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	03/27/2026

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 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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 63 residents who received meals from the kitchen when:1. Two open boxes with green lettuce and cheese were placed on the kitchen floor;2. Dietary staff did not fully cover the hair on the back of their head in the kitchen;3. One mesh bag of yellow onion was placed on the kitchen food storage room floor, and a bag of dry cereal and flour were not sealed in a container,4. Spinach was thawed in a sink next to two open chemical buckets; and5. A plastic food cover, an open box of gloves, and a grill cleaner was kept in a kitchen cabinet with cleaning supplies. These failures had the potential of leading to food borne illness (an illness that comes from eating contaminated food) in the 63 residents eating facility prepared meals.Findings: 1. During a concurrent observation and interview on 03/24/26 at 8:23 a.m., with the Dietary Supervisor (DS) and Dietary Aide (DA) 2 in the kitchen, DA 2 placed two open cardboard boxes containing lettuce and cheese on the kitchen floor in front of the freezer. DA 2 confirmed the boxes were open, had holes on the bottom, and exposed the food items to the floor. DA 2 stated food items should not be placed on the floor and doing so could cause contamination.2. During a concurrent observation on 3/24/26 at 8:31 a.m., DA 1 was observed wearing a hairnet that did not fully cover the back of her head. DA 1 confirmed the hairnet did not fully cover her hair and stated it should cover all of her hair to prevent contamination. During a concurrent observation and interview on 3/24/26 at 8:33 a.m., the [NAME] (CK) confirmed the hairnet did not fully cover the DA 1's hair and stated all hair should be covered.3. During a concurrent observation and interview on 3/24/26 at 8:34 a.m., in the kitchen dry storage room with the DS and the CK, a mesh bag of onions was observed on the floor, a bag of cereal was observed in a plastic bag that was tied but not stored in a sealed container, and an open paper bag of flour was observed on the shelf and was not stored in an airtight container. The CK confirmed the onion bag was open and placed on the floor, the cereal bag was not sealed in a container, and the flour was not stored in an airtight container. The CK further stated open food items should be stored in sealed containers and not placed on the floor.4. During a concurrent observation and interview on 3/26/26 at 8:44 a.m., with the CK, nine plastic bags of uncooked spinach were observed thawing under running water in the middle compartment of a three-compartment sink. Open buckets containing chemicals were present in the adjacent sink compartments. The CK confirmed the spinach was thawed next to open chemical containers and stated food should not be thawed near chemicals and should be thawed in a designated area away from contamination sources.5. During a concurrent observation on 03/26/26 at 11:35 a.m. in a walk-in storage area, a plastic food cart cover in an open box, an open box of gloves, and grill cleaner were stored together in a cabinet with cleaning supplies, a dust bin, and a broom. The DS stated there was no issue with storing food-related items with cleaning supplies; however, these items were stored in the same cabinet, creating the potential for contamination.During (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a concurrent interview and record review of photographic evidence on 3/26/26 at 3:49 p.m. with the Registered Dietitian (RD) and DS, the RD stated that cross contamination could occur when staff do not follow proper food handling practices. The RD stated food should not be placed on the floor, should be stored in sealed containers, and should be thawed away from chemicals. The RD further stated that hairnets should cover all hair.During a concurrent interview and record review of photographic evidence on 03/27/26 at 10:02 a.m. with the Administrator (ADM), the ADM reviewed the observations and confirmed that facility expectation is for dietary staff to maintain sanitary conditions in all food service areas. The ADM stated that hair and facial hair must be fully covered with appropriate hairnets, food items must be stored off the floor in sealed containers, and food must be thawed in a controlled environment away from chemicals. The ADM confirmed that the observed practices, including exposed food items placed on the floor, improper hair coverage, improper thawing of food next to chemicals, and improper storage of food and food-related items with cleaning supplies, were not acceptable and did not meet facility standards for safe food handling and infection control practices. During a review of the facility's P&P titled, Food Receiving and Storage, dated 2001, the P&P indicated, .Food shall be received and stored in a manner that complies with safe food handling. some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.Food in designated dry storage areas are kept at least six (6) inches off the floor. During a review of the facility's P&P titled, Food Preparation and Service, dated 2001, the P&P indicated, .Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness.Cross contamination can occur when harmful substances i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces.Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.Areas for cleaning dishes and utensils are located in a separate area from the food service line to assure that a sanitary environment is maintained. During a review of the Food and Drug Administration (FDA) Food Code 2022, 2-402.11 Hair Restraints .(A) FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage and refuse were properly contained in the kitchen and outside dumpster areas for a total facility census of 64 residents, when one trash can inside the kitchen and one of two outside dumpster lids were observed not closed. This failure had the potential to expose the resident's environment to pests, odors, and disease.Findings:During an observation on 3/24/26 at 8:56 a.m. with the Dietary Supervisor (DS) in the kitchen, a trash can was observed with the lid propped open.During a concurrent observation and interview on 3/24/26 at 8:57 a.m. with the [NAME] (CK) in the kitchen, the CK confirmed the trash can was not closed. The CK stated the trash can should have been fully covered with a lid.During a concurrent observation and interview on 3/24/26 at 9:09 a.m. with the DS in the outside dumpster area of the facility, a dumpster was observed with the lid propped open. The DS stated the dumpster lid should have been closed to prevent contamination and pests.During an interview on 3/26/26 at 3:49 p.m. with the Registered Dietitian (RD), the RD stated that trash bins inside the kitchen and outside dumpster areas should remain covered to prevent pest exposure.During an interview on 3/27/26 at 10:02 a.m. with the Administrator (ADM), the ADM stated that dumpster lids should remain closed at all times.During a review of the facility's policy and procedure titled Sanitation, dated 2022, the policy indicated, .the food service area is maintained in a clean and sanitary manner. All kitchens and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. Garbage and refuse containers are maintained in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). Areas used for garbage disposal are free from odors and waste accumulation and maintained to prevent pests .Review of the U.S. Food and Drug Administration (FDA) Food Code 2022, Section 5-501.15, Outside Receptacles, indicated, .receptacles and waste handling units for refuse shall be designed and constructed to have tight-fitting lids, doors, or covers., (https://www.fda.gov/media/164194/download)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 64 residents when:1. Resident 102's nebulizer tubing (plastic tubing used to deliver breathing treatments) was not stored in a protective bag after use.2. The facility did not implement their identified control measures (an action aimed to eliminate a hazard or at least reduce the risk) in order to identify any potential growth of Legionella (a bacteria that can grow in water systems and cause a serious lung infection, especially in older adults and those with weak immune systems) in the water system.These failures had the potential to increase the risk of infection transmission to residents, staff, and visitors.Findings:1. Review of Resident 102's admission RECORD indicated Resident 102 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (lung disease that makes breathing difficult), dependence on supplemental oxygen, heart failure, muscle weakness, and need for assistance with personal care.Review of Resident 102's physician's order dated 3/13/26 indicated an order for ipratropium-albuterol solution (a medication that helps open the airways) 0.5 mg-2.5 mg/3 ml (milligrams of medication in milliliters - unit measure), 3 (three) ml every two hours as needed for shortness of breath and wheezing via nebulizer (a machine that turns medicine into a mist).During a concurrent observation and interview on 3/24/26 at 2:31 PM, with Resident 102 in Resident 102's room, Resident 102 was lying in bed with a nebulizer machine (a machine that turns medicine into a mist to breathe into the lungs) placed on the bedside table on the right side of the bed. A nebulizer mask connected to the machine via nebulizer tubing was placed on top of the nebulizer machine with the mask face down. A protective storage bag dated 3/21/26 was hanging below the nebulizer machine. Resident 102 stated that a Licensed Nurse (LN) administered the nebulizer treatment, then removed the mask from Resident 102's face and placed the nebulizer tubing on top of the nebulizer machine. During a concurrent observation and interview on 3/24/26 at 2:44 PM, with LN 3 in Resident 102's room, Resident 102 was lying in bed with a nebulizer mask and tubing placed on top of the nebulizer machine on the bedside table on the right side of the bed. LN 3 stated that nebulizer tubing was not in the protective storage bag and that not storing the nebulizer tubing in the protective storage bag after use could spread infection.During a concurrent interview and record review on 3/27/26 at 7:57 AM, with the Licensed Nurse Supervisor (LNS), Resident 102's Medication Administration Record (MAR), dated 3/26 was reviewed with the LNS. Resident 102's MAR indicated that on 3/24/26, the ipratropium-albuterol solution (nebulizer treatment) was last administered by a LN at 6:36 AM. LN 3 stated it had been eight hours since