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	02/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide needed care and treatment to three out of six sampled residents (Resident 1, Resident 2, and Resident 3) when:1. Resident 1's clinical record did not indicate ADL (activities of daily living-essential self-care tasks such as bathing, dressing, eating) care was provided 12 out of 19 days during the day shift, 1 out of 19 days during the evening shift, and 5 out of 19 days during the night shift for a period from 2/1/26 through 2/19/26;2a. Resident 2's clinical record did not indicate treatment to a stage 3 pressure ulcer (a serious, full-thickness skin injury extending through the dermis into the subcutaneous fat layer) to coccyx (tailbone) was provided 3 out of 19 days from 2/1/26 through 2/19/26; and,2b. Resident 3's clinical record did not indicate treatment was provided to a stage 4 pressure ulcer (most severe level of skin damage, characterized by full-thickness tissue loss exposing underlying muscle, tendon, ligament, or bone) to left shoulder and left hip, and an unstageable (a severe full-thickness wound where the base is completely covered by dead tissue, making it impossible to determine the true depth or stage, these wounds are generally Stage 3 or 4) pressure ulcer to left trochanter (the bony point on the outside of the thigh) on 2/15/26.These failures had the potential for Resident 1 not to receive required care on a daily basis and potential for increased risk for infection and delayed healing for Resident 2 and Resident 3's pressure ulcers. Findings:1.During a review of Resident 1's clinical record titled, admission RECORD, dated 2/19/26, the record indicated Resident 1 was admitted to the facility with diagnoses including palliative care (specialized medical care for people living with a serious illness), senile degeneration of the brain (progressive, age-related cognitive decline), and vascular dementia (form of dementia caused by reduced blood flow to the brain). During a review of Resident 1's clinical record titled, MDS, (Minimum Data Set-an assessment tool) dated 12/18/25, under Section C-Cognitive Patterns, the MDS indicated, Resident 1 had .severely impaired cognitive skills for daily decision making . During a review of Resident 1's clinical record titled, Care Plan Report, (a form where you can summarize a person's health conditions, specific care needs, and current treatments) revised date 1/10/23, the report indicated, .Resident has PHYSICAL FUNCTIONING DEFICIT .requires physical staff assistance in ADLs .During a phone interview on 2/18/26, at 1:28 p.m. with the Complainant, the Complainant indicated the facility staff do not provide care to Resident 1. An unannounced visit to the facility was conducted on 2/19/26 to investigate the Complainant's concern. During an observation on 2/19/26 at 10:40 a.m. in Resident 1's room, Resident 1 was in bed, lying on her right side, wearing a blue hospital gown, covered with a blanket, and a pull sheet underneath the blanket. During an observation on 2/19/26 at 3:35 p.m. in Resident 1's room, Resident 1 was in bed, lying on her right side, wearing a blue hospital gown, covered with a blanket, and a pull sheet underneath the blanket. During a review of Resident 1's ADL care plan under the column titled, Interventions, (any action a nurse performs to help patients reach expected outcomes) revised date 9/2/24, the care plan listed the interventions as follows, .Provide assistance in ADL but (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
	055201	A. Building B. Wing	02/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	encourage to perform at her highest and safest functional level, intervene as she is unable to complete task .Provide gentle range of motion as tolerated with daily care .Provide staff assistance and support to initiate, sequence and complete ADL .Provide supportive care, assistance with mobility .Document assistance .During an interview on 2/20/26 at 2:04 p.m. with the Director of Staff Development (DSD), the DSD stated she provided in-services (training) to Certified Nurse Assistants (CNAs) on ADL care, stated she gave competency skills on nail and hair care, oral care, and showers. The DSD stated CNAs demonstrated proper care and watched care performed to make sure ADL care was properly done. The DSD stated she also provided in-services on proper documentation of ADLs to reflect that care was performed and provided to residents.During a review of Resident 1's clinical record titled, Documentation Survey Report, dated 2/26, the report indicated the interventions/tasks CNAs should have performed and provided to Resident 1 was to ensure her ADL needs were meet. This report also listed the days and shifts ADL care did not have documented evidence to reflect these interventions/tasks were performed and provided. The interventions/tasks were listed including the following: .Turn and Reposition per resident comfort .BED MOBILITY: Roll left and right .Passive Range of