STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Post Acute	4545 Shelley Court Stockton, CA 95207

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 1) from abuse when Resident 2, who was assigned one-on-one supervision (a single staff member is assigned to be in constant physical proximity to a resident to ensure their safety and provide immediate assistance), was left alone for a period of time and Resident 2 entered Resident 1's room, hitting him with a wheelchair footrest on 8/20/25.These failures had the potential to negatively affect Resident 1's health and psychosocial well-being. Findings:A review of Resident 2' s medical record titled admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses including paranoid schizophrenia (a mental health condition that can cause one to struggle to interpret what's real and what is not), insomnia (persistent problems falling and staying asleep), major depression disorder (a mental health disorder characterized by depressed mood or loss of interest in activities), and anxiety disorder (a mental health conditions characterized by excessive and persistent worry, fear, and nervousness).A review of Resident 2's medical record titled, Order Summary Report, dated 9/19/25, indicated the following: An active order for one-on-one supervision 24 hours a day was initiated on 6/8/25 and an active order for monitoring episodes of verbally aggressiveness and paranoid thought was initiated on 12/23/24.A review of Resident 2's medical record titled, Interdisciplinary Care Conference., dated 8/21/25, indicated, .On 8/20/25, it was reported to management that a possible altercation between this resident and another resident may have occurred.This resident stated that the alleged victim was ringing the bell and then the alleged perpetrator went into the room and shook his foot.Recommendations.remain on 1 on 1 [one staff supervises one resident at a time].During an interview on 9/18/25 at 10:33 AM in Resident 2's room, Certified Nurse Assistant (CNA) 1 stated in accordance to the one-on-one acknowledgement, staff who were assigned to one-on-one care should have monitored Resident 2 closely and never have left Resident 2 unattended. CNA 1 further stated staff who were assigned to provide supervision should have coordinated with other staff to find replacement for the staff break times when they would have to step away from Resident 2. During a concurrent observation and interview on 9/18/25 at 1:52 PM, Resident 1 (alleged victim) stated that Resident 2 (alleged perpetrator) was on one-on-one supervision, and the facility staff were responsible to be present and directly supervise him 24 hours a day due to his aggressive behavior toward other residents, including entering other residents' rooms. Resident 1 stated, on 8/20/25 in the early morning, Resident 2's aggressive behaviors were triggered when Resident 1 started ringing the call bell to receive assistance from nursing staff when Resident 2 became agitated and started screaming at him to stop ringing the call bell. Resident 2 entered Resident 1's room in his wheelchair and physically attacked Resident 1 with a wheelchair footrest which he had in his hand. Resident 1 further stated he sustained a skin injury and pain in his right foot because of that incident. During an interview on 9/18/25 at 2:41 PM, with the Social Service Director (SSD), the SSD confirmed that Resident 2 had an order for one-on-one supervision 24 hours per day related to aggressive behaviors toward other residents. The order for one-on-one supervision was initiated on 6/8/25. The SSD stated, on 8/20/25 in the early morning, Resident 2 entered Resident 1's room when the staff who was assigned to provide one-on-one supervision left (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him unattended. The SSD added it was necessary for the safety of residents in the facility to monitor and supervise Resident 2 closely to redirect him when needed. The SSD further stated her expectation from staff was to be present and supervise Resident 2 as was ordered by the Medical Doctor (MD). During an interview on 9/18/25 at 3:29 PM, with CNA 2, in Resident 2's room, CNA 2 stated Resident 2 had behaviors of combativeness (ready or eager to fight) toward staff and other residents and had a tendency of entering other residents' rooms. CNA 2 added the facility provided one-on-one monitoring to prevent these concerns from happening. CNA 2 stated staff who were assigned to provide one-on-one supervision for Resident 2 should stay with him and should not have left him unattended. CNA 2 added, for the safety of Resident 2 and other residents in the facility, Resident 2 should have been withing eyesight of the staff and the staff should have followed him everywhere he went. CNA 2 stated the staff who were assigned to one-on-one supervision were responsible for coordinating with other staff to find coverage when the staff wanted to take breaks. CNA 2 stated she received an in service on how to provide one-on-one care and the facility expectation from staff.During an interview on 9/18/25 at 3:51 PM, with the Licensed Nurse (LN) 1, LN 1 