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	12/12/2025

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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(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	Based on observation, interview, and record review, the facility failed to develop a care plan to reduce the potential risk of pressure injury for one of three sampled residents (Resident 1) when a low air loss mattress (LAL mattress, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) was not included in Resident 1's care plans. This failure had the potential to place Resident 1 at risk for possible skin complications and not receiving effective and person-centered care. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility originally in 2020 and re-admitted in the Summer of 2025 with multiple diagnoses including encounter for palliative care (a patient-centered care that provider focuses on improving quality of life for serious illnesses, managing symptoms such as pain, anxiety, fatigue, offering emotional/spiritual support, working alongside curative treatments), senile degeneration of brain (an age-related cognitive decline, a progressive loss of brain function due to damaged brain cells), vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels, restricting blood flow and oxygen to the brain), pressure ulcer of sacral region stage 3 (full-thickness skin loss where fat tissue is visible, but bone, tendon or muscle is not exposed yet on the tailbone, requiring urgent care like pressure relief and dressing change to prevent infections), and pressure ulcer of the left buttock stage 3 (a deep thickness skin loss showing visible fat but not bone, muscle, or tendon, requiring urgent care like pressure relief and dressing change to prevent infections).Review of Resident 1's Order Summary Report, indicated an active order for a LAL mattress for prophylactic (preventive) skin management due to a history of pressure injury as per manufacturer guidelines was ordered on 7/8/25.During an observation on 12/11/25, at 9:17 AM, in Resident 1's room, Resident 1 was observed lying on her right side on a LAL mattress.During a concurrent interview and record review on 12/11/25, at 3:25 PM, with License Nurse (LN) 3, Resident 1's order summary report and care plans were reviewed. LN 3 confirmed that Resident 1 had an active physician order for a LAL mattress, which was initiated on 7/8/25 for prophylactic skin management. LN 3 further confirmed that there was no active care plan addressing the use of a LAL mattress documented in Resident 1's care plans. LN 3 stated that a care plan served as a guiding tool and a communication method for nursing staff to follow specific interventions to provide person-centered care and meet Resident 1's medical and physical needs. LN 3 further stated that Resident 1 had a history of pressure injuries and that a LAL mattress was implemented to reduce the risk of recurrence. LN 3 stated that to coordinate care effectively, nurses needed to develop and maintain care plans to ensure appropriate interventions were implemented to meet the residents' needs. LN 3 further stated that the absence of an active care plan for a significant intervention such as a LAL mattress could result in a negative outcome and increased risk for decline in Resident 1's skin condition, as the LAL mattress was intended to prevent or reduce the incidence of pressure injuries for a resident who was immobile and unable to express her needs.During an interview on 12/12/25, at 8:34 AM, LN 2 stated that care plans had an important impact on residents' care and should be individualized to meet each resident's needs. LN 2 further stated that care plans served as a guide for providing care, managing symptoms, and function as a helpful reference and checklist for nursing staff to follow the established plan of care. LN 2 stated that without care plans, nurses would lack clear guidelines to follow, resulting in a lack of continuity of care and no point of reference. LN 2 further stated that all residents' concerns, physician orders, treatments, behaviors, and interventions should be included in the resident's care plan. LN 2 explained that nursing staff needed to routinely review and update care plans to ensure residents' safety and that their needs were appropriately met. During a concurrent interview and record review on 12/12/25, at 1:12 PM, with the Director of Nursing (DON), Resident 1's active care plans, and the facility policy and procedure (P&P) titled, CARE PLAN COMPREHENSIVE, dated 8/25/21 were reviewed. The DON confirmed there was no care plan found that addressed the use of a LAL mattress in Resident 1's current care plans. The DON stated that a care plan for the LAL mattress should have been created and maintained to reflect Resident 1's current plan of care. The DON further stated that care plans served as a method of communication for staff regarding how to provide proper care to the residents, and the absence of a care plan addressing LAL mattress could have negatively affected Resident 1's health condition. The DON explained that her expectation was for nursing staff to develop a person-centered care plan for the LAL mattress and to implement interventions consistent with Resident 1's health condition for as long as there was an active order. The DON confirmed

