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	01/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure adequate storage and labeling of medications and biologicals (complex medicines made from living organisms that treat diseases by targeting specific part of the immune system) for a census of 115 residents when the treatment cart was left opened and unattended with residents' identifiable medications and biologicals.This failure had the potential for misuse of prescribed medications, risk for harm or injury to residents due to unsafe med storage practices. Findings:During an observation on 1/16/26, at 1:30 p.m., at the middle nursing station, near rooms 15A to 24B, the treatment cart was left opened and there were multiple residents observed pacing up and down the hallway floor. During an observation on 1/16/26, at 1:44 p.m., with Licensed Nurse (LN) 1, LN 1 walked down the hallway and locked the treatment cart.During a concurrent observation and an interview on 1/16/26, at 1:46 p.m., with LN 1, LN 1 confirmed, the treatment cart was left opened and it had prescription creams, Betadine (a widely used antiseptic and disinfectant that kills germs, preventing infection in minor cuts, also use for skin prep before surgery), gauze, bandages, and a nail clipper stored in it. LN 1 stated he could not recall who left the treatment cart open. LN 1 further stated staff should always close the treatment cart before and after each use. LN 1 explained the treatment cart contained residents' medical information on the creams, ointments, other medications and it would be dangerous if residents had access to those medications and creams. LN 1 further explained it posed a risk of reactions to chemicals and medications and violations of the resident's privacy.During an interview on 1/16/26, at 2:38 p.m., with the Director of Nursing (DON), the DON stated the medication carts and treatment carts should be always locked because there were sterile solutions, medications with residents' identity in them. The DON further stated risk for leaving the treatment cart opened was injury to residents, and that residents would be able to grab anything from the treatment cart.A review of facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/23, indicated, .Policy heading.the facility stores all medications and biologics in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.Medication Storage.2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of and refuse their garbage for a census of 115 residents when:1. Garbage area was not maintained in a sanitary condition; there was a trash bag filled with residents' personal trash (used diapers and other trash) left on the ground outside of the garbage dumpster container,2. There were used Personal Protective Equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses such as gloves and masks) left scattered on the ground in the garbage area outside of the dumpster; and,3. Dumpsters were not covered, and left open with overfilled trash bags.This failure had the potential to harbor feeding of pests, and spread infection amongst residents, threatening their health and well-being.Findings:1. During an observation on 1/16/26, at 9:41 a.m., outside of the facility near the parking area, at the dumpster containers area, there was scattered trash noted (couple of used masks and gloves, baby/sanitary wipes) left on the ground. There was also a trash bag filled with residents' personal trash (used diapers with brown substance) in them. The dumpster containers were left open and trash bags were piled up to the top of the dumpster containers. During an interview on 1/16/26, at 11:21 a.m., with the Infection Preventionist (IP), the IP stated nursing staff were expected to take the trash out in a designated trash barrel. The IP further stated the best practice was that Certified Nursing Assistants (CNAs) and/or housekeepers would take the filled barrels to the dumpster, and dispose the trash into the dumpster when the barrels were full or at the end of their shift on every shift. The IP stated that staff should follow this practice to minimize the risk of spills, contain trash, and to prevent cross contamination and spread of germs and bacteria. The IP further stated if every staff member was taking out one trash bag at a time on multiple occasions throughout their shift, that this practice could pose a risk for spills, as there could be holes in the trash bags, or the risk that the trash bag was not double bagged. The IP further stated it was also not efficient for staff to take the trash out individually (single bag at a time). The IP stated this was not an expected practice to handle or dispose of a resident's trash, and for trash to be scattered on the ground in the dumpster area. The IP further stated trash should be contained in the trash bag, placed inside the dumpster container and the dumpster lid should be closed at all times.2. During a concurrent observation and an interview on 1/16/26, at 12:11 p.m., with the IP near the conference room window facing the facility's dumpster area, the IP confirmed there was a trash bag filled with residents' trash still lying on the ground next to the two open dumpster containers. The IP further confirmed the trash scattered on the ground near the dumpster area were PPEs and other trash from the residents' personal trash. The IP further confirmed the briefs (adult diapers) appeared to have stool in them and that they were residents' personal trash. The IP stated Maintenance was responsible for checking the front of the facility, but she was not sure whether they were also responsible for the back dumpster area, which was the facility's main trash area.During an interview on 1/16/26, at 2:35 p.m., with Dietary Staff (DS) 1, DS 1 stated dietary staff emptied trash in the dumpster outside the double doors of the kitchen. DS 1 further stated dietary had their own trash bins for recycling and trash and when they were filled, staff would empty them into the main dumpster. DS 1 stated the bins were placed outside the kitchen door and not inside the kitchen.3. During a concurrent observation and interview on 1/16/26, at 3 p.m., with the Dietary Services Manager (DSM), near the conference room window facing the facility's dumpster area, the DSM confirmed there were couple of masks and gloves on the ground by the dumpster. The DSM stated nursing, housekeeping, central supply, and all departments used the dumpsters and should always close the dumpster lids to prevent the spread of infection, as bacteria would grow faster when it was open to air. The DSM further stated by not containing the trash and (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	leaving the dumpsters open, the facility was inviting many insects to come through the door into the food or food area, as the double doors to the kitchen were right next to dumpster area. During an interview on 1/26/26, at 3:06 p.m., with the Maintenance Director (MS), the MS acknowledged he saw the trash (gloves and masks) laid on the ground by the dumpster containers and the dumpster containers were left open. The MS stated this was not the correct practice for infection control purposes. The MS further stated the facility's goal was to prevent any kind of spread of infection, such as on windy days, if the dumpster was left open, it would scatter the trash all over the ground. The MS stated as per the city regulations, the facility was to keep the dumpsters always closed.A review of facility's policy and procedure (P&P) titled, Food Related Garbage and Refuse Disposal, dated 2017, indicated, .Policy statement. food-related garbage and refuse are disposed of in accordance with current state laws. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests.7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding liter.A review of facility's P&P titled, Infection Prevention and Control Program, dated 9/18/24, .Purpose.An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of contaminated disease and infections.Policy.1. The infection prevention and control program is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary.3. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program.