stated Resident 2 had a couple of altercations with other residents in the facility. LN 1 added, Resident 2 was independent with transfer from the bed to the wheelchair and vice versa (the other way around). LN 1 stated Resident 2 was on one-on-one supervision since 6/25 related to aggressive behaviors toward other residents. LN 1 further stated to ensure the safety of Resident 2 and other residents, Resident 2 should have been within the eyesight of the staff who were assigned to provide one-on-one supervision.During a concurrent interview and record review, on 9/18/25, at 4 PM, with the Director of Staff Development (DSD), Resident 2's order listing report and one-on-one care acknowledgement form were reviewed. The DSD confirmed Resident 2 was on one-on-one monitoring due to having behavior of entering other residents' room and aggression toward other residents. The DSD stated the facility scheduled CNA students, activity staff, and nursing staff to provide one-on-one supervision for Resident 2 to prevent altercations. The DSD added, when activity staff or CNA students were scheduled to supervise Resident 2 who was on one-on-one care, they should have stayed with Resident 2 to monitor him closely and never leave him unattended. The DSD further stated her expectation from assigned staff was that Resident 2 should have been kept within a direct line of sight of the staff, never left Resident 2 unattended, and confirmed with other staff who would relieve the monitoring staff member for breaks. During an interview on 9/18/25, at 4:51 PM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 2 was on one-on-one care and supervision since 6/8/25. The ADON explained that during an interview on 8/20/25, Resident 1 described the situation and how the altercation occurred. The ADON stated on that day when Resident 1 was ringing the call bell to receive assistance, Resident 2 started yelling at him to stop ringing the call bell. Resident 2 then rolled down in his wheelchair, entered Resident 1's room, and hit him with a wheelchair footrest which he had in his hand. The ADON added that Resident 1 defended himself by throwing a water pitcher at Resident 2. The ADON stated nursing staff intervened and redirected Resident 2 back to his room. The ADON further stated the purpose of one-on-one care was to provide direct supervision for Resident 2 and not to leave him unattended. The ADON further added to ensure the safety of all residents, and to prevent the altercation from happening, adherence to the facility one-on-one care expectation was required.During a phone interview on 9/19/25 at 10:10 AM with CNA 3, CNA 3 described the situation which happened on 8/20/25 in the early morning. CNA 3 explained that while she was in the middle of providing care to the residents (unable to recall the room number), the Activity Assistant (AA) entered into the room and asked her to cover Resident 2 while he was taking a break. CNA 3 stated she told the AA to wait until she finished her job and then she would cover for him. CNA 3 stated when she finished her job and came out of the room, she noticed the AA looked scared. CNA 3 stated when she asked the AA if something went wrong, the AA shook his head and did not say anything. CNA 3 added later that shift, the AA told her that when he came back from his break, he noticed that Resident 2 was rolling down in his wheelchair in the hallway in the Center (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Station going back to his room. CNA 3 further stated Resident 2 was on one-on-one monitoring and should have been always kept within the eyesight of the staff so they could supervise him directly. CNA 3 stated when Resident 2 was left unattended, this placed Resident 2 and other residents at risk of injury due to his aggressive behaviors toward others.During a phone interview on 9/19/25 at 10:46 AM, the AA confirmed that he was assigned to provide one-on-one supervision for Resident 2 on 8/20/25 when a resident-to-resident physical altercation occurred. The AA described the situation and stated he tried to find staff coverage to relive him when he took a break but was unsuccessful. The AA confirmed that he left Resident 2 unattended and took his break when he observed Resident 2 in bed sleeping. The AA added he left the room for about five to eight minutes and on his way back to Resident 2's room, he observed Resident 2 in the hallway in the Center Station rolling in his wheelchair down toward his room. The AA stated he observed Resident 2 with wet clothing, and Resident 1 was yelling and cursing at Resident 2. The AA further stated that he had received in services (additional education) on one-on-one supervision prior to the incident, and that he should not have left Resident 2 unattended.During an interview on 9/19/25 at 11:25 AM, with the Administrator (ADMN), the ADMN stated for each resident who was on one-on-one care, there were different ways of supervising them. The ADMN explained and provided examples, and stated that for fall risk resident, staff who were assigned to one-on-one supervision should be in close proximity to prevent resident from falling