Motion-Bilateral Upper Extremities [the movement of a joint through its available range by an external force-such as a therapist, caregiver, or machine-without effort from the patient's own muscles] .Mouth Care-cleaning of teeth/dentures/mouth.PERSONAL HYGIENE.The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.PERSONAL HYGIENE: Toileting.This report revealed there was no documented evidence that these ADL interventions/tasks were provided during the day shift on 2/1/26, 2/2/26, 2/3/26, 2/6/26, 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/14/26, and 2/15/26. This report also revealed there was no documented evidence that these interventions/tasks were provided during the evening shift on 2/4/26 and during the night shift on 2/2/26, 2/3/26, 2/6/26, 2/8/26, and 2/9/26.During a concurrent interview and record review on 2/20/26 at 3:12 p.m. with the DSD, Resident 1's Documentation Survey Report from 2/1/26 through 2/19/26 was reviewed. The DSD confirmed the interventions/tasks listed on the report did not have documentation that indicated Resident 1 received the necessary care during the day shift on 2/1/26, 2/2/26, 2/3/26, 2/6/26, 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/14/26, 2/15/26, during the evening shift on 2/4/26, and during the night shift on 2/2/26, 2/3/26, 2/6/26, 2/8/26, and 2/9/26. The DSD stated if it was not charted it was not done and expected the ADL care should have been recorded when provided. The DSD also stated the risk for skin breakdown of any type could increase if ADL care was not provided daily.During review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, 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, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); Mobility.Elimination (toileting).2a. During a review of Resident 2's clinical record titled, admission RECORD, dated 2/20/26, the record indicated Resident 2 was admitted to the facility with diagnoses including pressure ulcer of sacral (refers to the sacrum, which is a triangular bone at the base of the spine) region, stage 3.During a review of Resident 2's clinical record titled, MDS, dated 12/20/25, under Section C-Cognitive Patterns, the MDS indicated, Resident 2 had a BIMS (Brief Interview for Mental Status) score of 9 out of 15 suggesting a moderate cognitive impairment.During a review of a complaint report the Department received on 2/9/26, the report indicated, .This place is.unsafe. An unannounced visit to the facility was conducted on (continued on next page)

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	02/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/19/25 to investigate the anonymous Complainant's concern.During an interview on 2/20/26 at 9:22 a.m. with Licensed Nurse (LN) 1, LN 1 stated residents were not safe because certain skin treatments such as pressure ulcers were not consistently provided. LN 1 also stated pressure ulcers would get worse if treatments were missed.During an interview on 2/20/26 at 2:18 p.m. with LN 2, LN 2 explained the facility had one treatment nurse who usually worked during the week and provided treatment care during those days. LN 2 also explained that in the absence of the treatment nurse such as the weekends or certain days during the week, the charge nurse assigned on each unit was responsible to provide treatment care for the residents with pressure ulcers who were on their respective units. LN 2 stated she observed that the date on some of the dressings applied to residents' pressure ulcer did not indicate the treatment was done.During a concurrent observation and interview on 2/20/26 at 2:55 p.m. with LN 2 in Resident 2's room, Resident 2's stage 3 pressure ulcer to the coccyx did not have a dressing applied. LN 2 stated Resident 2's pressure ulcer should have a dressing with the appropriate treatment applied to her coccyx according to the treatment order.During a review of Resident 2's clinical record titled, TREATMENT ADMINISTRATION RECORD (TAR-a document used in long-term care to track scheduled treatments), dated from 2/1/26 through 2/28/26, the record indicated, .TX [treatment]: STG [stage] 3, P/U [pressure ulcer] coccyx, cleanse with normal saline, dry, apply medihoney [medical-grade honey intended for wound care] gel, and cover with a dry dressing 3x [3 times] a week and as needed until resolved one time a day every Mon, Wed, Fri -Start Date 01/28/2026 -0900 -D/C [discontinued] Date-02/10/2026 1344 [1:44 p.m.] .Start Date-02/11/2026 0900 [9:00 a.m.] .During a concurrent interview and clinical record review on 2/20/26 at 3:33 p.m. with the Director of Nursing (DON), Resident 2's TAR, dated 2/26 was reviewed. The TAR indicated there were no LN initials on Friday, 2/6/26; Monday, 2/9/26 and Wednesday, 2/11/26 to demonstrate the treatment to Resident 2's stage 3 pressure ulcer was performed. The DON confirmed the LN's initials were missing on those days and she stated if it was not recorded the treatment was not done. The DON also stated the risk of poor outcome with the potential for delayed healing and infections could affect Resident 2's well-being. 