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	12/03/2025

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 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. (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 0656 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 develop a comprehensive care plan for one of three sampled residents (Resident 1) when:1. Resident 1 was readmitted on [DATE] to the facility with new skin issues; and, 2. Resident 1 had known skin scratching behavior. These failures placed Resident 1 at risk for further skin breakdown and potential worsening of the existing skin issues due to the skin scratching behavior. Findings:1. Review of Resident 1's medical record titled, admission RECORD, indicated Resident 1 was admitted to the facility in mid-2025 with diagnoses that included type 2 diabetes mellitus (a condition when the body cannot control blood sugar levels), end stage renal disease (when they kidneys are no longer able to function on their own to filter waste and excess fluid from the body) and dependence on renal dialysis (a treatment to filter waste and excess fluid from the blood).Review of Resident 1's medical record titled, Body Check. dated 10/30/25, indicated .Body Check completed with Skin Issues. 31) Right buttock [butt cheek] - 0. 5 cm x 0.5 cm [centimeter-a unit of measure] scattered skin scrape. 32) Left buttock - 0.5 cm x 0.5 cm scattered skin scrape.Other (specify). 0.5 cm x 0.5 cm right scrotum [part of a males reproductive organs-a thick sac (pouch) of skin] skin scrape.Additional Comments: MD order to monitor for now. During a concurrent interview and record review on 12/2/25, at 3:45 p.m., with Licensed Nurse (LN) 1, LN 1 stated Resident 1 had scratches on his buttocks area and had an MD order for staff to just monitor the areas. LN 1 reviewed Resident 1's medical record and verified on 10/30/25 Resident 1 was readmitted to the facility and had a Body Check assessment completed which indicated he had scrotum and bilateral (both left and right side) buttock skin scrapes. LN 1 reviewed Resident 1's care plans and confirmed there were no care plans initiated for the new skin issues found during Resident 1's readmission on [DATE]. LN 1 stated the nurse who did Resident 1's skin assessment on his readmission on [DATE] should have created a care plan for the new skin issues. LN 1 stated it was important to have a care plan to track wound healing and should have been done every time a new skin issue was found. LN 1 stated the risk of not having a care plan in place would be risk of infection and worsening of skin issues. During an interview on 12/2/25, at 4:40 p.m., with LN 2, LN 2 stated if a resident had a change in a current skin issue or was found to have new skin issues, a care plan should be initiated. During an interview on 12/3/25, at 12:00 p.m., with LN 4, LN 4 stated Resident 1 was readmitted to the facility on [DATE] and had skin issues on his buttocks and right scrotum area. LN 4 stated he could not recall if he created Resident 1's care plan for the skin issues found on 10/30/25. LN 4 stated Resident 1 needed a care plan and monitoring orders to be in place for the skin issues found when he was readmitted to the facility on [DATE]. During a concurrent interview and record review on 12/3/25, at 2:01 p.m., with the Director of Nursing (DON), the DON stated it was expected for the nurses to treat a re-admission like a new admission, which would include a full skin assessment. The DON stated it was important for a resident to have a care plan for new skin issues to know the interventions on how to take care of the problem for a positive outcome. The DON stated it was expected for the nurse to have created a care plan for any new skin issue. The DON stated the risk of not having a care plan in place would be poor outcome for the residents, not preventing worsening of issues and not planning to make it better. Review of facility's policy titled, Readmission, dated 3/22/22, indicated .III.PROCEDURE.B. A Licensed Nurse will do the following upon the readmission: Complete an admission Assessment.Update Care plan.Review of facility's policy titled, CARE PLAN COMPREHENSIVE, dated 8/25/21, indicated .I. PURPOSE.An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident.III. PROCEDURE.7. Assessments of residents are ongoing and reviewed and revised as information about the resident and the resident's condition change.8. The Interdisciplinary Team is responsible for evaluation and updating of care plans:.c. When the resident has been readmitted to the facility from a hospital stay.2. During a concurrent observation and interview on 12/2/25, at 11:16 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 had no known skin issues that she knew of. CNA 1 stated Resident 1 used adult briefs (used for a lack of bowel and bladder control) and would sometimes use the toilet with assistance. CNA 1 checked Resident 1's skin under his adult brief and stated she saw some redness, with some scabbing, and pink areas on his buttocks area.During a concurrent interview and record review on 12/2/25, at 3:58 p.m., with LN 1, LN 1 reviewed Resident 1's orders and stated Resident 1 had scratches on his buttocks area with an MD order to monitor them. LN 1 stated Resident 1 had a habit of self-scratching based