then continued, for residents who had aggressive behaviors toward other residents, staff who were assigned to provide one-on-one supervision should have residents within eyesight and should not leave the residents unattended. The ADMN stated all staff in the facility received acknowledgement on how to provide one-on-one care/supervision to residents and what were the expectations for one-on-one care. The ADMN added staff were responsible for coordinating with other staff who would relieve them prior to taking any breaks during their shifts. The ADMN stated Resident 2 had been involved in multiple resident-to-resident altercations, and it was a battle to keep him from doing it. The ADMN added Resident 2 had aggressive behaviors which were triggered easily. The ADMN confirmed that on 8/20/25 Resident was left unattended when the incident happened. The ADMN stated the incident was preventable if the assigned staff for the one-on-one supervision for Resident 2 had found a replacement for the duration of the break. The ADMN further stated her expectation from staff was to stay with Resident 2 and never leave him unattended. The ADMN further added staff did not meet her expectations and did not follow the facility's policy to ensure that the safety of all residents had been maintained.Review of Resident 2's medical record titled, Care Plan Report, created on 1/27/25 and revised on 6/9/25, indicated, .[Resident 2] with potential/risk to exhibit psycho-social distress [emotional episodes] related to the following: 1. Resident served in Vietnam war. 2. Hx [history] of Homelessness.4. Dx of schizophrenia and hx of stroke [when there is a disruption on oxygen to the brain]. 5. Physical Aggression triggered by paranoia r/t name calling, staring, being within close proximity with another person. (Res-to-Res Altercations:) - 1/24/2025 - 1/29/2025 - 2/26/2025 - 3/5/2025 - 3/10/2025 - 3/19/2025 - 3/24/25 - 4/17/2025 - 4/23/2025 - 5/9/2025 - 6/7/2025.Goal.Resident [Resident 2] will reduce or decrease episodes of PTSD [Post-traumatic stress disorder is a mental health condition that's caused by an extremely stressful or terrifying event] triggered by altercations.Interventions.Resident [Resident 2] to have 1:1 [one staff member supervises one resident at a time] staff support as indicated. The review indicated that Resident [Resident 2] was involved in multiple (11 in total) Resident-to-Resident altercations according to the documentation of dates in Resident 2's care plan.Review of Resident 2's medical record titled, Care Plan Report, created on 8/21/25, indicated, .RESIDENT-TO-RESIDENT POSSIBLE ALTERCATION.Goal.resident will have no episodes of resident-to-resident altercation x 30 days.Continue 1:1 supervision.Review of the facility record titled, ONE-ON-ONE CARE ACKNOWLEDGEMENT FORM, dated 8/25, indicated, .purpose of this form is to ensure that all staff members understand the expectations and responsibilities of providing one-on-one [1:1] care to residents.Expectations for One-on-One Care.Confirm who will relieve you for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch and breaks before starting your assignment. Never leave the resident unattended for any reason. If relief does not arrive on time, remain with the resident.Keep the resident within your direct line of sight at all times.Consistent adherence to these expectations is required to ensure the safety and well-being of all residents.Review of the facility's policy and procedure titled, Abuse Prohibition, revised on 10/25/24, indicated, .Policy; .Prevention of occurrences.Purpose: To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse.for all patients.Process: 6.b. If the suspected abuse is resident-to-resident, the resident who has in any way threatened or attacked another will be removed from the setting.The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure resident medical records were complete and accurately documented for one of three sampled residents (Resident 2) when, Resident 2's every 15-minute safety checks were not consistently documented on by staff for the dates of 8/18/25, 8/20/25, and 8/25/25.This failure had the potential to result in information not being available to ensure accuracy or communication across health care professionals and did not provide for an accurate representation of actual events that occurred to ensure Resident 2's care plan goals and interventions were being met. Findings:A review of Resident 2' s medical record titled admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses including paranoid schizophrenia (a mental health condition that can cause one to struggle to interpret what's real and what is not), insomnia (persistent problems falling and staying asleep), major depression disorder (a mental health disorder characterized by depressed mood or loss of interest in activities), and anxiety disorder (a mental health conditions characterized by excessive and persistent worry, fear, and nervousness).Review of Resident 2's medical record titled, Care Plan Report, created on 1/27/25 and revised on 6/9/25, indicated, .