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	02/11/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADL) were provided to maintain good hand and fingernail hygiene for two of four sampled residents (Resident 2 and Resident 4) when on 2/11/26:1. Resident 2 had long fingernails with a brown substance embedded under them; and2. Resident 4 had dirty hands and fingernails with long sharp edges and contained a dark brown substance embedded under them. In addition, Resident 4 was not assisted, asked, or educated on why it was important to perform hand hygiene before eating his lunch meal.These failures had the potential for Resident 2 and Resident 4 to cut their own skin, or the skin of others, which could lead to infection from harboring microorganisms (bacteria, viruses, or fungus) due to poor hand and fingernail hygiene.Findings:1. A review of Resident 2's Minimum Data Set (MDS -an assessment and care screening tool) dated 1/26/26, indicated, Resident 2 was independent and able to make reasonable decisions for daily decision making. Further review of Resident 2's MDS, indicated Resident 2 needed substantial/maximal assistance (helper does more than half of the effort) with personal hygiene and mobility (movement of the body). The MDS also indicated Resident 2 was totally dependent (help does all the effort) on staff for bathing/showering. During a concurrent observation and interview on 2/11/26 at 8:05 AM, in Resident 2's room, Resident 2 was observed lying in bed. Resident 2's fingernails were observed to be approximately one-quarter inch long with a brown substance accumulated under them. Resident 2 stated he did not like his nails that long and confirmed he had dirt embedded under his nails. Resident 2 stated that he had asked staff to cut his nails for a few weeks, but they had not done it. Resident 2 stated he felt gross eating with dirty fingernails. During a concurrent observation and interview on 2/11/26 at 12:49 PM, in Resident 2's room, Certified Nursing Assistant (CNA) 2 was observed brining Resident 2 his lunch tray. Resident 2 asked for his nails to be cut. CNA 2 confirmed his nails were very long and dirty with a brownish substance under them. CNA 2 stated that CNA's were not allowed to cut residents fingernails. CNA 2 stated the nails could be brushed clean during bathing but that they were not allowed to trim the nails. A review of Resident 2's, Care Plan (a documented and personalized roadmap outlining a resident's health conditions, specific care needs, goals, and interventions) with the focus of Resident 2's skin inflammation, revised 2/4/26, indicated, .Secondary Dermatitis [inflammation of the skin] on Bilateral [both] Legs and Back.[Resident 2's] skin will remain intact, clean and dry with reduction of skin irritation.Educate [Resident 2] and caregivers to avoid scratching. 2. A review of Resident 4's MDS dated [DATE], indicated Resident 4 scored 15 out of 15 a in Brief Interview for Mental Status (BIMS) which indicated Resident 4 was cognitively intact (normal thought process). In addition, a review of Resident 4's MDS dated [DATE], indicated that Resident 4 needed substantial/maximal assistance with showering/bathing and supervision/touching assistance (helper provides verbal cues and/or touching/steadying) during personal hygiene. During a concurrent observation and interview on 2/11/26 at 10:07 AM, in Resident 4's room, Resident (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4 was observed with visible brown colored dirt stuck in the crease of his palms of his hands and on the back of his hands. In addition, Resident 4 was observed with long, dirty fingernails all past the tips of his fingers Resident 4's fingernails had a brown and black colored substance caked under his nails. Resident 4 stated he told his CNA's that he wanted his fingernails trimmed but the staff told him they were not allowed to cut his nails. Resident 4 stated his hands and nails were dirty because he could not get staff to help him with them. Resident 4 could not recall the name of the CNA he asked for help. During a concurrent observation and interview on 2/11/26 at 12:44 PM, with CNA 2, CNA 2 was observed assisting Resident 2 set up his lunch tray. CNA 2 confirmed Resident 4's hands were dirty and that Resident 4 had long nails with dirt caked under them. CNA 2 did not offer to assist Resident 4 to clean his hands before his lunch meal. CNA 2 did not offer to assist Resident 4 with nail trim. CNA 2 stated she had previously encouraged Resident 4 to clean his hands prior to eating meals and added that he often refused, so she did not ask. CNA 2 stated the facility procedure was to encourage the residents and assist the residents with hand hygiene before meals, and if they refused care they were supposed to get the nurse involved to assist with cooperation. CNA 2 explained after they get the nurse involved they are supposed to document in the resident's medical record (a detailed, chronological history of a person's health, illnesses, and treatments done by healthcare providers) that the resident refused care. During an interview on 2/11/26 at 1 PM with Licensed Nurse (LN) 