the nebulizer treatment was administered and the nebulizer tubing had been left on a surface, which increased the risk of contamination and infection transmission in the facility.During an interview on 3/27/26 at 9:32 AM, with the Director of Nursing (DON), the DON stated that nebulizer tubing should be stored in a protective storage bag after use to protect the nebulizer tubing from exposure to contaminated surfaces and prevent transmission of infection from one resident to another. Review of facility's policy and procedure (P&P) titled Administering Medications through a Small Volume (Handheld) Nebulizer, dated 3/26, the P&P indicated, .When equipment [nebulizer] is completely dry, store in a plastic bag with the resident's name and the date on it.2. During an interview on 3/26/26 at 10:13 AM with the Director of Maintenance (DOM), the DOM stated that the facility did not implement testing of control measures such as water temperature, water pH (a measure of how acidic or basic the water is), and water chlorine. The DOM stated that he did not perform other control measures such as flushing water in areas with stagnant water and did not document cleaning of the buildup of bacteria on wet surfaces. The DOM further stated that without performing control measures and documentation, the facility was at risk for the growth of Legionella bacteria in the water system.During a concurrent interview and record review on 3/27/26 at 8:28 AM, the facility's [Facility name and address] WATER MANAGEMENT PROGRAM [WMP] 2025-2026, dated 3/24, was reviewed with the Licensed Nurse (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Supervisor (LNS). The WMP indicated that control points were identified in the water management plan diagram. The LNS stated that control measures were not implemented for the identified control points in the WMP diagram to prevent the growth of Legionella in the facility's water system. The LNS stated that water temperature, water pH, and water disinfectant (chemicals such as chlorine used to kill germs) were not tested, and other control measures were not performed, such as flushing water in areas with stagnant or slow-moving water or areas not commonly used, and there was no documentation of biofilm cleaning (a buildup of bacteria on wet surfaces). The LNS further stated that the purpose of control measures was to prevent the growth of Legionella in the facility's water system and to protect residents from acquiring Legionella infection.During an interview on 3/27/26 at 9:54 AM with the Director of Nursing (DON), the DON stated that control measures should be implemented and documented as part of the WMP, and that without implementation of control measures, the facility had no monitoring of conditions that increase the risk of Legionella growth in the facility's water system. The DON further stated that without monitoring, Legionella could grow in the building, and the facility was at increased risk for a Legionella outbreak (an increase in cases of infection), especially because the facility's population was elderly and vulnerable.Review of facility's policy and procedure (P&P), titled Legionella Water Management Program revised in 3/26, the P&P indicated .The identification of areas in the water system that could encourage the growth and spread of Legionella.Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants).The control limits or parameters that are acceptable and that are monitored.A diagram of where control measures are applies.A system to monitor control limits and the effectiveness of control measures.Documentation of the program.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS; an assessment tool) comprehensive assessments were completed for 4 of 30 sampled residents (Resident 52, Resident 68, Resident 76, and Resident 87), when comprehensive assessments were not performed within the required time frame for Resident 52, Resident 68, Resident 76, and Resident 87.This failure had the potential to result in failure to evaluate residents' overall health status, delayed or absent care plan initiation, and inappropriate interventions, placing residents at risk for harm.Findings:1. A review of Resident 52's admission Record indicated Resident 52 was admitted to the facility in 2026 with diagnoses which included acute embolism (a sudden, life-threatening obstruction of a lung artery, usually caused by a blood clot traveling from a deep vein thrombosis (DVT) in the legs) and thrombosis of unspecified deep veins of left lower extremity, hemiplegia and hemiparesis (Hemiplegia; severe/total paralysis) and hemiparesis (mild/partial weakness) are neurological conditions affecting one side of the body, usually caused by brain damage from stroke, trauma, or congenital conditions), paroxysmal atrial fibrillation (a type of irregular heart rhythm (arrhythmia) that starts and stops suddenly on its own), and dysphagia (difficulty swallowing).During a concurrent interview and record review on 3/25/26 at 3:01 PM, Resident 52's MDS tracking (a section in the electronic health record that contains MDS information such as due dates and in-progress and/or completed assessments) was reviewed with the Minimum Data Set Coordinator Nurse (MDSN; nurse responsible for completing resident assessments for care planning and reporting). The MDSN verified that Resident 52's admission MDS assessment was due to be completed on 2/5/26. The MDSN confirmed that Resident 52's admission assessment was not completed as of 3/25/26.2. A review of Resident 68's admission Record indicated Resident 68 was admitted to the facility in 2020 with diagnoses which included hemiplegia and hemiparesis, aphasia (impaired ability to understand or produce speech, as a result of brain disease or damage), hyperlipidemia (a common condition characterized by high levels of lipids (fats), such as LDL cholesterol and triglycerides, in the blood), and atherosclerotic heart disease of native coronary artery (a condition where plaque (fats, cholesterol) builds up in the heart's natural arteries, reducing blood flow).During a concurrent interview and record review on 3/25/26 at 3:05 PM, Resident 68's MDS tracking was reviewed with the MDSN. The MDSN confirmed that Resident 68's annual MDS assessment was due to be completed on 2/11/26. The MDSN confirmed that Resident 68's annual assessment was not completed as of 3/25/26.3. A review of Resident 76's admission Record indicated Resident 76 was admitted to the facility in 2023 with diagnoses which included unspecified atrial fibrillation, hyperlipidemia, polyosteoarthritis (a chronic condition involving the degradation of cartilage in multiple joints (typically five or more), leading to pain, stiffness, and reduced mobility), and muscle weakness.During a concurrent interview and record review on 3/25/26 at 3:06 PM, Resident 76's MDS tracking was reviewed with the MDSN. The MDSN confirmed Resident 76's annual MDS assessment was due to be completed on 2/15/26. The MDSN confirmed that Resident 76's annual assessment was not completed as of 3/25/26.4. A review of Resident 87's admission Record indicated Resident 87 was admitted to the facility in 2024 with diagnoses which included essential hypertension (high blood pressure), hyperlipidemia, spondylosis (a common, age-related degenerative condition of the spine-often called spinal osteoarthritis-affecting the discs, joints, and ligaments in the neck [cervical] or lower back (lumbar)), contracture (a permanent or long-lasting tightening of muscles, tendons, ligaments, or skin, causing joint stiffness and limited mobility) of right food, contracture of left foot, and dysphagia.During a concurrent interview and record review on 3/25/26 at 3:07 PM, Resident 87's MDS tracking was reviewed with the MDSN. The MDSN confirmed Resident 87's annual MDS assessment was due to be completed on 2/8/26. The MDS stated that Resident 87's annual assessment was not completed as of 3/25/26.During an interview on 3/25/26 at 3:10 PM, the (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN stated that if a resident's comprehensive assessment was not performed within the required time frame, the resident's current condition and care needs would not be accurately reflected. The MDSN further stated that resident's comprehensive MDS assessment triggered care plan initiation, and without it, staff could have implemented inappropriate interventions, placing the resident at risk for harm. During an interview on 3/27/26 at 9:40 AM with the Director of Nursing (DON), the DON stated residents' comprehensive MDS assessments were expected to be completed by the facility within the required time frame. The DON stated that comprehensive MDS assessments identified residents' healthcare needs and helped staff provide timely interventions. The DON further stated that if comprehensive MDS assessments were not completed, residents' conditions and care needs would not be identified in a timely manner, which could delay meeting the residents' needs and pose a safety risk to residents.Review of a facility's policy and procedure (P&P) titled, Comprehensive Assessments, revised 3/22, the P&P indicated .Comprehensive assessments are conducted to assist in developing person-centered care plans.admission Assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day .Annual Assessment is a comprehensive assessment for a resident that must be completed on annual basis (at least every 366 days).Review of a facility's P&P titled, Resident Assessments dated 3/26, the P&P indicated .A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations [Omnibus Budget Reconciliation Act - federal law that sets rules for nursing home care] and PPS requirements [Protective Payment System - Medicare payment system based on resident assessments].OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents.include.admission Assessment.Annual Assessment.Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.Review of a facility's P&P titled, MDS Completion and Submission Timeframes, revised 3/26, the P&P indicated .facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure residents' assessments were completed for 4 of 30 sampled residents (Resident 55, Resident 46, Resident 56, and Resident 84), when quarterly Minimum Data Set (MDS; an assessment tool used by the facility) assessments were not performed within the required time frame for Resident 55, Resident 46, Resident 56, and Resident 84.This failure had the potential to result in failure to identify changes in residents' status, delayed care plan updates, and inappropriate interventions, placing residents at risk for harm.Findings:1. A review of Resident 55's admission Record indicated Resident 55 was admitted to the facility in 2025 with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar levels), diplopia (double vision, is the perception of two images of a single object, either constantly or intermittently), muscle weakness, need for assistance with personal care, atrioventricular block (a type of heart block where electrical signals controlling the heartbeat are delayed or blocked between the heart's upper (atria) and lower (ventricles) chambers), and repeated falls.During a concurrent interview and record review on 3/25/26 at 3:02 PM with the Minimum Data Set Coordinator Nurse (MDSN; nurse responsible for completing resident assessments for care planning and reporting), Resident 55's MDS tracking (a section in the electronic health record that contains MDS information such as due dates and in-progress and/or completed assessments) was reviewed. Resident 55's MDS tracking indicated that Resident 55 had a due date for a quarterly assessment to be completed on 2/12/26, which should have been submitted to the Centers for Medicare & Medicaid Services (CMS) within 14 days after completion. The MDSN stated that Resident 55's quarterly assessment was not completed as of 3/25/26.2. A review of Resident 46's admission Record indicated Resident 46 was admitted to the facility in 2025 with diagnoses which included chronic obstructive pulmonary disease (COPD; a progressive, treatable, but incurable lung disease), chronic respiratory failure (a long-term, progressive condition where the lungs cannot adequately oxygenate the blood or eliminate carbon dioxide, often causing severe fatigue, shortness of breath, and confusion), cachexia (wasting syndrome, is a complex, often irreversible condition linked to chronic illnesses like cancer, characterized by severe, involuntary loss of weight, muscle mass, and fat), and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable worry or fear that interferes with daily life, work, or relationships).During a concurrent interview and record review on 3/25/26 at 3:03 PM, Resident 46's MDS tracking was reviewed with the MDSN. Resident 46's MDS tracking indicated that Resident 46 had a due date for a quarterly assessment to be completed on 2/19/26, which should have been submitted to CMS within 14 days after completion. The MDSN stated that Resident 46's quarterly assessment was not completed as of 3/25/26.3. A review of Resident 56's admission Record indicated Resident 56 was admitted to the facility in 2023 with diagnoses which included hemiplegia and hemiparesis (Hemiplegia (severe/total paralysis) and hemiparesis (mild/partial weakness) are neurological conditions affecting one side of the body, usually caused by brain damage from stroke, trauma, or congenital conditions), dysphagia (difficulty swallowing), chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot properly filter blood, often leading to waste buildup), and muscle weakness.During a concurrent interview and record review on 3/25/26 at 3:04 PM with the MDSN, Resident 56's MDS tracking was reviewed with the MDS. Resident 56's MDS tracking indicated that Resident 56 had a due date for a quarterly assessment to be completed on 2/7/26, which should have been submitted to CMS within 14 days after completion. The MDSN stated that Resident 56's quarterly assessment was not completed as of 3/25/26.4. A review of Resident 84's admission Record indicated Resident 84 was admitted to the facility in 2024 with diagnoses which included other fracture (a medical term for a broken bone, occurring when force exceeds the bone's strength, commonly causing intense pain, swelling, and bruising) of lower end of femur (the longest, strongest, and heaviest bone in the human (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body, extending from the hip joint to the knee joint), pain, malignant neoplasm of prostate (prostate cancer, is the uncontrolled growth of cells in the male reproductive gland, often forming slow-growing adenocarcinomas (a common, often aggressive cancer that begins in glandular cells lining organs like the lungs, breasts, prostate, and colon)), and immunodeficiency (a condition where the immune system's ability to fight infections and diseases is compromised, resulting in frequent, severe, or long-lasting infections).During a concurrent interview and record review on 3/25/26 at 3:08 PM, Resident 84's MDS tracking was reviewed with the MDSN. Resident 84's MDS tracking indicated that Resident 84 had a due date for a quarterly assessment to be completed on 2/11/26, which should have been submitted to CMS within 14 days after completion. The MDSN stated that Resident 84's quarterly assessment was not completed as of 3/25/26.During an interview on 3/25/26 at 3:10 PM, the MDSN stated that if a resident's quarterly assessment was not performed within the required time frame, the resident's current condition and care needs would not be accurately reflected, which could prevent the care plan from being accurately updated and could result in inappropriate interventions, placing the resident at risk for harm. During an interview on 3/27/26 at 9:40 AM with the Director of Nursing (DON), the DON stated residents' quarterly assessments were expected to be completed by the facility within the required time frame. The DON stated that quarterly assessments identified residents' changes in healthcare needs and helped staff provide timely interventions. The DON further stated that failure to complete the assessment could pose a safety risk to residents. Review of a facility's policy and procedure (P&P) titled, Quarterly Assessments, revised 3/26, the P&P indicated .Quarterly MDS assessments are conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored.The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act - federal law that sets rules for nursing home care] non comprehensive assessment for a resident that is completed at least every 92 days following the previous OBRA assessment of any type.The MDS completion date.will be no later than 14 days after the ARD [Assessment Reference Date - the specific date that sets the time period of competing a resident's assessment].Review of a facility's P&P titled, Resident Assessments, dated 3/26, the P&P indicated .OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents.include.Quarterly Assessment.Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.Review of a facility's P&P titled, MDS Completion and Submission Timeframes, revised 3/26, the P&P indicated .facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

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	03/27/2026

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

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately treat pain as ordered for six of thirty sampled residents (Resident 10, Resident 12, Resident 31, Resident 45, Resident 46, and Resident 47) when:1. Resident 10 received acetaminophen (an over-the-counter pain medication) for a documented pain level (using a numerical pain scale of 1 through 10 that measures the pain intensity and impact on daily life: 0 = no pain, 1 through 3 = mild pain, 4 through 6 = moderate pain, 7 through 9 = severe pain, and 10 = the worst pain imaginable) rated as a 7 or 8 when the order was written for a mild pain level of 1-3; and,2. Resident 12 received hydrocodone-acetaminophen (a combination opioid (strong) pain medication and a mild pain reliever) 5/325mg (milligram - a unit of measurement) for a documented moderate pain level rated as 6 when the order was written for severe pain level of 7-10. Resident 12 did not have a pain medication ordered to treat a moderate pain level; and,3. Resident 31 received acetaminophen 500mg for a documented pain level rated as a 4 when the order was written for mild pain level 1-3, and received acetaminophen 1000mg for a documented pain level rated 7 when the order was written for moderate pain level of 4-6. Resident 31 did not have a pain medication ordered to treat a severe pain level; and,4. Resident 45 received acetaminophen 325mg for a documented pain level rating of 4 or higher when the order was written for a mild pain level of 1-3. Resident 45's pain medication regimen was not addressed with the physician when Resident 45 experienced side effects when using a stronger pain medication and was not documented that Resident 45 experienced side effects from the stronger pain medication; and,5. Resident 46 received morphine 100mg/5ml (opioid pain medication in liquid form, mg/ML is milligram per milliliter, a unit of measure for the dose) for a documented pain level rating of 0-5 when the order was written for severe pain level of 7-10; and,6. Resident 47 received acetaminophen 325mg for a documented pain level rating of 5 or higher when the order was written for mild pain level of 1-4. Resident 47 did not have a pain medication ordered to treat moderate or severe pain.These failures to properly assess the residents rated pain level and administer the correct ordered pain medication based on the assessed pain levels could place Resident 10, Resident 12, Resident 31, Resident 45, Resident 46, and Resident 47 at risk for receiving inadequate pain relief or overmedicating that could lead to side effects such as lethargy, decreased respiratory rates, and declines in functional ability.Findings:1. A review of Resident 10's clinical document titled admission RECORD indicated that Resident 10 was admitted to the facility with diagnoses that included Rheumatoid arthritis (RA - is a chronic disease where the body's immune system mistakenly attacks healthy joint tissue, causing painful inflammation, swelling, and stiffness), chronic pain syndrome (a condition where pain lasts for more than 3 to 6 months-well beyond normal healing time-and is accompanied by significant emotional and functional issues like depression, anxiety, and fatigue), pain in right shoulder, pain in left shoulder, and osteoarthritis (a common wear-and-tear joint disease where the protective cartilage cushioning the ends of bones gradually wears away, leading to pain, stiffness, and grinding as bones rub together).During a review of Resident 10's clinical document titled Brief Interview for Mental Status (BIMS - a screening test, often used in nursing homes, to assess a person's short-term memory and mental sharpness. It is scored from 0 to 15, with higher scores indicating better cognitive function), dated 2/6/26, indicated Resident 10 had a BIMS score of 14 indicating intact cognitive function.During a review of Resident 10's clinical document titled Order Summary Report, dated 3/1/26, the report indicated that Resident 10 had a physician order