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	11/26/2025

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

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from involuntary seclusion (a type of abuse that includes separation of a resident from other residents or from her/his room or confinement to her/his room) when Certified Nursing Assistant (CNA) 1, placed and sat in a chair in Resident 1's doorway, blocking Resident 1 from exiting her room during the 9/17/25 night shift (NOC shift).This failure had the potential to result in physical injury and psychosocial trauma (lasting emotional and psychological distress caused by a distressing event) for Resident 1.Findings:A review of Resident 1's admission RECORD, dated 9/22/25, indicated Resident 1 was initially admitted to the facility with diagnoses which included Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), Dementia (a group of conditions that cause a gradual decline in cognitive abilities, such as memory, thinking, language, and judgment, severe enough to interfere with daily life), and Unspecified Mood Disorder [Affective-a clinical diagnosis for someone exhibiting symptoms of a mood disorder that do not meet the full criteria for other diagnoses]. During a telephone interview on 9/22/25 at 10:25 a.m. with CNA 2, CNA 2 stated, during the night shift that began on 9/17/25, she saw CNA 1 hold the wrist of Resident 1 and lead her down the hallway toward Resident 1's room (room [ROOM NUMBER]). CNA 2 stated, before they (Resident 1 and CNA 1) entered room [ROOM NUMBER], they went into room [ROOM NUMBER], got a chair, then continued into room [ROOM NUMBER]. CNA 2 stated she heard Resident 1 yelling and went to room [ROOM NUMBER]. CNA 2 stated CNA 1 was sitting in a chair in the doorway of room [ROOM NUMBER] preventing Resident 1 from exiting her room. CNA 2 stated, it was normal for Resident 1 to wander inside the facility at night because she liked to sleep during the day and stay awake during the night. CNA 2 stated, Resident 1 had wandered inside of the facility from approximately 11 PM to 3 AM before this incident occurred. During an interview on 9/22/25 at 1:05 p.m., the Administrator (ADMIN) stated that during her investigation into the allegation of involuntary seclusion, Nursing Assistant (NA) 1 reported hearing CNA 1 say, If I could lock you in your room, I would. The ADMIN added that CNA 2 stated she observed CNA 1 hold Resident 1's hand, retrieve a chair from room [ROOM NUMBER], and sit in front of the door to prevent Resident 1 from leaving her room. When the ADMIN spoke with CNA 1 about the incident, CNA 1 confirmed she took care of Resident 1 on the NOC shift which started on 9/17/25 and stated Resident 1 was going into other residents' rooms and wanted to stop her from doing that. The ADMIN further stated, CNA 1 admitted to telling Resident 1 that if she could lock her in her room, she would. The ADMIN continued, CNA 1 confirmed she sat in a chair in the doorway of room [ROOM NUMBER] and had a rolling tray table next to the chair to stop Resident 1 from leaving her room. The ADMIN stated, CNA 1 had been a CNA for many years, but had not comprehended that seclusion (involuntarily holding a resident in their room) was a form of abuse.During a concurrent interview and record review on 9/22/25 at 2:38 p.m. with the Director of Staff Development (DSD), an undated facility training module titled, Preventing Abuse (Hand in Hand by CMS [Centers for Medicare & Medicaid Services-a federal agency that provides health coverage to millions of people through (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	programs like Medicare, Medicaid] Module 2) was reviewed. Module 2 indicated, .The module begins by highlighting why abuse in dementia care is a critical concern.Elders with dementia may struggle to report abuse due to impaired short-term memory (lasting 5 minutes to a couple of days) and cognitive decline, making it hard for them to recall or articulate facts about abuse.Key terms include.Unreasonable Confinement: Restricting movement without proper justification or consent.The module categorizes different types of abuse.Involuntary Seclusion: Separating an elder from others or confining them to a room against their will. The DSD stated the topic of isolation and seclusion were discussed during the training. During the same concurrent interview and record review on 9/22/25 at 2:38 p.m. with the DSD, an undated facility training module titled, Preventing Abuse (Hand in Hand by CMS Module 5) was reviewed. Module 5 indicated, .Understanding Abuse.Detaining someone