1, LN 1 stated the CNAs were supposed to help residents who needed assistance with washing their hands before meals were provided. LN 1 further stated that nail care was supposed to be given to all the residents every Sunday. LN 1 explained that any CNA or LN could provide the service to the residents. LN 1 further explained that any resident with long nails especially if they were dirty, that wanted them trimmed was expected to be done on Sundays. LN 1 stated that long and dirty fingernails could put the residents at risk of cutting themselves further by putting them at risk for infection. LN 1 added that dirty hands and fingernails were bad hygiene in general. A review of Resident 4's medical record revealed an order dated 5/12/24, which indicated, .May cut nails.one time a day every 4 [four] weeks on Sun [Sunday]. A review of Resident 4's Care Plan with the focus of Resident 4 being at risk for skin issues, revised 11/3/25, indicated, .Goal.[Resident 4] will participate in partial washes on shower days if refusing.[Resident 4] will improve hygiene status.Interventions.assess and document reasons for refusal. A review of Resident 4's Care Plan with the focus of Resident 4's risk for self-care deficit/decline, revised 10/11/25, indicated, .[Resident 4] will be able to safely perform (to maximum ability) self-care activities.Assure that all tasks are done up to facility standards.Encourage independence, but intervene when patient cannot perform. During a concurrent observation and interview on 2/11/26 at 3:49 PM with the Director of Nursing (DON) the fingernails of Resident 2 and Resident 4 were observed. The DON confirmed that both Resident 2 and Resident 4 should have had their nails trimmed either weekly on Sunday or as needed. The DON stated they appeared to not have had their nails trimmed for several weeks or months and confirmed they had brownish black substance under the fingernails. The DON further stated the long, dirty nails did not meet her expectation for hygiene. The DON stated her expectation was that if a resident was a diabetic (a chronic [long-term] condition that affects how the body turns food into energy) she expected the nurse to trim the nails. The DON further stated that the CNA's or LN's do not need an order to trim fingernails unless the doctor specifies, and that it was included in basic hygiene. The DON explained it was her expectation that all residents hands be cleaned prior to eating a meal. The DON further explained it was her expectation if a resident was unable to do to on their own that the staff assisted them with hand hygiene. The DON added residents could use hand sanitizer, or warm soapy water in a bin, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to rinse and cleanse hands, prior to eating. The DON stated it was important to prevent germs and infection, so the residents did not get sick. The DON further stated if residents refused hand hygiene or a nail trim, she expected her staff to educate the residents on why it was important and to document the refusals and education given in the residents medical record each time. During a concurrent record review and interview on 2/11/26 at 4 PM with the DON, Resident 4's medical records were reviewed. The DON reviewed Resident 4's medical record and confirmed that Resident 4 was not diabetic and could have a fingernail trim and does not need an order. The DON further reviewed Resident 4's medical record stated that she only saw two refusals of bathing documented, one on 1/15/26 and one on 1/22/26. The DON confirmed there were no other documented refusals, or progress notes indicating that Resident 4 had refused hand hygiene, bathing, or nail care. During an interview on 2/11/26 at 4:14 PM with the Administrator (ADM), the ADM stated nail care was important to prevent infections and because it was sanitary. The ADM further it was important to keep nails clean, short, and trimmed to prevent injury to the residents in case they scratched themselves and caused a wound. A review of a facility policy and procedure (P&P) titled, Activities of Daily Living (ADLs), revised 3/18, the P&P indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with: a. Hygiene.Dining.If a resident resists or refuses care, staff will attempt to identify the underlying cause.consider approaching the resident in a different way.or having another staff member speak with the resident. A review of an undated facility P&P titled, Nail Care, the P&P indicated, .POLICY: To provide residents safe, hygienic, and thorough nail care assistance. Direct care staff will consult with an RN [registered nurse] if for any special directions as they may apply to a diabetic resident.document any nail care provided.