2b. During a review of Resident 3's clinical record titled, admission RECORD, dated 2/20/26, the record indicated Resident 3 was admitted to the facility with diagnoses including pressure ulcer to left hip, stage 4 pressure ulcer of other site, stage 4, and pressure ulcer of left hip, unstageable.During a review of Resident 3's clinical record titled, MDS, dated 1/27/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 3 had a BIMS score of 4 out of 15 suggesting a severe cognitive impairment.During a review of a complaint report the Department received on 2/9/26, the report indicated, .This place is.unsafe. An unannounced visit to the facility was conducted on 2/19/25 to investigate the anonymous Complainant's concern.During an interview on 2/20/26 at 9:22 a.m. with LN 1, LN 1 stated residents were not safe because certain skin treatments such as pressure ulcers were not consistently provided. LN 1 also stated pressure ulcers would get worse if treatments were missed.During an interview on 2/20/26 at 2:18 p.m. with LN 2, LN 2 explained facility had one treatment nurse who usually worked during the week and provided treatment care during those days. LN 2 also explained that in the absence of the treatment nurse such as the weekends or certain days during the week, the charge nurse assigned on each unit provided treatment care for the residents with pressure ulcers who were on their respective units. LN 2 stated she observed that the date on some of the dressings applied to residents' pressure ulcer did not indicate the treatment was done.During a concurrent observation and interview on 2/20/26 at 3:00 p.m. with LN 2 in Resident 3's room, Resident 3's stage 4 pressure ulcers to the left shoulder and left hip, and unstageable pressure ulcer to the left trochanter (large, bony prominence on the upper femur (thighbone) that serves as an attachment point for (continued on next page)

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	02/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	major hip muscles) did not have a dressing applied. LN 2 stated Resident 3's pressure ulcers should have a dressing with the appropriate treatment applied according to the treatment orders.During a review of Resident 3's clinical record titled, TREATMENT ADMINISTRATION RECORD (TAR-), dated from 2/1/26 through 2/28/26, the record indicated the treatment orders as follows: .TX: Stage 4 pressure ulcer-L [left] hip-Cleanse w n/s [with normal saline], pat dry, silver alginate [advanced, absorbent antimicrobial wound dressing made from seaweed-derived fibers infused with silver ions], cover with dry dressing every day shift-Start Date-01/24/26.TX: Stage 4 pressure ulcer-L Scapula [shoulder]-Cleanse w n/s, pat dry, silver alginate, cover with dry dressing every day shift-Start Date-01/24/26.TX-Unstageable Necrosis [dead tissue]-Left greater trochanter p/u-Cleanse w n/s, pat dry, Silvadene [a prescription topical antibiotic cream used to treat and prevent infections in severe burns and, sometimes, chronic sounds like pressure ulcers], cover with dry dressing every day shift-start Date 01/28/26.During a concurrent interview and clinical record review on 2/20/26 at 3:33 p.m. with the Director of Nursing (DON), Resident 3's TAR, dated 2/26 was reviewed. The TAR indicated there were no LN initials on 2/15/26 to demonstrate the treatment to Resident 3's two stage 4 pressure ulcers and one unstageable were performed. The DON confirmed the LN's initials were missing on that day and she stated if it was not recorded the treatment was not done. The DON also stated the risk of poor outcome with the potential for delayed healing and infections could affect Resident 3's well-being. During a review of the facility's undated document titled, Wound Prevention, the document indicated, .The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds.During a review of the facility's undated procedure titled, Wound Care, the procedure indicated, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Place one (1) gauze to cover all broken skin.Remove dry gauze. Apply treatments as indicated.Dress wound.Mark tape with initials, time, and date and apply to dressing.The following information should be recorded in the resident's medical record.The date and time the wound care was given.During a review of the facility's job description titled, Registered Nurse (RN), revised 7/24, the job description indicated, .Monitor the skin health of the resident; provide preventative skin care; administer wound treatments as ordered.Maintain documentation of all nursing care and services provided to the residents.During a review of the facility's job description titled, Licensed Practical (Vocational) Nurse (LPN)(LVN), revised 5/22, the job description indicated, .Monitor the skin health of the resident; provide preventative skin care; administer wound treatments as ordered.Maintain documentation of all nursing care and services provided to the residents.