

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/09/2026
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)		
F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on interview, and record review, the facility failed to provide written notice to the State Agency (SA) at the time of the position change of the Director of Nursing (DON) for a census of 104 residents, when the current DON started the DON position on 6/26/26, and the facility did not report the change of the DON position to the SA as of 7/9/26. This failure delayed the SA from verifying that the DON was qualified to lead clinical services at the skilled nursing facility, which had the potential to compromise resident safety and compliance with federal and state regulation for a census of 104 residents. Findings: During an interview on 7/9/26, at 10:30 AM, with the Administrator (ADM), the ADM stated the facility had a new interim DON. The ADM further stated she had paperwork for the notification of change of the DON, form HS 215A (The form is used to verify compliance with state health and safety regulations during the facility licensing process or when changes in ownership/management occur. Requires owners, operators, and key management of health or community care facilities to disclose their personal details, employment history, criminal records, and affiliations with other licensed care facilities). During an interview, on 7/9/26, at 12:07 PM, with the DON, the DON stated she started working at the facility on 6/26/26 as the interim DON. During a concurrent interview and record review on 7/9/26, at 3:10 PM, with the DON, the DON's HS 215A form was reviewed. The DON confirmed that she signed the form on 7/8/26. The DON stated that she was aware of the state requirement to submit the application. During an interview on 7/9/26, at 3:12 PM, with the ADM, the DON's HS 215A form was reviewed. The ADM confirmed that it had not been submitted to the SA. The ADM stated that the purpose to submit the application form was for license verification along with the applicant's work history and resume. The ADM further stated that it was important to submit this form to the SA to provide notification of change as to who managed the facility. The ADM stated that if the change of leadership notification was not submitted timely, the SA would not be able to determine if proper staff were in place. A review of the SA database did not indicate the DON application was received from the facility.		

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