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	12/02/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one out of three sampled residents (Resident 1) was provided with adequate pain management when Resident 1's new pain medication order was not carried out by the facility for 35 days. This failure contributed to Resident 1 experiencing pain and had the potential to cause unnecessary psychosocial distress.A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including palliative care (If an illness that cannot be cured, palliative care makes the person comfortable as possible by managing pain and other distressing symptoms), dementia (affecting a person's ability to remember, think, and make decision), mild neurocognitive disorder (a condition where a person's memory or thinking skills have slightly declined), history of falling, and legal blindnessDuring a phone interview on 9/23/25, at 12:37 PM, with Family Member (FM) 1, FM 1 stated she went to the facility on September 17 to visit Resident 1, she saw Resident 1 crying, gasping for breath, and looked uncomfortable and in pain. FM 1 stated the nurse told her that Resident 1 missed her pain medication. FM 1 stated Resident 1 was still in bed and in pain when the Assistant Director of Nursing (ADON), the administrator (ADM) and Social Worker (SW) came to the room and explained that the pain medication, morphine sulfate, was PRN (as needed) and if Resident 1 was showing signs of pain like moaning or groaning they could provide her the pain medication. FM 1 stated she called the hospice agency (palliative care agency), and she was told by the hospice nurse that Resident 1 actually had morphine sulfate ordered to be given every six hours routinely since August 12. FM 1 stated the facility told her that hospice needed to reevaluate Resident 1 before they changed the order to routine. FM 1 stated she came back the next day and asked the nurse if Resident 1 had been given morphine sulfate, and the nurse told her that Resident 1 had not been given any morphine sulfate since September 15.A review of the Resident 1's medical record titled, [company name] Hospice Physician's order dated 6/24/25, indicated . Morphine Sulfate 100mg/5ml [100 milligrams per 5 milliliters, units of measure] give 0.25ml q4hrs [every 4 hours] PRN [as needed].A review of the Resident 1's medical record titled, [company name] Hospice, Inc POC/IDG [Plan of Care/Interdisciplinary Group] Review, dated 8/20/25, indicated, Order Date 8/12/2025 Start Date 8/12/2025 Type New Medication Morphine Sulfate 20mg/mL Concentrated Solution.Dosage 10mg (0.5ml) EVERY 6hrs [6 hours] around the clock.Indication PainDuring an interview on 9/24/25, at 10:11 AM, with Licensed Nurse (LN) 1, LN 1 stated it was important to address a resident's pain because the resident needed to be comfortable. LN 1 stated if the resident's pain was not addressed, it would be considered neglect to the resident and the resident's condition could get worse and they wanted to avoid that. LN 1 stated if the pain medication was PRN and the resident does not verbalize that they are in pain, the nurses use a pain scale for non-verbal residents called the PAINAD scale (Pain Assessment in Advanced Dementia, with scores ranging from 0 to 10 to indicate mild to severe pain). LN 1 stated this scale uses breathing and facial expressions of the resident to assess their pain instead of relying on the resident to say if they were in pain.During an interview on 9/24/25, at 11:06 AM, with LN 2, LN 2 stated when providing residents with pain medication, he could tell if the resident was in pain by the resident's facial expressions, like facial grimacing. LN 2 stated it was important to address the resident's pain because the pain could increase in severity and it could cause more problems, and the resident could be distressed and experience restlessness. LN 2 stated it was change of shift when Resident 1 started crying on September 17, but he did not give her pain medication during his shift because she was not in pain at that time. LN 2 stated Resident 1's pain medication, morphine sulfate was ordered as PRN.During a concurrent interview and record review of Resident 1's medical record on 9/24/25, at 11:12 AM, with the Assistant Director of Nursing (ADON), the ADON stated it was important to address a resident's pain and if it was not addressed, there would be continuation of pain. The ADON stated that when the hospice provider orders a pain medication for a resident on hospice, the hospice provider will fax the order to the facility, and the hospice staff will also call to verify if the fax was received. The ADON stated the nurses notify the facility's doctor, and the doctor normally follows what the hospice doctor ordered. Resident 1's medical record was reviewed with the ADON, Resident 1 was admitted to hospice on 6/24/25, with an order for PRN morphine sulfate 0.25 ml dated 6/24/25. The ADON stated the routine morphine sulfate 0.5 ml every 6 hours was ordered on 9/17/25 and she still had the PRN morphine sulfate 0.25 ml. Resident 1's medical records from the hospice agency indicated Resident 1 had an order for Morphine Sulfate 0.5 ml every 6 hours around the clock for pain dated 8/12/25 when the