dated 1/25/26 for acetaminophen tablet 325mg, 2 tablets every 6 hours as needed for mild pain rated a (1 to 3) and a physician order dated 1/25/26 for Morphine 100mg/5ml give 0.25ml by mouth every 6 hours as needed for moderate pain (4-6) or give 0.5ml by mouth every 6 hours as needed for severe pain (7-10).During a review of Resident 10's clinical document titled ?MEDICATION ADMINISTRATION RECORD (MAR - a document-paper or electronic-used by caregivers to track every medication given to a patient), dated 1/1/26 through (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/31/26, the MAR indicated Resident 10 had received acetaminophen 325mg 2 tablets above the ordered pain level parameter as follows:1/8/26 for pain level rating of 81/12/26 for pain level rating of 71/13/26 for pain level rating of 7Further review of the same document indicated that Resident 10 was not medicated with morphine as ordered for the documented level of pain.During a review of Resident 10's MAR, dated 2/1/26 through 2/28/26, the MAR indicated Resident 10 had received acetaminophen 325mg 2 tablets above the ordered pain level parameter as follows:2/2/26 for pain level rating of 42/16/26 for pain level rating of 42/21/26 for pain level rating of 7Further review of the same document indicated that Resident 10 was not medicated with morphine as ordered for the documented level of pain.During a review of Resident 10's MAR, dated 3/1/26 through 3/31/26, the MAR indicated Resident 10 had received acetaminophen 325mg 2 tablets above the ordered pain level parameter as follows:3/1/26 for pain level rating of 43/8/26 for pain level rating of 8Further review of the same document indicated that Resident 10 was not medicated with morphine as ordered for the documented level of pain.During a review of Resident 10's clinical document titled Care Plan Report, the document indicated that Resident 10 had a care plan (a written, step-by-step roadmap for a person's health, outlining their conditions, goals, and the actions needed to manage them) that was initiated on 10/16/25 for ALTERATION IN COMFORT/PAIN. The care plan included an intervention (a specific action or step taken by a healthcare provider like a nurse, doctor, or therapist to help a patient reach a health goal listed on the care plan) that indicated that nursing should ADMINISTER MEDICATIONS AS ORDERED. NOTIFY MD [medical doctor] IF NOT EFFECTIVE.During review of Resident 10's clinical document titled Progress Notes, dated 1/2/26 through 1/30/26, 2/2/26 through 2/22/26, and 3/1/26 through 3/14/26, there was no documentation that indicated the MD had been contacted to report that acetaminophen had been given for a pain level rating higher than the ordered parameter.During a concurrent interview and record review on 3/26/26 at 1 PM with Licensed Nurse (LN) 5, Resident 10's MARs for January 2026, February 2026 and March 2026 were reviewed. LN 5 confirmed that Resident 10 had received acetaminophen during those months for a pain level above the ordered parameter of 1-3 and that Resident 10 should have received morphine 0.25ml for a pain level rated at 4-6 or morphine 0.5ml for a pain level rated at 7-10. LN 5 stated that not providing Resident 10 with the proper pain medication for that rated pain level placed Resident 10 at risk for unrelieved pain that could impact her overall health.2. A review of Resident 12's clinical document titled admission RECORD indicated that Resident 12 was admitted to the facility with diagnoses that included dementia (a decline in mental ability-such as memory, thinking, or reasoning-severe enough to interfere with daily life) and presence of left artificial hip joint.During a review of Resident 12's clinical document titled Brief Interview for Mental Status, the BIMS indicated that Resident 12 had a score of 0, which indicated Resident 12 cognitive function was severely impaired.During a review of Resident 12's clinical document titled Order Summary Report, dated 3/1/26, the report indicated that Resident 12 had a physician's order dated 12/30/25 for acetaminophen 500mg 1 tablet every 6 hours as needed for mild pain, scale of 1 to 3. The report also indicated that Resident 12 had a physician's order dated 1/22/26 for hydrocodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed for severe pain, scale 7-10. The report indicated that there were no physician orders that would address an assessed pain level of 4-6.During a review of Resident 12's MAR dated 1/1/26-1/31/26, the MAR indicated that Resident 12 received hydrocodone-acetaminophen on 1/16/26 for a documented pain level of 6.During a review of Resident 12's MAR dated 2/1/26 through 2/28/26, the MAR indicated that Resident 12 received hydrocodone-acetaminophen on 2/17/26 and 2/19/26 for a documented pain level of 6.During a review of Resident 12's clinical document titled Care Plan Report, the report indicated that Resident 12 had a care plan that was initiated on 7/8/25 and revised on 11/6/25 for ALTERATION IN COMFORT/PAIN.RELATED TO INFLAMMATION, GENERALIZED PAIN, PRESENCE OF LEFT ARTIFICIAL HIP JOINT.WITH ACCEPTABLE PAIN SCALE OF 0/10 . An intervention listed on the care plan indicated that nurses were to .ADMINISTER MEDICATIONS AS ORDERED. NOTIFY MD IF NOT EFFECTIVE.During a review of Resident 12's clinical document titled Progress Notes, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 1/1/26 through 3/31/26, there were no documented progress notes indicating that the physician had been contacted to discuss the need for possible changes in Resident 12's pain regimen to address moderate pain rating of 4-6.During a review of Resident 12's clinical document titled Minimum Data Set (MDS - a mandated tool to measure resident health status-including cognitive, physical, and functional abilities), dated 1/20/26, the MDS indicated that Resident 12 rated her pain level at a 4 which indicated Resident 12 was experiencing moderate pain that was not addressed by the current medication regimen ordered by the physician.During a concurrent interview and record review on 3/27/26 at 9:00 AM with LN 5, LN 5 stated that due to Resident 12's cognitive level, the nurse was to use the non-verbal pain scale (an observation tool used by caregivers to measure pain in patients who cannot speak, such as those with dementia. It translates behaviors-like frowning, moaning, restlessness, or body tension-into a numerical score (e.g., 0-10) to determine necessary pain relief.) LN 5 reviewed Resident 12's physician orders for acetaminophen and hydrocodone. LN 5 confirmed that Resident 12 did not have an order in place that would address Resident 12's documented pain level between 4-6. LN 5 reviewed Resident 12's MAR for January 2026 and February 2026 and confirmed that Resident 12 received hydrocodone one time for a documented pain level of 6 in January 2026 and two times in February 2026. LN 5 confirmed that the documented pain level of 6 was below the pain level parameter indicated for the hydrocodone. LN 5 stated that Resident 12's physician should have been contacted to review the active pain medication regimen and to discuss adding or changing the pain medications so that when Resident 12 was assessed to have a pain level between 4 to 6, pain medication could be administered.3. A review of Resident 31's clinical document titled admission RECORD indicated Resident 31 was admitted with diagnoses that included dementia, unspecified cord compression (pressure placed on the spinal cord, but the specific cause (such as a tumor, injury, or degenerative disease) has not been fully determined), and spinal stenosis lumbar region without neurogenic claudication (a narrowing of the spinal canal in the lower back that compresses nerves, causing localized back pain or numbness/tingling, but without the classic, severe leg pain, cramping, or heaviness while walking that is relieved by sitting).During a review of Resident 31's clinical document titled Brief Interview for Mental Status (BIMS), dated 12/24/25, the BIMS score was 6, indicating that Resident 31 cognitive function was severely impaired. During a review of Resident 31's clinical document titled Order Summary Report, dated 3/1/26, the report indicated that Resident 31 had a physician's order dated 8/6/25 for acetaminophen 500 mg 1 tablet every 6 hours as needed for mild pain (1-3) and a physician's order dated 8/6/24 for acetaminophen 500 MG 2 tablets every 6 hours as needed for moderate pain (4-5). There were no physician's orders in place that would address if Resident 12's pain level was assessed to be between 7-10.During a review of Resident 31's MAR dated 1/1/26 through 1/31/26, the MAR indicated that Resident 31 received acetaminophen 500mg 2 tablets for a documented pain level that was outside of the indicated parameter of 4-6 as follows:1/1 - pain level 7 1/2 pain level 7 1/3 pain level 7 1/4 pain level 71/6 pain level 7 1/7 pain level 7 1/8 pain level 7 1/9 pain level 71/12 pain level 7 1/16 pain level 7 1/17 pain level 7 1/19 pain level 71/21 pain level 7 1/25 pain level 7 1/29 pain level 0 1/30 pain level 3During a review of Resident 31's MAR dated 2/1/26 through 2/28/26, the MAR indicated that Resident 31 received acetaminophen 500mg 2 tablets for a documented pain level that was outside of the indicated parameter of 4-6 as follows:2/3 pain level 7 2/8 pain level 7 2/21 pain level 7 2/22 pain level 7During a review of Resident 31's MAR dated 3/1/26 through 3/31/26, the MAR indicated that Resident 31 received acetaminophen 500mg 2 tablets for a documented pain level that was outside of the indicated parameter of 4-6 as follows:3/14 pain level 7 3/16 pain level 3 3/18 pain level 8 3/21 pain level 8 During a review of Resident 31's clinical document titled Care Plan Report, the report indicated that Resident 31 had a care plan that was initiated on 8/7/24 and revised on 11/22/25 for ALTERATOIN IN COMFORT/PAIN.RELATED TO CORD COMPRESSION, AND SPINAL STENOSIS. An intervention listed on the care plan indicated that nurses were to .ADMINSTER MEDICATIONS AS ORDERED. NOTIFY MD IF NOT EFFECTIVE.During a review of Resident 31's clinical document titled (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Notes, dated 1/1/26 through 3/31/26, there were no documented progress notes that indicated that Resident 31's physician had been contacted to discuss the need for possible changes in Resident 31's pain regimen to address the assessed pain level between 7-10, nor were there any progress notes that indicted the physician had been contacted to notify of the acetaminophen 500mg 2 tabs being given for parameters outside of the order.During a concurrent interview and record review on 3/27/26 