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	12/08/2025

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to protect the rights of two of 4 sampled residents (Resident 3 and Resident 6) to be free from physical abuse when:1. Resident 1 with a history of multiple resident-to-resident altercations, made racial slurs and pushed Resident 6 on 9/18/25; and,2. Resident 4 hit Resident 3 in the face on 8/30/25. These failures resulted in Resident 3 sustaining an injury to her mouth and Resident 6 falling from his wheelchair. Findings:1. A review of Resident 1' s medical record titled, admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including paranoid schizophrenia (a mental health condition that is characterized hearing and seeing things that are not real), 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 1's medical record titled, Order Summary Report, dated 9/24/25, indicated there was an active physician's order for one-on-one supervision (one staff member monitors one resident) 24 hours a day that was initiated on 6/8/25. There was also an active physician's order for monitoring episodes of aggressive behavior as evidenced by (AEB) striking out at others and was initiated on 9/10/25.A review of Resident 1's medical record titled, Interdisciplinary Care Conference - V5, dated 9/19/25 indicated, .On 9/18/25, it was reported that this resident [Resident 1] was involved in an altercation. [Resident 1] struck at [Resident 6]. [Resident 6] attempted striking back. Residents were separated immediately and assessed for injuries.Recommendations. 72 hour monitoring - Q [every] 30 min safety checks.A review of Resident 1's medical record titled, Progress Notes, dated 9/18/2025 at 11:30 AM, indicated, .per observer or witnesses [Resident 1] was verbally aggressive to [Resident 6] and contact was made but was separated by staff.A review of Resident 1's medical record titled, Care Plan Report, indicated the following:-6/28/22, .Interventions.Monitor for mood and/or behavior changes or symptoms, assist in finding alternative interventions to aid resident's [Resident 1] adjustment and understanding of need.maintain a safe environment with minimal stimulation.-11/02/24, Goal. Promote respectful interactions with peers and staff.Interventions.Educate the resident on the importance of non-violent communication and conflict resolution.Implement regular observations to assess behavior and provide immediate feedback.-6/9/25, .Focus.Resident [Resident 1] with potential/risk to exhibit psycho-social distress related to the following: 1. Resident served in Vietnam war. 2. Hx [history] of Homelessness.4. Dx [diagnosis] of schizophrenia and hx of stroke [a brain injury related to an event where oxygen to the brain is blocked]. 5. Physical Aggression triggered by paranoia r/t [related to] name calling, staring, being within close proximity with another person. (Res [resident]-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 1] will reduce or decrease episodes of PTSD [Post-traumatic stress disorder, a mental health condition that's caused by an extremely stressful or terrifying event] triggered by altercations.Interventions. Resident to have 1:1 [one staff supervised one resident] staff support as indicated. Resident [Resident 1] will be supported in participating in restorative conversations, as appropriate. -8/21/25, .Goal.Resident [Resident 1] will have no decline in psychosocial well-being.resident [Resident 1] will have no episodes of resident-to-resident altercations.Interventions. continue 1:1 supervision.A review of Resident 6' s medical record titled, admission RECORD, indicated Resident 6 was admitted to the facility with diagnoses including schizophrenia (a chronic mental health condition characterized by a combination of symptoms that significantly impair a person's thoughts, perceptions, and behaviors), muscle weakness, major depression disorder, and anxiety disorder.A review of Resident 6's medical record titled, Interdisciplinary Care Conference - V5, dated 9/19/25, indicated, .On 9/18/25, Resident to resident altercation contributed to witnessed fall.A review of Resident 6's medical record titled, SBAR Communication Form, dated 9/18/2025 at 12:45 PM, indicated, .APPEARANCE . [Resident 1] began making racial slurs to [Resident 6] [Resident 6] then grabbed [Resident 1] by the collar of his shirt and began cursing. [Resident 1] was able to wheel self backwards with the help of his nurses aid. [Resident 6] then fell forward onto his hands and knees.A review of Resident 6's medical record titled, Care Plan Report, indicated the following:-4/24/25, .Goal.Resident will demonstrate a reduction in episodes of aggression/restlessness.Interventions.Monitor and document behaviors .maintain consistent routines to minimize confusion and anxiety.-9/08/25, Goals.resident will have no falls .During a concurrent observation and interview on 9/24/25 at 11:00 AM, Resident 1 was observed in his bed and stated he did not like Resident 6 and Resident 6 made him mad. Resident 1 stated he pushed