against their will.This module covers various forms of abuse.Involuntary seclusion. The DSD stated, the topic of isolation and seclusion were taught and discussed during required trainings either as an in-service or when assigned as an online module.During the same concurrent interview and record review on 9/22/25 at 2:38 p.m. with the DSD, CNA 1's undated cumulative training record from SNF (skilled nursing facilities) CLINIC (a web-based electronic learning management system to provide skilled nursing facilities with training resources, compliance tools, and staff management capabilities) was reviewed. The training records indicated CNA 1's completion of the following sections: CNA - The Non-Compliant Resident, completed on 9/4/25. Resident Altercation, completed on 6/10/25. Abuse, Neglect, and Exploitation, completed on 5/8/25. Preventing Abuse (Hand in Hand by CMS Module 5), completed on 4/2/25. Resident and Patient Rights, completed on 3/1/25. Dealing with Disruptive Behavior, completed on 3/1/25. Physical and Verbal Aggression in Residents, completed on 3/1/25. What is Abuse (Hand in Hand by CMS Module 2), completed on 2/23/25.During an observation on 9/22/25 at 3:05 p.m., Resident 1 was observed walking throughout the facility without supervision. Staff who redirected or spoke to Resident 1 called her by name. Resident 1 was observed in the following manner: Went from her room (20-B) into room [ROOM NUMBER]. The resident in 18-B stated, Go, go, go, to Resident 1 and Resident 1 returned to her room. Wandered out of her room and walked toward the Central Nurse Station and the hallway in front of the station. Attempted to open a locked door marked, Oxygen Storage. Went to counter at Central Nurse Station and flipped the pages of the staff schedule binder. Was redirected by staff member at Central Nurse Station to go out to the main hallway. Wandered down main hallway to the North Hall and touched another resident who was in a wheelchair on the shoulder, then continued walking. Walked up to a resident in the hallway of North Hall who told Resident 1 to go back to her side of the facility. Resident 1 continued to wander through all 3 halls in the facility (South, North, and Central). Resident 1 touched items such as a cleaning cart (rolling cart which contains cleaning supplies) and a medication cart (a mobile, wheeled storage unit designed to securely organize and transport medications and related supplies to residents' rooms for administration). Resident 1 went back to her room and touched items belonging to her roommate. Resident 1 went back to the front lobby area where her feet were nearly rolled over by another resident in a wheelchair (a staff member nearby intervened to prevent injury to Resident 1).During an interview on 9/22/25 at 4:40 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, it was reported that CNA 1 shouted at Resident 1 saying she would lock her in her room if she could. The ADON stated, CNA 1 admitted she had said those words to Resident 1. The ADON stated if she was in a room and not allowed to leave, she would feel upset and agitated and would wonder why she could not leave. During an interview on 9/22/25 at 5:10 p.m. with Licensed Nurse (LN) 1, LN 1 stated, if staff prohibited a resident from leaving their room the problem would be seclusion, and that would be a form of abuse. LN 1 stated, if she was placed in a room and not allowed to leave, she would feel nervous, scared, and confused, and would wonder why she was not allowed to leave. LN 1 further stated, if a resident was not allowed to leave their room, it could escalate unwanted behaviors and could potentially lead to physical injury if the resident tried to get out.Review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 2/23/21, indicated, .HealthCare Centers prohibit abuse.This includes.Involuntary seclusion. Abuse is defined as the willful infliction of injury, unreasonable confinement.Abuse also includes the deprivation [the state of lacking or being denied something that is needed or desired by an individual] [by] a caretaker. that are necessary to attain or maintain physical, mental or psychosocial well-being.Review of a facility document titled, Stockton Nursing Center 5-Day Incident Summary Report, dated 9/22/25, indicated, .Investigation Findings.a fellow CNA confirmed [CNA 1] blocked the resident from leaving her room.[CNA 1] admitted to making the statement and acknowledged preventing the resident from leaving.Conclusion.The facility determined the incident constituted resident seclusion.