at 9:00 AM with LN 5, LN 5 stated that due to Resident 31's cognitive level, the nurse was to use the non-verbal pain scale. LN 5 reviewed Resident 31's physician orders and confirmed that there were orders for acetaminophen 500mg, give 1 tablet every 6 hours as needed for mild pain 1-3 and 2 tablets every 6 hours as needed for moderate pain 4-6. LN 5 confirmed that there were no orders in place that would address an assessed pain level greater than 6. LN 5 reviewed Resident 31's MAR for January 2026, February 2026, and March 2026. LN 5 confirmed that resident had received acetaminophen 2 tablets multiple times over the 3-month period for a pain level rated and documented at greater than 6. LN 5 stated that the MD should have been contacted to review Resident 31's assessed pain level and request a change in the pain regimen to address the pain when it was assessed at being over 6. LN 5 was asked if giving the acetaminophen for pain level assessed out of the ordered parameter constituted a medication error, and LN 5 stated yes and that it should have been reported to the MD and the DON.4. A review of Resident 45's clinical document titled admission RECORD indicated that Resident 45 was admitted to the facility with diagnosis that included multiple sclerosis (a chronic disease where the immune system mistakenly attacks the protective coating (myelin) of nerves in the brain and spinal cord).During a review of Resident 45's clinical document titled Brief Interview for Mental Status (BIMS), dated 3/19/26, the BIMS score was 13 indicating Resident 45's cognitive status was intact.During a review of Resident 45's clinical document titled Order Summary Report, dated 3/1/26, the report indicated that Resident 45 had a physician's order dated 8/7/25 for acetaminophen 325mg 1 tablet every 6 hours as needed for mild pain scale 1-3 and a physician's order dated 8/7/25 for hydrocodone-acetaminophen 5/325mg 2 tablets every 4 hours as needed for moderate pain 4-6 or severe pain 7-10.During a review of Resident 45's MAR, dated 1/1/26-1/31/26, the MAR indicated that Resident 45 had received acetaminophen 325mg 1 tablet for a documented pain level that was outside of the indicated parameter of 1-3 as follows:1/4 pain level 4 1/6 pain level 4 1/12 pain level 5 1/16 pain level 71/29 pain level 4During a review of Resident 45's MAR, dated 2/1/26-2/28/26, the MAR indicated that Resident 45 had received acetaminophen 325mg 1 tablet for a documented pain level that was outside of the indicated parameter of 1-3 as follows:2/5 pain level 4 2/8 pain level 6 2/8 pain level 7 (second dose that day)2/9 pain level 6 2/9 pain level 4 (second dose that day) 2/15 pain level 4 2/14 pain level 6 During a review of Resident 45's MAR, dated 3/1/26-3/31/26, the MAR indicated that Resident 45 had received acetaminophen 325mg 1 tablet for a documented pain level that was outside of the indicated parameter of 1-3 as follows:3/1 pain level 6 3/5 pain level 5 3/7 pain level 7 3/20 pain level 6During a review of Resident 45's clinical document MDS, dated 12/17/25, section J-Health Condition indicated that resident was experiencing pain at the time of the assessment and rated her pain at a level 3 out of 10.During a review of Resident 45's clinical document titled Care Plan Report, the report indicated that Resident 45 had a care plan that was initiated on 6/4/25 for ALTERATION IN COMFORT/PAIN.RELATED TO MULTIPLE SCLEROSIS AND GENERALIZED PAIN.ACCEPTABLE LEVEL OF PAIN 0/10. An intervention listed on the care plan indicated that nurses were to .ADMINISTER MEDICATIONS AS ORDERED. NOTIFY MD IF NOT EFFECTIVE. During a review of Resident 45's clinical document titled Progress Notes, dated 1/1/26 through 3/24/26 indicated that there were no documented progress notes that Resident 45's physician had been contacted to review that acetaminophen 325mg had been given outside of the ordered parameters or to review Resident 45's pain regimen for possible needed changes. During a concurrent observation and interview on 3/25/26 at 9:19 AM with Resident 45, Resident 45 indicated that she had muscle pain as well as pain in her shoulder and neck. Resident stated that acetaminophen was effective in treating her pain and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that she did not like to take anything stronger like Norco (hydrocodone-acetaminophen), because it made her feel weird and lost. Resident 45 stated that she had not taken anything stronger than acetaminophen for the last couple of months.During a review of Resident 45's MAR, dated 1/1/26-1/31/26, the MAR indicated that Resident 45 had received hydrocodone-acetaminophen 5/325mg 2 tablets for moderate (4-6) or severe (7-10) pain 43 times with no side effects documented as present. During a review of Resident 45's MAR, dated 2/1/26-2/28/26, the MAR indicated that Resident 45 had received hydrocodone-acetaminophen 5/325mg 2 tablets for moderate (4-6) or severe (7-10) pain 34 times with no side effects documented as present. During a review of Resident 45's MAR, dated 3/1/26-3/31/26, the MAR indicated that Resident 45 had received hydrocodone-acetaminophen 5/325mg 2 tablets for moderate (4-6) or severe (7-10) pain 8 times with no side effects documented as present. During a review of Resident 45's clinical document titled Progress Notes, dated 1/1/26 through 3/24/26. there were no documented progress notes indicating that the physician had been contacted to review Resident 45's report of feeling weird or lost when taking the hydrocodone-acetaminophen 5/325mg.During a concurrent interview and record review on 3/27/26 at 9:00 AM with LN 5, LN 5 indicated that when Resident 45 initially admitted to the facility she would request acetaminophen or hydrocodone-acetaminophen depending on her reported pain level, but as time went on the request for hydrocodone-acetaminophen had decreased and Resident 45 now only asked for acetaminophen. LN 5 stated that Resident 45 had complained of pain in legs, back, and shoulders. LN 5 denied knowing that the hydrocodone-acetaminophen made Resident 45 feel weird or lost. LN 5 stated that if that had been reported by Resident 45 to a nurse, then the nurse should have documented on the MAR as a side effect and the MD should have been notified. LN 5 reviewed Resident 45's MARs for January 2026, February 2026, and March 2026 and confirmed that Resident 45 had received acetaminophen 325mg 1 tablet for a pain level outside of the ordered parameters. LN 5 stated that a nurse should have contacted Resident 45's physician for further review of Resident 45's pain regimen.5. A review of Resident 46's clinical document titled admission RECORD, indicated that Resident 46 was admitted to the facility with diagnosis that included opioid dependence (a physical and psychological state where the body adjusts to regular opioid use, resulting in tolerance (needing more for the same effect) and withdrawal symptoms if stopped).During a review of Resident 46's clinical document titled Brief Interview for Mental Status (BIMS), dated 2/19/26, the BIMS score was 15, which indicated that Resident 46's cognitive status was intact.During a review of Resident 46's clinical document titled Order Summary Report, date 3/1/26, the report indicated that Resident 46 had a physician's order dated 1/25/26 for acetaminophen 325mg 1 tablet every 6 hours as needed for mild pain (1-3) or 2 tablets every 6 hours as needed for moderate pain (4-6). The report indicated that Resident 46 also had a physician's order dated 1/25/26 for morphine sulfate 100mg/5ml give 1.5ml every 1 hour as needed for severe pain (7-10) or shortness of breath.During a review of Resident 46's MAR, dated 1/1/26 through 1/31/26, the MAR indicated that Resident 46 had not been administered acetaminophen 325mg 1 tablet or 2 tablets during the month of January. Resident 46 was administered morphine sulfate 100mg/5ml 1.5ml outside of the indicated parameter of 7-10 as follows:1/2 pain level 0 (x3 doses) 1/5 pain level 0 (x1 dose) 1/7 pain level 0 (x1 dose)1/9 pain level 6 (x4 doses) 1/10 pain level 0 (x1 dose) 1/15 pain level 0 (x1 dose)1/20 pain level 0 (x3 doses) 1/21 pain level 0 (x1 dose) 1/22 pain level 0 (x1 dose)1/29 pain level 6 (x 1 dose) 1/30 pain level 0 (x2 doses) 1/31 pain level 0 (x2 doses)During a review of Resident 46's MAR, dated 2/1/26 through 2/28/26, the MAR indicated that Resident 46 had not been administered acetaminophen 325mg 1 tablet or 2 tablets during the month of February. Resident 46 was administered morphine sulfate 100mg/5ml 1.5ml outside of the indicated parameter of 7-10 as follows:2/2 pain level 6 (x1 dose) 2/3 pain level 6 (x1 dose) 2/4 pain level 0 (x3 doses)2/6 pain level 0 (x4 doses) 2/7 pain level 0 (x1 dose) 2/12 pain level 0 (x2 doses)2/14 pain level 0 (x1 dose) 2/17 pain level 0 (x5 doses) and pain level 6 (x1 dose)2/18 pain level 6 (x1 dose) 2/20 pain level 6 (x1 dose) 2/23 pain level 0 (x3 doses)2/24 pain level 0 (x2 doses) 2/25 pain level 6 (x1 dose) 2/26 pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level 0 (x 1 dose)2/28 pain level 6 (x1 dose)During a review of Resident 46's MAR, dated 3/1/26 through 3/31/26, the MAR indicated that Resident 46 had not been administered acetaminophen 325mg 1 tablet or 2 tablets during the month of March. Resident 46 was administered morphine sulfate 100mg/5ml 1.5ml outside of the indicated parameter of 7-10 as follows: 3/2 pain level 6 (x1 dose) 3/11 pain level 6 (x1 dose) 3/12 pain level 0 (x2 doses) and pain level of 5 (x1 dose) 3/13 pain level 0 (x3 doses) 3/15 pain level 0 (x1 dose)3/16 pain level 0 (x1 dose) 3/20 pain level 6 (x1 dose) 3/23 pain level 0 (x1 dose)During a review of Resident 46's clinical document titled Care Plan Report, the report indicated that Resident 46 had a care plan that was initiated on 5/16/25 and revised on 5/20/25. The care plan indicated ALTERATION IN COMFORT/PAIN.RELATED TO: GENERALIZED PAIN.PATIENT'S ACCEPTABLE LEVEL OF PAIN: 0/10. An intervention listed on the care plan indicated that nurses were to .ADMINISTER MEDICATIONS AS ORDERED. NOTIFY MD IF NOT EFFECTIVE.During a review of Resident 46's clinical document titled Progress Notes, dated 3/1/26 through 3/31/26 indicated that there were no documented progress notes that Resident 46's physician had been contacted to review that morphine sulfate 100mg/5ml had been given outside of the ordered parameters.During a concurrent interview and record review on 3/26/26 at 1:17 PM with LN 3, Resident 46's January 2026, February 2026 and March 2026 MARs were reviewed. LN 3 confirmed that per the physician's order for morphine dated 1/25/26 Resident 46 could receive the morphine for a pain rating of 7-10 or for shortness of breath (SOB). LN 3 stated that on the MAR when the entry was documented as NA, those entries meant Resident 46 was given the morphine for SOB and not pain. LN 3 reviewed the entries that were documented as 0 and 6 on Resident 46's MARS. LN 3 stated that those documented pain levels were outside of the ordered parameter for severe pain 7-10 and the doses should not have been given if that was Resident 46' stated pain level. LN 3 stated that Resident 46 should not have received morphine for a pain level rating of 6, but instead should have received acetaminophen 325mg 2 tablets for a pain level of 6. LN 3 stated that the MD should have been contacted and the DON notified if medications of any kind were administered outside of the ordered parameter. 