident 1 stated she had not changed position in bed.During a concurrent observation and interview on 5/19/26 at 2:17 PM with the Assistant Director of Nursing (ADON) in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM, 1:05 PM, and 1:45 PM. The ADON acknowledged Resident 1 had remained in the same position in bed since the prior (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations.During an interview on 5/19/26 at 2:24 PM, Certified Nursing Assistant (CNA) 1 stated Resident 1 was assigned to her during the current AM shift. CNA 1 stated Resident 1 was turned to her side for incontinent care at approximately 10:00 AM and then placed back lying flat on her back after incontinent care was completed. CNA 1 further stated Resident 1 remained lying flat on her back since 10 AM.During a joint interview on 5/19/26 at 2:37 PM with Licensed Treatment Nurse (LTN) 1 and LTN 2, LTN 1 stated Resident 1's MASD had resolved that day (5/19/26) and LTN 2 stated Resident 1 had a history of pressure injury to the sacrococcyx area (lower back near the tailbone). LTN 1 further stated it was important for Resident 1 to be repositioned due to fragile skin, a history of pressure injury that could easily reopen, and recent resolved MASD. LTN 1 and LTN 2 acknowledged that Resident 1 staying in one position in bed could result in skin breakdown. During a concurrent interview and record review on 5/19/26 at 5:11 PM with the Director of Nursing (DON), Resident 1's Care Plan, initiated 4/29/26, in the section titled Focus, indicated .[Resident 1] ALTERATION IN SKIN INTEGRITY .AS EVIDENCED BY: MASD SITE: RIGHT BUTTOCK . In the section titled Interventions/Tasks, the Care Plan indicated .TURN AND REPOSITION SEVERAL TIMES PER SHIFT AND PRN . The DON stated staff were expected to reposition Resident 1 at least every two hours to prevent skin impairment and provide pressure relief. Review of the facility's policy and procedure titled Repositioning, revised 3/2025, indicated .to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation, and provide pressure relief for residents . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief . A turning/repositioning program included a continuous program for changing the resident's position and realigning the body . Residents who are in bed should be on at least an every-two-hour (q2 hour) repositioning schedule .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) had access to water and fluids when Resident 1 complained of dry mouth, dry lips, and thirst and was unable to obtain fluids because the water pitcher was not within Resident 1's reach and no cup was available, which prevented Resident 1 from accessing and consuming fluids when needed.These failures had the potential to place Resident 1 at risk for dehydration (when the body does not get enough fluids to function properly), falls, and choking.Findings:Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including unspecified diastolic heart failure (a condition where the heart is stiff and does not fill properly, making it harder to pump blood), type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar that has caused damage to the kidneys), rheumatoid arthritis (a disease that causes joint pain, swelling, and stiffness), anxiety disorder, recurrent dislocation of the right shoulder, muscle weakness, chronic pain syndrome (long-lasting pain), pain in the right shoulder, pain in the left shoulder, spondylosis (wear and tear of the spine), primary generalized osteoarthritis (joint damage causing pain and stiffness in multiple joints), diverticulosis of the intestine (small pouches in the intestines), gout (a type of arthritis that causes sudden joint pain, often in the big toe), and repeated falls.Review of Resident 1's Brief Interview for Mental Status (BIMS-to check a resident's thinking and memory), dated 5/8/25, Resident 1 BIMS score was 14 which showed that Resident 1 had intact cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).Review of Resident 1's Care Plan, initiated 10/16/25, in the section titled Focus indicated .