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse directly to the facility administrator and to the Department (a state agency that licenses, regulates, and inspects skilled nursing facilities (SNFs) to ensure they comply with state and federal regulations) within two hours after the suspicion of abuse was recognized on 9/18/25 by facility staff for one of four sampled residents (Resident 1).This failure delayed the facility and the Department's abuse investigation, potentially allowing continued abuse of Resident 1 and other residents, or causing further psychosocial harm.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline) Unspecified Dementia (a group of conditions that cause a gradual decline in cognitive abilities, such as memory, thinking, language, and judgment, severe enough to interfere with daily life), Moderate with Other Behavioral Disturbance, and Unspecified Mood Disorder (a clinical diagnosis for someone exhibiting symptoms of a mood disorder that do not meet the full criteria for other diagnoses).During a telephone interview on 9/22/25 at 10:25 a.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated, during the night shift (NOC) she witnessed a suspected case of staff to resident (Resident 1) abuse on 9/18/25 at approximately 4:30 a.m. when CNA 1 sat in the doorway of Resident 1's room preventing her from exiting. CNA 2 stated that she was going to report the incident to the Administrator (ADMIN) on the morning of 9/18/25 after her shift ended but did not.During an interview on 9/22/25 at 1:05 p.m. with the administrator (ADMIN), the ADMIN confirmed the alleged abuse occurred on 9/18/25 at approximately 5 AM and the nursing assistant (NA) also working the NOC shift on 9/18/25, made the initial report to her at approximately 9:30 a.m. that morning. The ADMIN confirmed that staff knew they were mandated reporters (individuals who are legally required to report suspected abuse or neglect to the proper authorities) and knew the 3, 2, 1 acronym: 3 entities (Police, the Department, ADMIN), 2 hours, 1 reporter.During an interview on 9/22/25 at 4:40 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, staff knew the process for abuse reporting included steps on what to do, in the absence of the ADMIN. The ADON stated seclusion (the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving) of Resident 1 in her room should have been reported to the proper authorities within 2 hours of the occurrence. The ADON confirmed that the notification to the Police Department did not occur until 10:00 a.m. on 9/18/25 and was not within the required 2-hour timeframe. The ADON further confirmed, the report to the Department was not made until 10:36 a.m. and did not meet the facility's 2-hour reporting requirements for abuse.During an interview on 9/22/25 at 5:10 p.m. the ADMIN confirmed, the facility's timeline for reporting suspected abuse was not followed when a written report was not faxed within 2 hours to the Department and Police Department contact was not made immediately.Review of an undated facility document titled, Process for Abuse Reporting, indicated, .WITHIN THE FIRST 2 HOURS FAX SOC-341 [a California state form, officially titled Report of Suspected Dependent Adult/Elder Abuse that is used to report suspected instances of abuse to the proper authorities and to document and report known or suspected abuse or neglect of an elderly person] TO CDPH [California Department of Public Health - the Department] AND OMBUDSMAN [an independent, neutral official who investigates complaints and mediates disputes between individuals and an organization, such as a skilled nursing facility].CALL NON-EMERGENCY POLICE DEPT [department] AND OBTAIN REPORT NUMBER.CALL ED [Executive Director - ADMIN]/DON/ADON IMMEDIATELY.CALL MD [medical doctor]/RP [responsible party] IMMEDIATLEY.Review of an undated facility training module titled, Preventing Abuse (Hand in Hand by CMS [Centers for Medicare & Medicaid Services-a federal agency that provides health coverage to millions of people through programs like Medicare, Medicaid] Module 2), indicated, Reporting Procedures.All nursing home staff (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are legally mandated reporters and must report abuse or suspected abuse immediately to the administrator after ensuring the elder's safety.Immediate Reporting: Report at the time you notice something.Chain of command: While you can inform supervisors, your legal responsibility is to ensure the administrator is notified directly.