

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER Oak Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe environment free of hazards for two of three sampled residents (Resident 1 and Resident 2) who were at risk for elopement (the act of leaving a facility unsupervised and without prior authorization), when: 1. Resident 1 and Resident 2's physician order for checking placement and function of the wander guard device (an alarm that alerts the facility when a wandering resident tries to leave the facility unattended) was not followed; and, 2. Resident 1 and Resident 2's monitoring of their wander guard placement (where the device is located on the body) and function were not consistently documented for the month of April 2026. These failures placed Resident 1 and Resident 2 at risk for elopement and had the potential to result in an injury. Findings: 1a. A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included anxiety disorder (excessive, persistent, and uncontrollable fear or worry that interferes with daily life) and multiple sclerosis (long term brain disease that causes weakness, fatigue, numbness/tingling, vision problems, and poor balance). A review of Resident 1's Order Summary Report indicated, Check wander guard for placement every shift .Order Date .4/09/2026 .A review of Resident 1's Care Plan Report initiated on 4/9/26, under the section titled, Focus, indicated, .Risk for Wandering/ Elopement Identified . Further review of the document indicated, .Interventions/ Tasks.Wander Guard to RUE [right upper extremity]. During a concurrent observation and interview on 4/22/26, at 8:28 AM, with Licensed Nurse (LN) 1, in Resident 1's room, Resident 1 was observed at bedside without a wander guard. LN 1 confirmed that Resident 1 was not wearing a wander guard device. During a concurrent observation and interview on 4/22/26, at 8:42 AM, with the Assistant Director of Nursing (ADON), Resident 1 was observed without a wander guard. The ADON confirmed that Resident 1 was not wearing a wander guard device. Resident 1 stated she did not know where her wander guard was. The ADON stated a wander guard device was indicated for Resident 1 because she had a behavior of trying to go out and could propel her wheelchair. The ADON further stated that if Resident 1 was not wearing her wander guard device then there was a risk of Resident 1 eloping. The ADON stated Resident 1 was confused and it was not safe for her to be outside unsupervised. The ADON further stated she expected staff to monitor the wander guard device by checking its placement and if it was working. 1b. A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility with diagnoses which included an anxiety disorder. A review of Resident 2's Order Summary, indicated, .Monitor wandergard [sic] for functioning every shift .Monitor wandergard [sic] placement daily every shift .Order Date 4/6/2026 .A review of Resident 2's Care Plan Report revised on 8/7/23, under the section titled, Focus, indicated, .risk for Elopement related to WANDERING . Further review of the document indicated, .Interventions.monitor function and placement of wanderguard daily every shift. During a concurrent observation and interview on 4/22/26, at 9:14 AM, with the ADON, Resident 2 was observed without a wander guard. The ADON confirmed Resident was not wearing a wander guard device. The ADON further stated they did not know when Resident 2's wander guard was removed. During an interview 4/22/26, at 9:47 AM, with LN 1, LN 1 stated he did not receive a report from the NOC (night) shift as to why Resident 2's (continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>wander guard was removed. LN 1 further stated that he just saw the wander guard on the med cart. LN 1 stated when a wander guard device was noted to be missing or was not functioning, the nurse needed to notify the DON (Director of Nursing) to have the wander guard replaced. LN 1 stated he was not sure if another wander guard was available for Resident 2.2a. During a concurrent interview and record review on 4/22/26, at 8:42 AM, with the ADON, Resident 1's Medication Administration Record (MAR) for the month of April 2026 was reviewed. The ADON confirmed that the NOC shift on had documented that Resident 1's wander guard had been checked for placement and function on 4/21/26. The ADON further confirmed the day shift did not document the placement and function of Resident 1's wander guard on April 11, 12, 15, 16, 17 and 18. 2b. During a concurrent interview and record review on 4/22/26, at 9:14 AM, with the ADON, Resident 2's MAR for the month of April was reviewed. The ADON confirmed that NOC shift documented on 4/21 that Resident 2's wander guard was functioning. The ADON further confirmed the day shift did not document if Resident 2's wander guard was functioning on April 11, 12, 15, 16, and 17 and were left blank on the MAR. During a concurrent interview and record review on 4/22/26, at 10:38 AM, with the DON, Resident 1's electronic medical record was reviewed. The DON stated Resident 1 had exit seeking behavior and had tried to leave the facility to go to the store. The DON confirmed Resident 1 had an order for the wander guard and it was also part of Resident 1's care plan. The DON stated the nurses were responsible for checking the placement and function of the wander guard every shift. The DON further stated the risk for a resident to not wear their wander guard could lead the resident to wander outside of the facility. The DON stated she expected the nurses to inform her or a supervisor if a resident's wander guard was missing or not functioning. A review of an undated facility policy and procedure (P&P) titled, Tab Alarms, Bed Alarms, Wanderguard System, indicated, .Wanderguard would be used for residents at risk for elopement. The Wanderguard bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed. The Wanderguard bracelets are checked daily on the night shifts by the Supervisor and are documented in the treatment book on the units. A review of the facility's P&P titled, Leave of Absence without Notice (LAWN), dated 1/16/26 indicated, .a resident deemed at risk for Leave of Absence without Notice by IDT are to consider the following measures but not limited to: Initiate/Update plan of care Consider application of a wander guard in collaboration with the physician and responsible party In the absence of a wander guard system the IDT to collaborate and identify measures necessary to avoid leaving the facility without notice/authorization.</p>		