6. A review of Resident 47's clinical document titled admission RECORD indicated that Resident 47 was admitted to the facility with diagnoses that included contusion (bruise) of the right knee, gout (a common, painful form of inflammatory arthritis caused by high levels of uric acid in the blood, which forms sharp crystals in joints, frequently the big toe), osteoarthritis (he most common chronic, degenerative joint disease, often called wear-and-tear arthritis), and presence of right artificial knee joint. During a review of Resident 47's clinical document titled Minimum Data Set (MDS), dated [DATE], the MDS section C indicated that Resident 47 had a BIMS score of 1 which indicated Resident 47's cognitive function was severely impaired. The MDS section J indicated Resident 47 had no pain at the time of the assessment.During a review of Resident 47's clinical document titled Order Summary Report, dated 3/1/26, the report indicated that Resident 47 had a physician order dated 3/1/26 for acetaminophen 325mg 2 tablets every 6 hours as needed for mild pain 1-4.During a review of Resident 47's MAR, dated 3/1/26 through 3/31/26, the MAR indicated that Resident 47 was administered acetaminophen 325mg 2 tablets outside of the indicated parameter of 1-4 as follows:3/4 pain level 8 3/9 pain level 5 3/17 pain level 6During a review of Resident 47's clinical document titled Care Plan Report, the report indicated that Resident 47 had a care plan that was initiated on 3/2/26 and revised 3/14/26. The care plan indicated ALTERATION IN COMFORT/PAIN.RELATED TO: HEADACHE, CHRONIC PAIN. An intervention listed on the care plan indicated that nurses were to .ADMINISTER MEDICATIONS AS ORDERED. NOTIFY THE MD IF NOT EFFECTIVE. During a review of Resident 47's clinical document titled Progress Notes, dated 3/1/26 through 3/31/26 indicated that there were no documented progress notes that Resident 47's physician had been contacted to review Resident 47's assessed pain level higher than 4, the ordered pain regimen or to report that Resident 47 had been administered acetaminophen outside of the ordered parameter. During a concurrent interview and record review on 3/27/26 at 9:00 AM with LN 5, Resident 47's physician orders and Resident 47's MAR for March 2026 were reviewed. LN 5 confirmed (continued on next page)

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	03/27/2026

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 47 had an order for acetaminophen 325mg 2 tablets every 6 hour as needed for mild pain scale 1-4. LN 5 reviewed Resident 47's March MAR and confirmed that Resident 47 received acetaminophen for a documented pain level of 8 on 3/4/26, 5 on 3/9/26, and 6 on 3/17/26. LN 5 stated that the documented pain level was higher than the parameter for the ordered medication and should not have been given. LN 5 stated that the MD should have been contacted to report that the resident was having pain that was assessed at a level higher than a 4 so that the pain medication order could be reviewed, and possible changes made that would have better managed Resident 47's pain. During an interview on 3/27/26 at 1:53 PM with Licensed Nurse Supervisor (LNS), the LNS stated that the nurses are to use a 1-10 pain scale to assess a resident's pain and pain levels are broken down as 1-3 for mild pain, 4-6 for moderate and 7-10 for severe. The LNS stated that pain medication orders should have a pain level parameter in the body of the order. The LNS stated the facility's expectation was that the nurse would administer the correct pain medication for the reported or assessed pain level. The LNS stated that if the resident was cognitively impaired, then the nurse should use the faces/non-verbal scale to assess the resident's pain level and then translate that assessment into a number on the 1-10 scale. The LNS stated that if pain medication was given outside of the ordered parameter, the nurse would be expected to contact the MD to review. The LNS stated that the nurse would also be expected to report it to the Nurse Supervisor or the DON. The LNS stated the nurse should also document the error and the physician's response in the affected resident's progress notes.During a review of the facility's policy and procedure titled, Pain Assessment and Management, dated 2/2026, the P&P indicated .When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider.Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.Monitor for the following factors to determine if the resident's pain is being adequately controlled: The resident's response to administered pain medications.Contact the provider immediately if the resident's pain or medication side effects are not adequately controlled. If pain has not been adequately controlled, the multidisciplinary team, including the provider, will reconsider approaches and make adjustments as indicated.During a review of the facility's policy and procedures titled, Administering Medications, dated 3/2026, the P&P indicated .medications are administered in accordance with prescriber orders.Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for 2 of 30 sampled residents (Resident 52 and Resident 101) when:Staff called Resident 52 a feeder during mealtime; and 2. Certified Nursing Assistant (CNA) 1 stood over Resident 101 while assisting with meals and did not position at Resident 101's eye level.These failures had the potential to negatively impact the psychosocial well-being (emotional and social functioning) of Resident 52 and Resident 101.Findings: 1. Review of Resident 52's admission RECORD indicated Resident 52 was admitted to the facility with multiple diagnoses including dysphagia oropharyngeal phase (difficulty swallowing caused by problems in the mouth or throat), and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or paralysis on the left side of the body due to a stroke). During an observation on 3/24/26 at 12:11 p.m., in the dining room, Licensed Nurse (LN 1) and Certified Nurse Assistant (CNA 2) were preparing to pass the meal tray to Resident 52. CNA 2 stated to LN 1, No, she is a feeder, in reference to Resident 52. CNA 2 then placed the meal tray in front of Resident 52. During an interview on 3/24/26 at 12:20 p.m., CNA 2 stated Resident 52 was a feeder because she required assistance with meals. CNA 1 acknowledged that referring to the resident as a feeder was inappropriate and stated she should not have used that term. During an interview on 3/24/26 at 12:25 p.m., LN 1 stated that labeling residents as feeders was inappropriate. LN 1 stated residents should be addressed by their name and treated with dignity and respect. LN 1 further stated that labeling residents could negatively impact their dignity. During an interview on 03/24/26 at 12:34 p.m., the Licensed Nursing Supervisor (LNS) stated that referring to residents as feeders was unacceptable. The LNS stated staff were expected to treat all residents with dignity and respect at all times and to address residents by their names. The LNS further stated that using terms such as feeder, in the presence of the resident or others, could negatively impact the resident's psychosocial well-being. A review of the facility policy titled Dignity, revised 3/26, the policy indicated, Policy Statement – Residents are treated with dignity and respect at all times. 1. Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem. 8. Staff speak respectfully to residents at all times, including addressing the resident by their name of choice and not labeling or referring to the resident by their room number, diagnosis, or care needs. 2. Review of Resident 101's admission RECORD indicated Resident 101 was admitted to the facility with diagnoses including encephalopathy (brain dysfunction causing confusion), hepatorenal syndrome (kidney failure related to severe liver disease), hypo-osmolality and hyponatremia (low salt levels in the blood), schizophrenia (mental disorder affecting thinking and behavior), anxiety disorder, depression, muscle weakness, need for assistance with personal care, abnormalities of gait and mobility, arthropathy (joint disease), gastro-esophageal reflux disease (acid reflux), and alcohol (continued on next page)

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	555186	A. Building B. Wing	03/27/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse. During a concurrent observation and interview on 3/24/26 at 12:51 PM with the Minimum Data Set Coordinator Nurse (MDSN: a nurse who is responsible for collecting and submitting assessment data for nursing home residents for their health and well-being) in Resident 101's room, Resident 101 was sitting upright in bed while CNA 1 assisted Resident 101 with eating the lunch meal while standing over Resident 101 at the side of the bed. The MDSN stated CNA 1 was not at eye level while assisting Resident 101 with meals and should have been positioned at eye level to promote dignity and provide respectful care. During an interview on 3/25/26 at 9:43 AM with CNA 1, CNA 1 stated she stood over Resident 101 while assisting Resident 101 with meals on 3/24/26. CNA 1 stated the best practice was to sit at eye level while assisting a resident with meals to maintain interaction with the resident and help the resident feel comfortable during care. During an interview on 3/27/26 at 9:35 AM with the Director of Nursing (DON), the DON stated staff were expected to maintain a connection with residents while assisting them with meals by maintaining eye-level interaction and not standing over residents. The DON further stated that standing over residents while assisting with meals created a non-comforting environment and affected residents' rights and dignity. Review of a facility's policy and procedure (P&P), titled Assistance with Meals revised 3/26, the P&P indicated .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example.Feed residents at eye level.