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide foot care for one of four sampled residents (Resident 4) when Resident 4 had long, overgrown, and discolored toenails with sharp edges on his left foot, and staff did not follow their facility process and doctors order (a specific actionable instruction given by a healthcare provider for a patients treatment or care) to provide nail care.This failure resulted in Resident 4 not being able to wear a sock or shoe on his left foot due to the pain the long toenails caused. This failure had the potential to affect Resident 4's foot health.Findings:A review of Resident 4's admission record indicated Resident 4 was admitted to the facility with diagnoses that included but not limited to, hemiplegia and hemiparesis affecting the left non-dominant side (weakness or total loss of movement on one side of the body) and peripheral vascular disease (a slow progressive circulation disorder involving the narrowing, blockage, or spasms in the blood vessels, mostly commonly affecting the legs).A review of Resident 4's MDS (Minimum Data Set; an assessment tool), dated 12/10/25, indicated Resident 4 scored 15 out of 15 a in Brief Interview for Mental Status (BIMS) which indicated Resident 4 was cognitively intact (normal thought process). A review of Resident 4's MDS dated [DATE], indicated that Resident 4 needed substantial/maximal assistance with showering/bathing and supervision/touching assistance (helper provides verbal cues and/or touching/steadying) during personal hygiene.During a concurrent observation and interview on 2/11/26 at 10:07 AM, in Resident 4's room, Resident 4 was observed to have a sock and shoe on his right foot, but his left foot was bare. Resident 4 was observed with the toenails on his left foot very long and with sharp edges, the length of the toenails extended past the end of his toes. The left toenails were observed discolored with yellow and dark brown colors. Resident 4 stated he had asked staff to have his toenails trimmed multiple times. Resident 4 further stated he could not wear a sock or shoe on his left foot because the toenails were too long and it hurt when he tried. Resident 4 explained he was told by his Certified Nursing Assistants (CNA) and Licensed Nurses (LN) that they could not cut his toenails and that they would have to charge him $50 [fifty dollars] for the service.During a concurrent observation and interview on 2/11/26 at 12:44 PM, CNA 2 confirmed Resident 4 had long, sharp, and discolored toenails on his left foot, and the toenails had not been trimmed for a long time. CNA 2 further stated Resident 4 often refused to let staff cut his nails. CNA 2 explained that when a Resident 4 refused hygiene care they were supposed to let the LN know so they could encourage the resident to cooperate, and then the LN could explain the risks to the resident for refusing nail care. CNA 2 added that only LN could trim toenails, CNA's just report to LN when they need attention, like in Resident 4's case.During an interview on 2/11/26 at 1 PM, LN 1 stated that Podiatry services (specialized medical or surgical care for feet) visited monthly and saw residents that needed toenail care or other foot services. LN 1 further stated Podiatry saw diabetic residents, those with complications to the feet, legs, and residents who requested it. LN 1 stated the Podiatry list was established by LN recommendations from their assessment. LN 1 further stated CNAs would check for skin, foot, and nail concerns during bathing and could also add residents to the podiatry list. LN 1 added that LN's could trim residents toenails with a doctors order. LN 1 explained the Social Services Department maintained the Podiatry list, and all residents could be added. LN 1 further explained that any refusal of services like toenail cutting must be documented in a progress note (a part of a patient's record, documenting their health status, treatment response, and changes during care to track progress, ensure accountability, and facilitate communication among healthcare providers) and the doctor should be notified if the service was ordered and the resident refused care.During an interview on 2/12/26 at 11:16 AM, with the Social Services Director (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(SSD), the SSD stated she reviewed her records and could not find where Resident 4 had been previously seen and was not on the current list to be seen by Podiatry. The SSD further stated any resident could be added by a LN or during angel rounds by staff that noticed the need for Podiatry services.During a concurrent interview and record review on 2/11/26 at 3:49 PM, the Director of Nursing (DON) reviewed Resident 4's medical record (a detailed, chronological history of a person's health, illnesses, and treatments done by healthcare providers) and confirmed that she could not find any progress notes or other documentation where Resident 4 had refused toenail care. The DON confirmed there was a doctor's order dated 5/12/24 for nail care to be done every four weeks on Sundays. The DON confirmed Resident 4's toenails were long, dirty, and had not been trimmed for several months. The DON confirmed that there was a Podiatry list established that was managed by the Social Service Department. The DON further stated with a doctor order Resident 4 did not need Podiatry service to trim his nails, however, if the nurse did not feel comfortable doing it, they were supposed to document a progress note and add him to the list to be seen by Podiatry. The DON stated the status of Resident 4's toenails did not meet her expectation for hygiene and could cause complications like infection (invasion and multiplication of microorganisms such as bacteria, viruses, or fungus, in body tissues that are not normally present) or injury to Resident 4.A review of Resident 4's medical record revealed an order dated 5/12/24, which indicated, .May cut nails.one time a day every 4 [four] weeks on Sun [Sunday].A review of a facility policy and procedure (P&P) titled, Activities of Daily Living (ADLs), revised 3/18, the P&P indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good.grooming and personal and oral hygiene.