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision for one of four sampled residents (Resident 1) with known Dementia (generally involves memory loss) and wandering behaviors when Resident 1 wandered into other resident rooms and walked throughout the facility without supervision.This failure placed Resident 1 at risk for elopement (when a resident leaves the facility without authorization, supervision, or a planned discharge), injury, and/or serious physical harm.Findings:During a telephone interview on 9/22/25 at 10:25 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she worked on the night shift (NOC) at the facility and consistently observed Resident 1 wandering in the hallways of the facility. CNA 2 further stated, Resident 1 had known wandering behaviors while awake and staff would call Resident 1 by name. CNA 2 continued, Resident 1 would sometimes go into other resident rooms, but with redirection would go back into a hallway. CNA 2 stated, Resident 1 does not have any assigned or direct supervision in the facility, and it was Resident 1's normal behavior to sleep during the day and wander in the late afternoon and night.During an interview on 9/22/25 at 1:05 p.m. with the Administrator (ADMIN), the ADMIN stated, Resident 1 was very pleasant and just wanders in the facility. The ADMIN stated, if Resident 1 was in the hallway, she would step up and listen to staff conversations and was known to walk into other resident rooms but could be redirected to leave that room. The ADMIN confirmed, Resident 1 had known wandering behaviors, but was not aggressive toward other residents.During an observation on 9/22/25 from 3:05 p.m. to 3:20 p.m., Resident 1 was observed walking throughout the facility without supervision. Staff who redirected or spoke to Resident 1 called her by name. Resident 1 was observed in the following manner: Went from her room (20-B) into room [ROOM NUMBER]. The resident in 18-B stated, Go, go, go, to Resident 1 and Resident 1 returned to her room. Wandered out of her room and walked toward the Central Nurse Station and the hallway in front of the station. Attempted to open a locked door marked, Oxygen Storage. Went to counter at Central Nurse Station and flipped the pages of the staff schedule binder. Was redirected by staff member at Central Nurse Station to go out to the main hallway. Wandered down main hallway to the North Hall and touched another resident who was in a wheelchair on the shoulder, then continued walking. Walked up to a resident in the hallway of North Hall who told Resident 1 to go back to her side of the facility. Resident 1 continued to wander through all 3 halls in the facility (South, North, and Central). Resident 1 touched items such as a cleaning cart (rolling cart which contains cleaning supplies) and a medication cart (a mobile, wheeled storage unit designed to securely organize and transport medications and related supplies to residents' rooms for administration). Resident 1 went back to her room and touched items belonging to 20-A bed (roommate). Resident 1 went back to the front lobby area where her feet were nearly rolled over by another resident in a wheelchair (a staff member nearby intervened to prevent injury to Resident 1).During a concurrent observation and interview on 9/22/25 at 3:23 p.m. with Licensed Nurse (LN) 2, LN 2 was standing nearby when Resident 1 walked up to another resident in the North Hallway; that resident told Resident 1 to go back to her side of the facility. LN 2 took Resident 1 by the hand and walked her back to her room in the Center Hallway. LN 2 stated, it was known behavior for Resident 1 to wander the entire facility and would go into resident rooms, and more often into rooms with male occupants. LN 2 stated, staff knew interventions like redirection, but redirection was a constant occurrence because Resident 1 was hard to watch. LN 2 stated, she was aware of staff members who had complained to management about Resident 1 constantly wandering in the facility. LN 2 continued, the risk to Resident 1 was a safety concern and that other residents did not like when Resident 1 went into their rooms. LN 2 stated, in the past, she had kept Resident 1 with her at the Center Nurse station, but that was not a realistic intervention if there was no one able to sit with Resident 1 as the LN's must do medication pass and be able to see to the needs of the other (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents.During a concurrent interview and record review on 9/22/25 at 4:10 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Care Plans (documents created by a care team to guide the care of an individual, outlining specific health conditions, needs, goals, and interventions) were