[Resident 1] POTENTIAL ALTERATION IN SKIN INTEGRITY RELATED TO.DECREASED BED MOBILITY.INCONTINENT OF BOWEL AND BLADDER AND HISTORY OF RESOLVED ULCER. In the section titled Interventions/Tasks, indicated .PROMOTE GOOD.HYDRATION.During a concurrent observation and interview on 5/19/26 at 11:55 AM with Resident 1 in Resident 1's room, Resident 1 was lying on her back in bed with the head of the bed slightly elevated. Resident 1 was repeatedly moistening her lips with her tongue while speaking, and her mouth and lips were dry in appearance. A water pitcher containing water was placed on the far corner of the overbed table on the right side of Resident 1's bed, outside Resident 1's reach. Resident 1 stated her mouth and lips were dry and that she was thirsty. Resident 1 attempted to reach the water pitcher but was unable to do so and stated she could not reach the water pitcher. Resident 1 further stated this was not the first time she needed a drink and could not access the water. During a concurrent observation and interview on 5/19/26 at 12:15 PM with Licensed Nurse (LN) 1 in Resident 1's room, Resident 1 was lying on her back in bed with the head of bed slightly elevated. LN 1 stated that Resident 1 had dry lips and dry mouth, which were signs of dehydration. LN 1 asked Resident 1 if she needed water, and Resident 1 stated she was thirsty and needed to drink but could not reach the water pitcher. LN 1 confirmed the water pitcher was not within Resident 1's reach and stated there was no cup available at Resident 1's bedside. LN 1 stated Resident 1 was unable to lift the water pitcher and staff should have poured water into a cup and ensured it was within Resident 1's reach.During a concurrent interview and record review on 5/19/26 at 3:05 PM with Assistant Director of Nursing (ADON), Resident 1's Care Plan, initiated on 10/16/25 was reviewed. In the section titled Focus indicated .[Resident 1] POTENTIAL FOR FALL/INJURY. In the section titled Interventions/Tasks, indicated .KEEP PERSONAL ITEMS.WITHIN REACH. The ADON stated Resident 1's water was considered a personal item and should be kept within Resident 1's reach. The ADON further stated if Resident 1's water was not within reach, Resident 1 was at risk for falling out of bed if Resident 1 attempted to reach for the water and at risk for dehydration, as Resident 1 could not drink fluids to remain hydrated. During an interview on 5/19/26 at 5:11 PM with the Director of Nursing (DON), the DON stated staff were expected to ensure water was within residents' reach to prevent falls, injury, and dehydration. Review of facility policy and procedure (P&P) titled, Hydration - Clinical Protocol, revised 9/17, the P&P indicated, .The staff will provide supporting measures such as supplemental fluids.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to timely fully assess Resident 1's pain and provide non-pharmacological (non-medication) interventions, such as repositioning, to help relieve pain for one of three residents (Resident 1), when Resident 1, who required staff assistance to reposition in bed, complained of back and buttocks pain and remained lying flat in bed for more than two hours without a complete pain assessment or repositioning.These failures resulted in Resident 1 continuing to experience pain and discomfort and delayed identification and implementation of appropriate interventions to relieve the pain.Findings:Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including, type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar that has caused damage to the kidneys), rheumatoid arthritis (a disease that causes joint pain, swelling, and stiffness), anxiety disorder, recurrent dislocation of the right shoulder, muscle weakness, chronic pain syndrome (long-lasting pain), pain in the right shoulder, pain in the left shoulder, spondylosis (wear and tear of the spine), primary generalized osteoarthritis (joint damage causing pain and stiffness in multiple joints), gout (a type of arthritis that causes sudden joint pain, often in the big toe), and repeated falls.Review of Resident 1's Brief Interview for Mental Status (BIMS-to check a resident's thinking and memory), dated 5/8/25, Resident 1 BIMS score was 14 which showed that Resident 1 had intact cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).During a concurrent observation and interview on 5/19/26 at 11:55 AM with Resident 1, in Resident 1's room, Resident 1 was lying on her back in bed with the head of the bed slightly elevated. Resident 1 grimaced (made a facial expression showing pain) and stated she had pain all over her body, primarily in her buttocks and back, and rated the pain as 7 out of 10 on a scale where 10 is the worst pain, indicating severe pain (1-3 = mild, 4-6 = moderate, 7-10 = severe). Resident 1 stated she had wounds on her buttocks and that no one had asked about her pain and she had not received pain medication.Review of Resident 1's [Facility Name] Documentation Survey Report v2 [version 2] May-26 for the period 5/1/26 through 5/19/26, in the