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to provide adequate care and services to promote healing and prevent pressure ulcers (a localized injury to the skin and/or underlying tissue because of pressure) for two of three sampled residents (Resident 1 and Resident 2), when both residents were observed lying on low-air loss mattresses (LAL mattress, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) that were not correctly adjusted according to Resident 1 and Resident 2's individual weights.These failures had the potential to place Resident 1 and Resident 2 at increased risk for developing pressure ulcers and/or skin breakdown. Findings:a. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility originally in 2020 and re-admitted in the Summer of 2025 with multiple diagnoses including encounter for palliative care (a patient-centered care that provider focuses on improving quality of life for serious illnesses, managing symptoms such as pain, anxiety, fatigue, offering emotional/spiritual support, working alongside curative treatments), senile degeneration of brain (an age-related cognitive decline, a progressive loss of brain function due to damaged brain cells), vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels, restricting blood flow and oxygen to the brain), pressure ulcer of sacral region stage 3 (full-thickness skin loss where fat tissue is visible, but bone, tendon or muscle is not exposed yet on the tailbone, requiring urgent care like pressure relief and dressing change to prevent infections), and pressure ulcer of the left buttock stage 3 (a deep thickness skin loss showing visible fat but not bone, muscle, or tendon, requiring urgent care like pressure relief and dressing change to prevent infections).Review of Resident 1's Order Summary Report, indicated an active order for a LAL mattress for prophylactic (preventive) skin management due to a history of pressure injury as per manufacturer guidelines was ordered on 7/8/25.Review of Resident 1's medical record titled, Weight Summary, dated 12/4/25, indicated, .112.2 LBS [pounds] Hoyer Lift [a mechanical or electric device used to safely lift and transfer individuals with limited mobility between a bed, chair, or other surfaces].During an observation on 12/11/25, at 9:17 AM, in Resident 1's room, Resident 1 was observed lying on her right side on a LAL mattress, which was set at 265 pounds (lbs, a unit for measuring weight). During a concurrent observation, interview, and record review on 12/11/25, at 9:40 AM, with Licensed Nurse (LN) 1, in Resident 1's room, LN 1 confirmed Resident 1 was lying on a LAL mattress set at 265 LBS. LN 1 stated that Resident 1 had a healed pressure ulcer to the coccyx (tailbone) area and was placed on a LAL mattress for prophylactic skin management due to a history of pressure injuries. Review of Resident 1's electronic health record (EHR), Resident 1's most recent weight, dated 12/4/25, showed the resident weighed 112.2 LBS, indicating the LAL mattress was not set according to the resident's current weight. LN 1 stated that it was the nurses' responsibility to ensure the LAL mattress setting was adjusted according to Resident 1's current weight. LN 1 further stated that an incorrect setting posed a potential risk for Resident 1's healed pressure ulcers to reopen. LN 1 explained that the purpose of the LAL mattress was to provide preventative care, and that failure to set it correctly could lead to skin deterioration and a prolonged healing process.During an interview on 12/11/25, at 11:36 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated he was waiting for another staff member to assist with transferring Resident 1 from the bed to a wheelchair using a Hoyer lift in order to take the resident to the activity room to join other residents. CNA 1 further stated Resident 1 was totally dependent on nursing staff for activities of daily living (ADLs, essential self-care tasks like bathing, dressing, eating, using the toilet, and walking) and mobility.During a concurrent interview and record review on 12/11/25, at 11:42 AM, with the Treatment (TX) nurse, the TX nurse stated when redness was noted over bony prominences to the coccyx and buttocks, a LAL mattress would be placed for preventive skin care. The TX nurse further stated that the nurse would contact the physician to obtain an order, after which maintenance staff would place the mattress on the bed frame. The TX nurse stated that nursing staff were responsible for adjusting the LAL mattress pressure to the resident's current weight. The TX nurse further stated that if the LAL mattress was not set correctly, proper airflow would not be achieved, increasing the risk for pressure injuries and/or delaying the wound-healing process. The TX nurse explained that nurses needed to verify the resident's weight to ensure accuracy prior to adjusting the air pressure. The TX nurse stated that nurses needed to readjust the setting whenever there was a change in the resident's weight and the setting must be checked daily to ensure the setup was correct and functioning properly.b. Review of Resident 2's admission RECORD, indicated