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure medical records were complete and accurately documented for one of three sampled residents (Resident 1 and Resident 2) when: 1. Resident 1's Treatment Administration Record (TAR) report for 11/2025 had missing documentation from a licensed nurse on multiple treatment orders; and, 2. Resident 2's TAR report for 11/2025 had missing documentation from a licensed nurse for the stage 3 pressure ulcer treatment to her coccyx (a deep wound on the tailbone area). These failures had the potential for both Resident 1 and Resident 2's medical records to have insufficient information to determine if treatment orders were being carried out as ordered and could place both residents at risk of complications. Findings:1. Review of Resident 1's medical record titled, admission RECORD, indicated Resident 1 was admitted to the facility in mid-2025 with diagnoses that included type 2 diabetes mellitus (a condition when the body is unable to regulate blood sugar levels), end stage renal disease (a condition when they kidneys are no longer able to function on their own to filter waste and excess fluid from the body) and dependence on renal dialysis (a treatment to filter waste and excess fluid from the blood). Review of Resident 1's medical record titled, TREATMENT ADMINISTRATION RECORD, for the month of 11/2025, indicated the following MD orders with missing documentation: a.0.5cm x 0.5cm [centimeter, a unit of measure] left buttock [butt cheek] scattered skin scrape. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Notify MD for worsening every shift. - order started on 10/30/25 with missing documentation on the morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25. b.0.5cm x 0.5cm right buttock scattered skin scrape. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Notify MD for worsening every shift. - order started on 10/30/25 with missing documentation on morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25. c.0.5cm x 0.5cm right scrotum [part of a male's reproductive organs-a thick sac (pouch) of skin] scattered skin scrape. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Notify MD for worsening every shift. - order started on 10/30/25 with missing documentation on morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25. d.L [left] hand swelling: Monitor for worsening of symptoms. Notify MD. D/C [Discontinue] order when resolved every shift. - order started on 9/21/25 with missing documentation on morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25.e.LEFT GREAT TOE BLACK DISCOLORATION: Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings. Notify MD for worsening. Every shift. - order started on 11/25/25 with missing documentation on morning shift for dates 11/26/25 to 11/28/25; and evening shift for date 11/27/25. f.Monitor for +4 pitting edema [severe fluid accumulation under the skin] to LUE [left upper extremity] Q shift [every shift]. Call MD for worsening, d/c when resolved. Every shift. - started on 7/9/25 with missing documentation on morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25. g.Monitor R [right] eye: watch for s/s [signs and symptoms] of infection or worsening such as redness, warmth, drainage, swelling or odor. Notify MD of significant findings. D/C when resolved every shift. -started on 7/9/25 with missing documentation on morning shift for dates 11/3/25, 11/9/25, 11/14/25 to 11/15/25, 11/26/25 to 11/28/25; and, evening shift for dates 11/10/25 and 11/27/25.h.REDNESS TO RIGHT GREAT TOE: Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings. Notify MD for worsening every shift. - started on 11/25/25 with missing documentation on morning shift for dates 11/26/25 to 11/28/25; and evening shift for date 11/27/25.i.Terbinafine HCL External Cream 1% [antifungal medication].Apply to bilateral feet and toenail topically every evening shift for tine pedis [fungal infection]. - started on 11/26/25 with missing documentation for evening shift on 11/27/25. j.TX-R [treatment-right] GREAT TOE - BETADINE [yellow liquid used for wound healing] SOAK, COVER W [WITH] DRY DRESSING. SOAK 4X4 GAUZE W BETADINE, COVER W DRY DRESSING. Every evening shift. - started on 11/26/25 with missing documentation on evening shift for dates 11/27/25 and 11/29/25. During a concurrent interview and record review on 12/2/25, at 4:58 p.m., with the Treatment Nurse (TN), the TN reviewed Resident 1's TAR monthly report for 11/2025 and confirmed the dates listed above lacked