section titled GG - Roll Left and Right, indicated Resident 1 was mostly dependent (helper does all of the effort) and was never independent with rolling and repositioning during the review period. This indicated Resident 1 was unable to independently reposition herself in bed and relied on staff assistance for pressure relief.During a concurrent observation and interview on 5/19/26 at 12:15 PM with Licensed Nurse (LN) 1 in Resident 1's room, Resident 1 stated she had pain. LN 1 stated Resident 1 was always in pain.During an interview on 5/19/26 at 12:25 PM with LN 1, LN 1 stated pain assessments (checking residents for pain) were conducted during the first medication pass around 8 AM to 8:30 AM, and that Resident 1 had reported pain. LN 1 stated she did not assess Resident 1's pain characteristics, including pain level or location, during the first medication pass and that Resident 1 did not receive pain medication at that time.During a concurrent observation and interview on 5/19/26 at 1:05 PM with Resident 1 in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM and 12:15 PM. Resident 1 stated she took Tylenol and it helped a little, but her buttocks and back still hurt.During a concurrent observation and interview on 5/19/26 at 1:45 PM with Resident 1 in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM, 12:15 PM, and 1:05 PM. Resident 1 stated she had not changed position in bed. During a concurrent observation and interview on 5/19/26 at 2:17 PM with the Assistant Director of Nursing (ADON) in Resident 1's room, Resident 1 remained lying on her back in bed in the same position as observed at 11:55 AM, 12:15 PM, 1:05 PM and 1:45 PM and stated her buttocks and back still hurt despite taking another medication she could not recall. The ADON acknowledged Resident 1 had remained in the same position in bed since the prior observations. The ADON acknowledged repositioning could relieve pain in addition to pain medication and that a complete assessment, including pain location and severity was important to determine appropriate interventions. During an interview on 5/19/26 at 2:24 PM, Certified Nursing Assistant (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA) 1 stated Resident 1 was assigned to her during the current AM shift. CNA 1 stated Resident 1 was turned to her side for incontinent care at approximately 10 AM and then placed Resident 1 on her back after incontinent care was completed. CNA 1 further stated Resident 1 remained lying flat on her back since 10 AM.During a concurrent interview and record review on 5/21/26 at 10:55 AM with the Director of Nursing (DON), Resident 1's Medication Administration Record (MAR) indicated Resident 1 received Tylenol 325 milligrams (mg - a unit of measure), two tablets, at 12:23 PM on 5/19/26 for pain rated 3 out of 10. Resident 1 then received a new order for Hydrocodone-Acetaminophen (Norco - a stronger pain medication used for moderate to severe pain) 5-325 mg, one tablet every eight hours, with a start date of 5/19/26 at 1 PM. Resident 1 received one tablet of Norco at 1:24 PM with a pain level of 8 out of 10. The DON acknowledged Resident 1 was not provided with non-pharmacological interventions, including repositioning, prior to the administration of Norco. Resident 1's Care Plan was also reviewed with the DON. Resident 1's Care Plan, initiated 10/16/25, in the section titled Focus, indicated .[Resident 1] ALTERATION IN COMFORT/PAIN. In the section titled Interventions/Tasks, indicated .ASSESS INTENSITY OF PAIN USING 0-10 SCALE BASED UPON THE FOLLOWING: PRESENT PAIN, WORST PAIN, BEST THE PAIN GETS, ACCEPTABLE LEVEL OF PAIN.NON-PHARMACOLOGICAL PAIN INTERVENTIONS, i.e., REPOSITIONING. The DON stated staff were expected to reposition Resident 1 at least every two hours to provide comfort and assist with pain control. The DON acknowledged Resident 1 was not repositioned while in bed during the observation period despite the care plan intervention requiring non-pharmacological pain interventions such as repositioning.Review of facility's policy and procedure (P&P), titled Repositioning, revised in 3/25, the P&P indicated .to promote comfort for all bed-or chair bound residents.Review of facility's P&P, titled Pain-Clinical Protocol, revised in 10/22, the P&P indicated .The staff and physician will identify the characteristics of pain such as location, intensity, frequency. Pattern, and severity.The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example.repositioning.Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example.repositioning.