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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 1 of 30 sampled residents (Resident 18) when, Resident 18 had a call light (device used to contact staff for assistance) that was not within Resident 18's reach.This deficient practice placed Resident 18 at increased risk for unmet care needs, delayed staff response, falls, and potential injury.Findings:Review of Resident 18's admission RECORD indicated Resident 18 was admitted to the facility with diagnoses including gram-negative sepsis (a serious infection caused by bacteria in the blood), urinary tract infection, obstructive and reflux uropathy (urine flow blockage or backward flow), dementia (memory loss and confusion), abnormalities of gait and balance (difficulty walking and maintaining balance), muscle weakness, need for assistance with personal care, and personal history of venous thrombosis and embolism (blood clots in veins or lungs).During a concurrent observation and interview on 3/24/26 at 11:29 AM, with Resident 18 in Resident 18's room, Resident 18 was sitting in a wheelchair on the left side of the bed, near the foot of the bed. Resident 18's call light was wrapped around the left bed siderail and was not visible from Resident 18's position. Resident 18 stated he could not find or reach the call light.During a concurrent observation and interview on 3/24/26 at 11:39 AM with the Licensed Nurse Supervisor (LNS) in Resident 18's room, the LNS confirmed Resident 18 was sitting in a wheelchair on the left side of the bed, near the foot of the bed, and the call light was wrapped around the left bedside rail. The LNS confirmed the call light was not within Resident 18's reach. The LNS stated Resident 18 was not able to propel himself in the wheelchair and required assistance. The LNS stated Resident 18 could fall if Resident 18 attempted to reach the call light.During an interview on 3/27/26 at 9:28 AM, with the Director of Nursing (DON), the DON stated call lights must be within residents' reach and answered promptly by staff. The DON further stated if a resident's call light was not within the resident's reach, staff would not be able to respond to the resident's needs in a timely manner, placing the resident at risk for safety concerns, increased risk of falls, and emotional distress (feeling upset or anxious).Review of Resident 18's care plan initiated on 3/4/26, in the section titled Focus indicated [Resident 18] POTENTIAL FOR FALL/INJURY., in the section titled Interventions/Tasks indicated .KEEP PERSONAL ITEMS/CALL LIGHT WITHIN REACH.Review of facility's policy and procedure (P&P), titled Answering the Call Light, revised 3/26, the P&P indicated .Ensure the call light is accessible to the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a homelike environment for 1 of 30 sampled residents (Resident 17) when, Resident 17 was provided a bathroom toilet that did not function.This failure negatively impacted Resident 17's homelike environment.Findings:During a concurrent observation and interview on 3/24/26, at 4:05 p.m., with Resident 17's family member (FM 1),Resident 17's bathroom door had a sign indicating, do not use. The toilet in Resident 17's bathroom did not have any water and a red and black build up in the toilet bowl was observed. FM 1 stated Resident 17 did not like that he had to go to another resident bathroom to use a toilet and instead of taking him to his own bathroom the facility had to assist Resident 17 to another resident bathroom.During a concurrent observation and interview in Resident 17's room on 3/24/26, at 4:30 p.m., with Licensed Nurse (LN) 4, LN 4 verified Resident 17's bathroom was not working and stated it had not been working for weeks.During an interview on 3/24/26, at 4:40 p.m., with the Director of Maintenance (DOM), the DOM stated the bathroom had not been functional for as long as he had worked at the facility. The DOM stated Resident 17 should have a bathroom that is working as part of his homelike environment.During an interview on 3/24/26, at 8:45 a.m., with the Assistant Director of Nursing (ADON), the ADON verified the facility policy was not followed and stated Resident 17 should have been provided a room with a working bathroom so he could use his own bathroom instead of going to another residents room. The ADON further stated she would feel uncomfortable using the bathroom that belonged to another person.During a review of the facility policy and procedure (P&P) titled, Homelike Environment revision date 3/2026, the P&P indicated,.The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary and orderly environment .

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	555186	A. Building B. Wing	03/27/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan (written plan that guides staff on daily care, safety, and interventions based on the resident's needs) for 1 of 30 sampled residents (Resident 63) when, Resident 63 refused to receive the COVID-19 (a contagious viral illness that affects the respiratory system) vaccine in April of 2025 and a care plan was not developed to help prevent Resident 63 from acquiring a COVID-19 infection.This failure resulted in Resident 63 acquiring a COVID-19 infection in the facility in September of 2025 and placed Resident 63 at risk of serious illness and complications related to COVID-19.Findings:Review of Resident 63's admission RECORD indicated Resident 63 was admitted to the facility with diagnoses including schizoaffective disorder (a mental health condition with mood problems and symptoms such as hallucinations or confusion), epilepsy (a condition that causes seizures), glaucoma (an eye disease that can damage vision due to increased pressure in the eye), visual loss, anxiety disorder, repeated falls, and alcohol dependence in remission (a history of alcohol addiction that is currently under control).During an interview on 3/26/26 at 10:15 AM with the Licensed Nurse Supervisor (LNS), the LNS stated that the facility's last COVID-19 occurrence was in September of 2025, and Resident 63 tested positive during that occurrence. Review of Resident 63's SBAR [Situation, Background, Assessment, and Recommendation - a structures communication tool used by nursing staff to report a resident's condition] Communication Form and progress note . dated 9/13/25, indicated that Resident 63 had a COVID-19 positive test on 9/13/25. During a concurrent interview and record review on 3/26/26 at 10:15 AM with the LNS, Resident 63's Informed Consent for COVID-19 Immunization [vaccine] . dated 4/9/25, and Resident 63's care plans were reviewed. Resident 63's informed consent indicated Resident 63 refused to receive the COVID-19 vaccine. The LNS stated that Resident 63's refusal to receive the COVID-19 vaccine placed Resident 63 at increased risk of acquiring COVID-19 infection during a COVID-19 occurrence in the facility in September of 2025. The LNS confirmed that Resident 63 had no care plan to address the refusal of the COVID-19 vaccine. The LNS further stated that care plan interventions for Resident 63's vaccine refusal could help prevent Resident 63 from acquiring COVID-19 infection during the COVID-19 occurrence in 9/2025 in the facility.During an interview on 3/27/26 at 9:52 AM with the Director of Nursing (DON), the DON stated that residents who refused the COVID-19 vaccine required a care plan with specific interventions to address the refusal and alert staff of the residents' increased risk for infection. The DON stated that failure to develop and implement such a care plan resulted in a lack of staff awareness and interventions, which increased the risk for COVID-19 transmission.Review of a facility's policy and procedure (P&P), titled Infection Prevention and Control Program, revised 3/26, the P&P indicated .Prevention of Infection.instituting measures to avoid complications or dissemination [spread of infection].educating staff and ensuring that they adhere to proper techniques and procedures.immunizing residents and staff to try to prevent illness.Review of s facility's P&P titled Care Plans, Comprehensive Person-Centered, revised 3/22, the P&P indicated, .A comprehensive, person-centered [individualized] care plan that includes measurable objectives and timetables to meet resident's physical, psychosocial [mental and social], and functional needs is developed and implemented for each resident.Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide necessary care and treatment for 1 of 30 sampled residents (Resident 47) when, Resident 47 complained of shortness of breath and the facility staff failed to obtain oxygen saturation as ordered and failed to implement available interventions, including administration of oxygen or an albuterol treatment (a quick-relief or rescue medication used to treat or prevent breathing difficulties), prior to Resident 47 being transferred to the hospital.This failure had the potential to delay timely assessment and intervention for respiratory compromise, placing residents at risk for decreased oxygen levels and worsening condition.Findings:Review of Resident 47's admission RECORD indicated Resident 47 was admitted to the facility with multiple diagnoses, including chronic obstructive pulmonary disease (a long-term lung disease that makes it difficult to breathe due to airflow limitation), chronic respiratory failure with hypoxia (a condition in which the lungs do not adequately oxygenate the blood), and a history of lung cancer (a condition in which abnormal cells grow uncontrollably in the lungs and impair normal breathing).Review of Resident 47's SBAR [Situation, Background, Assessment, and Recommendation - a structured communication tool used by nursing staff to report a resident's condition] Communication and progress note., dated 3/25/26 at 7:08 p.m., documented by the Licensed Nurse (LN 2), indicated the following sequence of events:- Resident 47 complained of shortness of breath at 6 p.m.- Resident 47's most recent vital signs (basic measurements that show how the body is functioning), including blood pressure (138/72), pulse (74), respiration (18), and temperature (96.7), were taken at 5:31 p.m.; oxygen saturation (a measurement of how much oxygen is in the blood) was last recorded earlier at 4:18 p.m. at 96% (88% to 100% are considered normal levels, dependent on the individual and history of lung disease) on room air.- Resident 47's Primary Care Clinician was notified at 6:05 p.m.- Nursing notes indicated Resident 47 was sent to the hospital at 6:30 p.m.During a concurrent interview and record review on 3/26/26 at 3:05 p.m. with LN 2, LN 2 reviewed the Medication Administration Record (MAR - a record used to track physician orders and document whether medications are administered) for Resident 47. LN 2 confirmed that Resident 47 had a physician order for albuterol nebulizer treatment (a medication used to open the airways and improve breathing) every 6 hours as needed for shortness of breath and an order to check oxygen saturation as needed for signs and symptoms of shortness of breath or respiratory distress. LN 2 confirmed that Resident 47 did not receive the ordered albuterol treatment and that Resident 47's oxygen saturation was not obtained at the time the resident exhibited symptoms of shortness of breath. LN 2 further acknowledged that the physician orders were not followed, and no documented evidence indicated that ordered interventions were implemented at the time of the resident's change in condition.During a concurrent interview and record review on 3/26/26 at 3:25 p.m. with the Director of Nursing (DON), the DON reviewed Resident 47's physician orders and confirmed that Resident 47 had orders to check oxygen saturation and for PRN (as needed) albuterol nebulizer treatment for shortness of breath. The DON stated these orders should have been implemented. The DON further confirmed there was no documentation that oxygen saturation was assessed, no respiratory assessment was documented, and the PRN albuterol treatment was not administered, indicating the physician orders were not followed.During an interview on 3/27/26 at 1:41 p.m. with Resident 47's Medical Doctor (MD 1), MD 1 stated that oxygen saturation is an important assessment when a resident was experiencing shortness of breath. MD 1 further stated that the licensed nurse could have administered oxygen and/or provided a breathing treatment (albuterol) to assist the resident at the time of symptoms.A review of the facility policy titled Medication and Treatment Orders, revised 3/26, indicated, .Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.A review of the facility policy titled Acute Condition Changes - Clinical Protocol, revised 3/26, indicated, .the nurse shall assess and document/report the following baseline information, including vital signs.