reviewed as follows: The Care Plan Focus, At risk for injury d/t [due to] wanders outside of the facility (elopement) revised on 3/24/25, indicated, .Goal.Resident will be safe at facility daily during stay.Resident will be able to be redirected when wandering by Exit doors.Interventions.Encourage resident to stay in common areas of building for observation if needed.When wandering redirect resident to another activity. The Care Plan Focus, Resident/Patient is at risk for wandering related to: Cognitive Loss/Dementia. Roommate complained she sat on her legs while in bed approximately 2 months ago, revised on 3/24/25. indicated, .Goal.Other: Will not invade roommates' [sic] space, sit on her or do any unwanted touching.Interventions.Monitor the residents/patient's location with visual checks at least routinely when in room, as needed.Familiarize resident with own belongings and surroundings. The Care Plan Focus, Risk for and actual ELOPMENT related to episodes of wandering, other contributing factors: cognitive impairment, communication impairment, poor safety awareness, requires verbal queuing and redirection; actual episodes of elopement; verbalizes having somewhere to go or take care of, verbalizes that friend is coming to pick her up. Revised 3/24/25, indicated, .Goal.Will remain safe during placement at Living Center.Interventions.Check resident wander guard [a discreet wearable device tracks movement and triggers automated security responses when a resident nears a restricted area or exit door] for functioning daily every shift.Involve patient in preferred activities.Redirect patient from doors.Take picture of patient upon admission for identification for updating elopement book. The Care Plan Focus, Impaired thought process due to: ALZHEIMER'S DISEASE w/ [with] late onset, DEMENTIA, DEPRESSION .has bouts of confusion, poor memory, poor safety awareness, requires verbal queuing and redirection on task to complete, communication impairment: usually understands others through verbal content, episodes of behaviors/wandering.Interventions.Encourage out of room activities.Give positive feedback when resident makes decisions.Reorient to person, place and time as needed.The ADON stated, Resident 1's interventions for wandering were mainly redirection and offering snacks at the Center Nurse Station. The ADON stated, the activities department attempted to get Resident 1 involved in coloring or other activities, but Resident 1 does not like to stay there for long. The ADON further stated, Resident 1 liked to watch people and things that occurred in the facility and liked to be up and around. The ADON confirmed, staff try to keep Resident 1 in her own area, in the Center Hall, but she was able to walk through the whole facility without direct supervision.During the same interview on 9/22/25 at 4:10 p.m. the ADON stated, when Resident 1 walked in the North and South Halls of the facility, other residents sometimes allowed her to walk in those locations, but some were territorial about their space and hall areas. The ADON stated, Resident 1 had gone into other resident rooms and does not have 1:1 supervision (one to one supervision- a facility staff member who provides constant, direct observation of a single resident). The ADON further stated, the risk for Resident 1 when she wandered in the facility without supervision, would be a safety issue and Resident 1 could have altercations with other residents. The ADON stated, during a recent investigation, it was revealed from staff that Resident 1 was walking up and down the hallways all day and night. The ADON stated she could not quantify how often staff complained about Resident 1, but it was a lot. The ADON confirmed, staff have always had to redirect Resident 1 since she has been in the facility.Review of the facility's policy and procedure (P&P) titled, Wandering and Elopement. Indicated, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm.Review of an online article from California Advocates for Nursing Home Reform (CANHR-a statewide nonprofit advocacy organization) titled, NURSING HOME CARE STANDARDS, dated 10/24/22, indicated, .The federal Nursing Home Reform Act of 1987 requires them [nursing homes] to help each resident attain or maintain the highest practicable physical, mental and psychosocial well-being. Safety and Preventing Accidents.This section addresses standards related to prevention of accidents and to a nursing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	home's duty to provide adequate supervision to keep residents safe. https://canhr.org/nursing-home-care-standards/