[Resident 2] with potential/risk to exhibit psycho-social distress [emotional episodes] related to the following: 1. Resident served in Vietnam war. 2. Hx [history] of Homelessness.4. Dx of schizophrenia and hx of stroke [when there is a disruption on oxygen to the brain]. 5. Physical Aggression triggered by paranoia r/t name calling, staring, being within close proximity with another person. (Res-to-Res Altercations:) - 1/24/2025 - 1/29/2025 - 2/26/2025 - 3/5/2025 - 3/10/2025 - 3/19/2025 - 3/24/25 - 4/17/2025 - 4/23/2025 - 5/9/2025 - 6/7/2025.Goal.Resident [Resident 2] will reduce or decrease episodes of PTSD [Post-traumatic stress disorder is a mental health condition that's caused by an extremely stressful or terrifying event] triggered by altercations.Interventions.Resident [Resident 2] to have 1:1 [one staff member supervises one resident at a time] staff support as indicated. The review indicated that Resident [Resident 2] was involved in multiple (11 in total) Resident-to-Resident altercations according to the documentation of dates in Resident 2's care plan.Review of Resident 2's medical record titled, Care Plan Report, created on 8/21/25, indicated, .RESIDENT-TO-RESIDENT POSSIBLE ALTERCATION.Goal.resident will have no episodes of resident-to-resident altercation x 30 days.Continue 1:1 supervision.During an interview on 9/18/25 at 10:33 AM in Resident 2's room, CNA 1 stated Resident 2 was on one-on-one supervision and every 15-minute safety checks related to aggressive behaviors such as striking at other residents and entering other resident rooms. CNA 1 added staff who were assigned to one-on-one supervision were responsible for documenting the location and status of Resident 2 every 15 minutes during their shifts. CNA 1 emphasized the importance of documentation and stated that staff should not leave any time frame blank to verify that Resident 2 was supervised during that time frame. CNA 1 further stated every 15-minute safety checks was a type of report and communication to notify staff about resident status and what he was doing during that time. During a concurrent interview and record review on 9/18/25 at 3:29 PM in Resident 2's room, the facility provided document titled, Q 15 MINUTE SAFETY CHECKS dated August 1 to August 31, 2025, was reviewed with CNA 2. CNA 2 acknowledged that every 15-minute safety check was not consistently documented on 8/18/25, 8/20/25, and 8/25/25. CNA 2 stated Resident 2 had aggressive behaviors toward other residents with a tendency to enter other rooms. CNA 2 stated Resident 2 was on one-on-one supervision 24/7 to prevent further altercations, and assigned staff were accountable to document every 15 minutes on the Q 15 MINUTE SAFETY CHECK form. CNA 2 stated, documenting every 15 minutes was a type of report and proof that Resident 2 was in eyesight and was not left unattended during that time frame.During an interview on 9/18/25, at 3:51 PM, Licensed Nurse (LN) 1 stated Resident 2 had been on one-on-one supervision since June 2025 for being involved in multiple altercations with other residents in the facility. LN 1 stated staff who were (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assigned to provide one-on-one supervision were accountable for staying with Resident 2, not leaving him unattended, and documenting every 15 minutes about his status. LN 1 added consistency of documentation was crucial element to ensure Resident 2 was supervised properly. LN 1 further stated not consistently documenting as it was instructed in every 15-minute safety checks, might indicate Resident 2 was not always kept within a direct line of sight. During an interview on 9/18/25, at 4:24 PM, CNA 4 stated she was assigned to provide one-on-one for Resident 2 several times. CNA 4 stated at the beginning of her shift prior to covering for the previous staff, she would review every 15-minute safety checks to ensure documentation was completed. CNA 4 stated staff who provided one-on-one supervision should document resident status every 15 minutes on the safety checks form. CNA 4 further stated if documentation was not filled out properly, it might state that Resident 2 was left unattended and not always supervised.During a concurrent interview and record review on 9/19/25, at 11:25 AM, in the conference room, with the Administrator (ADMN), Resident 2's record titled, Q 15 MINUTE SAFETY CHECKS for the dates of 8/18/25, 8/20/25, and 8/25/25 were reviewed. The ADMN confirmed that staff did not follow the facility provided document guidelines. Review of Resident 2's every 15-minute safety check for 8/18/25, 8/20/25, and 8/25/25 revealed that the records were not consistently documented. The ADMN stated her expectation from staff was to complete every 15-minute safety checks form consistently and properly. Review of the facility provided ONE-ON-ONE CARE ACKNOWLEDGEMENT FORM, dated 8/25, the record indicated, .Purpose.Proper supervision and adherence to these guidelines are critical in maintaining resident safety and preventing resident-to-resident altercations.Expectation for One-on-One Care.Observe and document changes in the resident's mood or behavior.Report changes immediately to the charge nurse.