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with: a. Hygiene.if a resident resists or refuses care, staff will attempt to identify the underlying cause.consider approaching the resident in a different way.or having another staff member speak with the resident.A review of an undated facility P&P titled Nail Care, the P&P indicated, .POLICY: To provide residents safe, hygienic, and thorough nail care assistance. Direct care staff will consult with an RN if for any special directions as they may apply to a diabetic resident.Document any nail care provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when on 2/11/26 an inspection of the facility, the kitchen, and the food storage areas were not maintained per recommendations from the facility's pest control service for a census of 114.This failure had the potential to spread infection and disease. In addition, this failure increased the risk of unsafe and unsanitary living conditions for the residents, staff, and visitors.Findings:During a review of the pest control documents provided by the facility, dated 2/6/26, the following issues were identified in the kitchen and food storage/pantry areas in October 2025 that were still not addressed during the last inspection by the pest control company on 2/6/26: . Condition: Food debris on shelf. Date created 10/3/2025, Last inspected 02/06/2026.Recommendation: Clean and sanitize shelving to prevent pests and contamination.Condition: Food particles and debris under ovens, fryers [and] coolers provide food for rodents, ants and cockroaches. Date Created 10/03/2025, Last Inspection 02/06/2026.Recommendation: Sanitize under ovens/fryers.Condition: Food particles and debris under tables provide food for rodents, ants and cockroaches. Date created 10/03/2025, Last Inspection 02/06/2026.Recommendation: Food and debris under tables/chairs needs to be removed.Condition: Grease deposits on floor. Date Created 10/03/2025, Last Inspection 02/06/2026.Recommendation: Sanitize floor and/or apply biologicals to remove grease and organics.Condition: Grease deposits on floors provide food for cockroaches and can cause slips/falls. Date Created 10/03/2025, Last Inspection 02/06/2026. Recommendation: Remove grease deposits on the floor or treat with enzymes.Condition: Wet organic matter accumulated in cracks at floor level breed fruit and phorid flies. Date created 10/17/2025, Last Inspection 02/06/2026. Recommendation: Remove wet organic matter from seams and cracks on floor.Condition: Wet organic matter on floor. Date created 10/17/25, Last Inspection 02/06/2026. Recommendation: Sanitize floor and/or apply biologicals to remove grease and organics.Additional review of the pest control service document related to the kitchen and food storage areas, dated 2/6/26, indicated, .Inspected and previous conditions still exist.Please address documented contributing conditions to support your pest management program.During an inspection of the facility's kitchen and food storage area on 2/11/26 at 8:22 AM with the Assistant Kitchen Manager (AKM) the following conditions were observed:-Tan colored food splatter and white colored powder on the wall, baseboard, and floor behind and to the side of the stove. A buildup of grease and brown and black food stains and brown food particles, as well as dust accumulated under the ovens. A white rectangular shaped sticky mouse and bug trap (a simple pest control tool designed to immobilize small pests using a strong glue surface) with black and brown dead unidentified bugs inside, behind the oven.-Moderate number of cobwebs with dead flies, dust, dirt and food particles accumulated on the pipes that led to and were behind the ice machine. Two sticky mouse and bug traps observed with several dead black and brown roach type bugs in them, also had accumulated dirt and dust on top of the devices, found behind the ice machine. [NAME] circular discolorations and particles observed in cracks in the floor under and behind the ice machine.-Large amount of food particles, crumbs, food splatter and grease build up found on the floor under the steam table.-A food preparation table with a shelf approximately 6 inches from the ground had stored clean pots and pans were found to have a tan food splattered particles on it. The food preparation table had several spots of black grease built up under it.-The steam table (a kitchen appliance used to keep pre-cooked food warm and safe during food service commonly used in cafeterias) in the middle of the kitchen was found to have food particles under it and grease built up under and in the cracks of the kitchen flooring near it.