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	555186	A. Building B. Wing	03/27/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure 1 of 30 sampled residents (Resident 63)) was free from unnecessary medication administration when, Resident 63 received an antihypertensive medication (used to manage high blood pressure; BP) outside of the hold parameters (when a medication is not to given based on blood pressure readings) four times between February and March of 2026.This failure increased the potential for Resident 63 to experience side effects such as low BP, leading to further heart related complication.Findings:A review of Resident 63's admission Record indicated Resident 63 was admitted to the facility with diagnoses that included but not limited to orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from a sitting or lying position), hypertension (a chronic condition where the force of blood pushing against artery walls is consistently too high), and repeated falls.A review of Resident 63's Order Summary Report dated 3/27/26, indicated, .Propranolol HCl [hydrochloride] Tablet [used to treat high blood pressure] 10 mg [mg, a unit of measurement]. by mouth three times a day for HYPERTENSION.HOLD IF SBP <100 (systolic blood pressure hold propranolol HCl 10 mg tablet if top number of blood pressure reading is above 120).During a concurrent interview and record review on 3/27/26, at 8:38 a.m., with the Assistant Director of Nursing (ADON), Patient 63's February 2026 and March 2026 Medication Administration Record (MAR) were reviewed. The ADON verified Patient 63 was administered Propranolol on 2/11/26, at 1:00 p.m., and 2/24/26 at 1:00 p.m., 3/3/26, at 9:00 a.m., and 3/5/26, at 9:00 a.m., outside of the medication order hold parameters and stated it was important to follow the parameters as ordered by the physician. The ADON stated Resident 63 was at risk of experiencing side effects of Propranolol that include drowsiness, headaches, and lethargy (a state of extreme tiredness, sluggishness, or a lack of energy and motivation).A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 3/26, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed.the following information is checked/verified for reach resident prior to administering medications.vital signs, if necessary.

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	555186	A. Building B. Wing	03/27/2026

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.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on observation, interview and record review, the facility failed to ensure antibiotic use was supported by ongoing reassessment and documented justification to determine if the antibiotic should be continued for 1 of 30 sampled residents (Resident 57) when, Resident 57 was prescribed an antibiotic for extended or long-term use.This failure placed Resident 57 at risk for unnecessary prolonged antibiotic exposure, adverse effects (harmful or unwanted side effects), antibiotic resistance (when bacteria no longer respond to the medication), and development and spread of MDROs (Multidrug-resistant organisms - germs that do not respond to multiple antibiotics) to other residents and staff in the facility.Findings:Review of Resident 57's admission RECORD, indicated Resident 57 was admitted with diagnoses including, palliative care (medical care for people with serious illnesses, focusing on relieving symptoms, pain, and stress to improve quality of life), anxiety, Atrial Fibrillation (or A.Fib, heart rhythm disease), and chronic nonhealing left knee and thigh wound with abscess (a pocket of infection with fluid accumulation under the skin) which was surgically drained during a hospitalization in April of 2025. Review of Resident 57's Discharge Summary from the hospital, dated 4/9/25, indicated Resident 57 was treated for a left knee/distal thigh deep abscess (a deep infection with pus near the knee and lower thigh, outside the joint) and underwent incision and drainage (I&D - a procedure to open and drain the pus from infection) on 4/1/25. The Discharge Summary indicated the discharge plan per Infectious Disease (ID - a doctor who specializes in treating infections) included Levaquin (Levofloxacin - an antibiotic taken by mouth) 750 mg (milligram-a unit of measure) every 48 hours through 4/21/25. Review of Resident 57's electronic medical record, under order history and Medication Administration Record (or MAR), for May 2025, the record indicated a physician ordered levofloxacin 750 mg to be given by mouth every 48 hours since 6/26/25, two months after the last hospitalization, without any clinical justification or notes in the medical record.Review of Resident 57's Progress Notes, from an orthopedic doctor (a doctor who treats bones and joints), dated 7/18/25, the note indicated Resident 57 was three months post I&D of a left knee deep abscess and was continued on suppressive therapy (long-term antibiotic use to prevent infection from returning) with levofloxacin 250 mg every 48 hours for chronic use, which was increased to 750 mg every 48 hours by the facility's primary Medical Doctor (MD 2).Review of Resident 57's electronic medical record and MAR, dated 9/25/25, the record indicated Resident 57 was started on palliative care with orders for comfort measures while continuing the antibiotic use.Review of Resident 57's Surgical Consult, dated 3/17/26, indicated Resident 57 had wounds to the left lateral (outer side) knee and left medial (inner side) leg. The Surgical Consult indicated no signs of infection were present at the time of evaluation, and Resident 57's wound was described as unchanged in size, requiring continued topical wound dressing care therapy. During a concurrent interview and record review on 3/26/26 at 10:15 AM, Resident 57's Lab (laboratory) Results Report, dated 6/9/25, was reviewed with the Licensed Nurse Supervisor (LNS). The Lab Results Report indicated a left knee wound culture revealed heavy growth of skin flora and no sensitivities (lab testing to determine which antibiotics are effective) were required. The LNS stated there were no subsequent wound cultures obtained to reassess Resident 57's continued use of levofloxacin.During a concurrent interview and record review on 3/26/26 at 10:15 AM, Resident 57's Infection Screening Evaluation (ISE) dated 7/17/25 was reviewed with the LNS. Resident 57's ISE indicated suspected skin and soft tissue (skin, muscle, and fat) infection based on Loeb's criteria (clinical guidelines used in nursing homes to help determine if antibiotics are appropriate). The LNS acknowledged that Resident 57 was not reassessed for ongoing use of levofloxacin, as there was no subsequent infection screenings completed after 7/17/25 to determine if Resident 57 continued to have an active infection or if antibiotic use was still necessary. The LNS stated that Resident 57's long-term use of levofloxacin placed Resident 57 at risk for adverse effects, antibiotic resistance (when bacteria no longer respond to the medication), development of MDRO, and transmission of MDRO infection to staff (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and other residents. During a concurrent interview and record review, on 3/26/26 at 11 AM, Resident 57's Pharmacist's Recommendation to Prescriber, dated 10/13/25, was reviewed with the Director of Nursing (DON). The Pharmacist's Recommendation to Prescriber indicated Resident 57 was receiving Levofloxacin 750 mg every other day for a chronic wound infection, with a recommendation from the pharmacist to update the levofloxacin order with a stop date or, if Levofloxacin was to be continued indefinitely, to document the reason for continued levofloxacin use. The Pharmacist's Recommendation to Prescriber had a handwritten response note indicating Resident 57 would continue levofloxacin per family request. The DON stated Resident 57's family requested continuation of levofloxacin, but there was no documented education provided to Resident 57's family regarding the risks and benefits of prolonged antibiotic use in Resident 57's electronic health record (EHR). During interview with the Primary Care Physician (MD) 2, on 3/26/26 at 3:11 PM, MD 2 stated Resident 57 was prescribed full dose (active infection treatment dose, not preventive antibiotic dose) Levofloxacin for long-term use to prevent recurrent infection, prevent re-hospitalizations, and provided comfort by minimizing wound drainage. MD 2 acknowledged Resident 57 was re-started on a full dose of levofloxacin on 6/26/25, two months after Resident 57's last hospitalization without any documented clinical justification or progress notes in the medical record to address the effectiveness of the long-term levofloxacin use. MD 2 stated Resident 57 had not been re-hospitalized for wound issues. MD 2 stated the topical wound care by the nurse had been effective in preventing recurrence of the infection. MD 2 stated Resident 57 was placed on palliative care and preventing a painful wound infection was a comfort measure. The MD 2 acknowledged Resident 57 was at increased risk for developing antibiotic resistance and at risk for the development of an MDRO due to prolonged Levofloxacin use. The MD 2 acknowledged Resident 57 was at increased risk for adverse effects, especially due to advanced age, and prolonged use of Levofloxacin. MD 2 stated there was no follow-up with an ID doctor to determine whether continuation of Levofloxacin was appropriate for Resident 57's wound management. MD 2 stated he was aware of multiple FDA warnings on the use of levofloxacin and drugs in the same class.During a concurrent interview and record review on 3/27/26 at 9:45 AM, the facility's policy and procedure (P&P) titled Antibiotic Stewardship - Orders for Antibiotics dated 2001, was reviewed with the DON. The P&P indicated .If an antibiotic is indicated, prescribers will provide.Duration of treatment: (1) Start and stop date; or (2) Number of days of therapy.Appropriate indications for use of antibiotics include: a. criteria met for clinical definition of active infection or suspected sepsis; and b. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). The DON stated that Resident 57 did not have a stop date or duration for levofloxacin, which increased the risk for antibiotic resistance, development of MDROs, and transmission of MDROs to other residents. The DON further stated that there was no reassessment or monitoring of Resident 57's continued use of levofloxacin, which prevented identification of alternative treatment options. The DON acknowledged that the lack of reassessment and monitoring resulted in prolonged and potentially unnecessary antibiotic use and that Resident 57's levofloxacin was continued despite no evidence of active infection and without reassessment or documented justification of continued need. Review of levofloxacin drug information from DailyMed (the official, free U.S. government database providing up-to-date, Food and Drug Administration [or FDA] approved, and manufacturer-submitted drug labeling information), last accessed on 4/7/26 viahttps://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=ac4001ca-882f-4d9b-a570-c1b9d7fd6830, the record indicated FDA through the Black Box Warning (BBW, the strongest drug safety actions that the U.S. Food & Drug Administration (FDA) can implement, and often warns of serious risks) had warned that levofloxacin and similar drugs carried risk of disabling, potentially permanent side effects involving tendons, muscles, joints, nerves, and the central nervous system (nerve system). The drug information further indicated Because fluoroquinolones (a class of antibiotics), including levofloxacin, have been associated with serious adverse reactions . reserve levofloxacin for use in patients who (continued on next page)

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