| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555470 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wagner Heights Nursing & Rehabilitation Center | 9289 Branstetter Place<br>Stockton, CA 95209 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, the facility failed to report an allegation of alleged abuse to the Department (the states licensing and certification agency whom conducts inspections of health care facilities) for one resident (Resident 1), in a sample of four residents when, Resident 1 reported to Family Member (FM) 1 that she had been hit on the head by an unknown person, FM 1 reported the allegation made by Resident 1 to facility staff on 7/30/25, and the allegation was not reported to the Department by the facility. This failure had the potential to result in continued abuse of Resident 1, with the potential to negatively affect Resident 1's physical and psychosocial well-being.Findings:A review of Resident 1's clinical document titled, admission RECORD, (contains clinical and demographic data) indicated Resident 1 was admitted to the facility with diagnoses which included hemiplegia (paralysis or weakness on one side of the body) of her right dominant side.During an interview with Family Member (FM) 1 on 9/18/25 at 1:42 p.m., FM 1 stated Resident 1 had complained to her that someone had hit her in the head while providing care. FM 1 explained she had informed the facility, and the facility stated they would investigate the allegation.During a follow-up interview with FM 1 on 9/23/25 at 12:12 p.m., FM 1 stated Resident 1 told her two staff were providing care to Resident 1 and one of them hit Resident 1 in the head. FM 1 stated she did not know if it was intentional or unintentional, that Resident 1 just did not like it the way she was hit, and Resident 1 said it hurt but not for very long.During an interview with the Social Services Director (SSD) 1 on 9/23/25 at 12:45 p.m., SSD 1 stated FM 1's allegation of abuse should have been reported to the Department and had not been. During an interview on 9/23/25 at 1:21 p.m., with the Director of Nursing (DON), the DON confirmed the allegations of abuse were not reported. The DON further confirmed a care plan was not initiated for Resident 1 regarding the allegations of abuse.During an interview on 9/23/25 at 3:45 p.m., with Licensed Nurse (LN) 3, LN 3 stated if a resident reported abuse to her, she would inform her supervisor and fill out form SOC 341 (State of California Department of Social Services; form used to report suspected abuse to the Department).During an interview on 9/23/25, at 4:14 p.m., the Director of Staff Development (DSD) stated that staff were mandated reporters (a person legally obligated to report suspected abuse or neglect), and it was their duty to report allegations of abuse weather or not they know it is factual or not. The DSD stated that any type of abuse, including an allegation of being hit on the head, should be reported to the Department, to the ombudsman (a government official who investigates and tries to resolve complaints), and to law enforcement. The DSD explained the investigation regarding the alleged abuse was what told you if the allegation was true or not. During an interview on 9/26/25 at 11:22 a.m., SSD 2 stated Resident 1's allegation of abuse should have been reported, and it was not. SSD 2 stated allegations of abuse not being reported could have been a risk to Resident 1's health and well-being. A review of Resident 1's clinical document titled, GRIEVANCE / COMPLAINT RESOLUTION REPORT, dated 7/30/25, indicated, .Specific Date of Alleged Occurrence: 07/30/2025. In the section titled Nature of Complaint / Concern, indicated, Please see Attached Statement . The attached statement indicated the following, On 7/30/2025 around 3:30pm notified by DON on [Resident 1] stating to [FM 1] that someone had hit her on her head, Statement was made to SSA [Social Services Assistant] and DON. SSA used translation services, but [Resident 1] unable to answer the questions, SSD called [FM 1] to follow up on statement, Per [FM 1] she stated [Resident 1] expressed a lady with black hair, medium build, light in color hit her on the head. SSD explained to [FM 1] that facility will follow up with investigation. [FM 1] said she knows [Resident 1's] mind is not sharp, and she has moments of forgetfulness .DON and SSA called language line (Cantonese) to communicate with [Resident 1]. DON asked [Resident 1] several question [sic] regarding abuse allegations, language line person was unable to understand [Resident 1]. DON and ssa [sic] then called [FM 1], [FM 1] let [NAME] [sic] and ssa [sic] know that she would need to visibly see [Resident 1] that is how she is able to understand [Resident 1] and is able to communicate better. DON and SSA video called [Resident 1's FM 1]. [FM 1] asked [Resident 1] what happened, [Resident 1] pointed to her head and according to [FM 1] who was translating for DON and SSA, [FM 1] stated that [Resident 1] said that someone hit her. [FM 1] translated that [Resident 1] stated that someone came in her room and hit her on the head and left out of the room.A record review of Resident 1's clinical record did not indicate any progress notes (a record of patient condition and care received), care plans (outlines a patient's health conditions, treatment and support required to achieve health goals), and social services notes regarding Resident 1's allegations of abuse.A review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 4/21, the policy indicated, All |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview and record review, the facility failed to report an allegation of alleged abuse to the Department (the states licensing and certification agency whom conducts inspections of health care facilities) for one resident (Resident 1), in a sample of four residents when, Resident 1 reported to Family Member (FM) 1 that she had been hit on the head by a staff person while care was being provided to Resident 1, FM 1 reported the allegation made by Resident 1 to facility staff on 7/30/25, and the allegation was not reported to the Department by the facility.This failure had the potential to result in continued abuse of Resident 1, with the potential to negatively affect Resident 1's physical and psychosocial well-being.Findings:A review of Resident 1's clinical document titled, admission RECORD, (contains clinical and demographic data) indicated Resident 1 was admitted to the facility with diagnoses which included hemiplegia (paralysis or weakness on one side of the body) of her right dominant side.A review of Resident 1's clinical document titled, GRIEVANCE / COMPLAINT RESOLUTION REPORT, dated 7/30/25, indicated, .Specific Date of Alleged Occurrence: 07/30/2025. In the section titled Investigative Actions/Pertinent Findings, did not indicate that other residents were interviewed during the facility's investigation of Resident 1's alleged abuse.During an interview with the Director of Nursing (DON) on 9/23/25, at 4:14 p.m., the DON confirmed no other residents were interviewed regarding Resident 1's allegations of abuse.During an interview with Social Services Director (SSD) 2 on 9/26/25, at 11:22 a.m., SSD 2 stated she did not know why other residents were not interviewed. SSD 2 explained it was part of the investigation process for alleged abuse that other residents were interviewed. A review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 4/21, the policy indicated, . All allegations are thoroughly investigated . The individual conducting the investigation as a minimum . interviews the resident's roommate, family member, and visitors . interviews other residents to whom the accused employee provides care or services . |