-Kitchen refrigerators were found with dust, food particles, black and brown grease and grime under them.-The food storage/pantry floor was (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dirty with crumbs of food and dust on the walking areas and areas under the food storage units.-The food storage/pantry floor had black and red tape with food particles stuck to and embedded in it.-The food pantry/floor had a mandarin type of orange on the floor under the storage rack and packaged crackers were found on the floor under the food storage units.During an interview on 2/11/26 at 8:32 AM, the AKM stated the expectation was that the kitchen and food storage areas were clean which included the baseboards, walls, and floors. The AKM further stated the cleaning included sweeping and mopping around, behind, and under appliances like the ovens, refrigerators, steam table, preparation tables, ice machines, and storage floors. The AKM explained it was important to make sure everything was cleaned and off the ground.During a concurrent interview and record review on 2/11/26 at 11:12 AM, with the Maintenance Director (MTD), the pest control service dated 1/23/26 and 2/6/26 were reviewed. The MTD confirmed the records indicated that the kitchen and food storage recommendations had not been addressed since the recommendations made in October 2025. The MTD explained that the facility had weekly inspections done by the pest control service since September 2024. The MTD stated he oversaw the outside perimeter and the resident hallways, rooms, bathrooms, and office areas and that the Certified Dietary Manager (CDM) oversaw the kitchen and pantry food storage areas related to pest control recommendations.During a concurrent interview and record review on 2/11/26 at 3:25 PM, with the Certified Dietary Manager (CDM), the results of the pest control service dated 2/6/26 were reviewed. The CDM stated she was not aware of the pest control recommendations. The findings of the kitchen inspection were reviewed with the CDM and the CDM stated the status of the kitchen and food storage areas did not meet her expectations for a clean and sanitary kitchen. The CDM explained that all kitchen staff were expected to clean the kitchen including sweeping, mopping, and cleaning behind and under the appliances. The cleaning schedule for January 2026, and a more extensive weekly cleaning schedule for January 2026 were reviewed with the CDM. The CDM stated each day the morning and afternoon cooks were expected to clean and sanitize all appliances in the kitchen and initial when completed. The CDM further stated the weekly cleaning schedule included a deeper cleaning schedule and was assigned to various kitchen staff, the schedule was also initialed by kitchen staff per the CDM. The CDM explained the weekly cleaning was to include sweeping, mopping, and scouring the appliances, the walls, baseboards, floors and included under and behind the appliances. The CDM further explained the expectation was for all crumbs, dirt, grease, grime, and food particles was to be removed from the kitchen and food storage areas. The CDM stated the risk of an unsanitary kitchen and food storage area was that it could attract bugs and rodents, and residents could become sick. The CDM further stated sanitation in the kitchen was important for overall cleanliness of the kitchen and pantry and to keep pests out.During an interview on 2/11/26 at 4:14 PM with the Administrator (ADM), the Administrator confirmed that the pest control service was contracted to come weekly. The ADM further stated that each week a copy of the report from the pest control service with their recommendations was given to the MTD, CDM, and housekeeping manager. The ADM stated she expected the kitchen and food storage areas to be clean of debris and sanitary.A review of the facility policy and procedure titled Environment, revised 6/25, indicated, .All food preparation areas food service areas.will be maintained in a clean and sanitary condition.The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls.The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.According to the 2022 Federal Food Code, section 4-202.11 Food-Contact Surfaces indicated, .(A) Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. and section 6-101.11 Surface (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Characteristics indicated, .(A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) SMOOTH, durable, and EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted.According to the 2022 Federal Food Code, section 4-202.16, indicated, .Nonfood-Contact Surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms. Well-designed equipment enhances the ability to keep nonfood-contact surfaces clean.According to the 2022 Federal Food Code, section 6-501.111, indicated . Controlling Pests .The premises shall be maintained free of insects, rodents, and other pests .by .routinely inspecting the premises for evidence of pests.Eliminating harborage conditions. (https://www.fda.gov/food/fda-food-code/food-code-2022)