

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/11/2025
NAME OF PROVIDER OR SUPPLIER  Blue Oak Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  850 Sonoma Ave Santa Rosa, CA 95404	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to protect one of five sampled resident's ( Resident 1) right to be free from psychological abuse by a Certified Nursing Assistant ( CNA 1) and Unlicensed Staff 1, when Resident 1 was forced to unclog her room's toilet , which contained urine and feces, with her own gloved hands while the door to room was purposely left open.This failure made Resident 1 feel embarrassed, humiliated and victimized and negatively impacted her psychological well-being.A review of Resident 1's admission record indicated she was admitted in 05/25, with the diagnosis of Paranoid Schizophrenia (a serious mental health condition where a person has a hard time telling the difference between what is real and what is not).A review of Resident 1's Minimum Data Set (MDS- a Federally Mandated assessment tool), dated 11/28/25, indicated Resident 1 had no memory impairment, no symptoms of depression, no hallucinations and no behavioral symptoms.A review of an SBAR (SBAR-Situation, Background, Assessment, Recommendation) note, dated 11/19 at 4:16 pm, indicated Resident 1 reported to the Case Manager and Program Director feelings of emotional distress after an interaction with staff. It further indicated Resident 1 had no prior incidents and reported feeling embarrassed and humiliated by the interaction.During an interview on 12/10/25 at 11:45 am, with Resident 1, Resident 1 recalled the incident in detail. Resident 1 stated that CNA A came to the dining room and asked Resident 1 to come with CNA A to her room where Unlicensed Staff C was waiting with a bag. CNA A proceeded to instruct Resident 1 to remove the contents of the toilet, which contained urine and feces, with gloved hands because it was not fair to Unlicensed Staff C. Resident 1 stated she was shocked and did not know what to do, so she complied. Resident 1 asked CNA A to please close the door and CNA A refused. Resident 1 stated, I felt extremely embarrassed, humiliated and victimized. I felt [CNA 1] was intentionally trying to humiliate and control me. During an interview on 12/10/25 at 3:36 pm, with the Director of the Behavioral Health Program (DBH), the DBH stated she was shocked by the accusation and CNA A's behavior was inappropriate and wrong and would not be tolerated, and CNA A and Unlicensed Staff B were both terminated due to the incident. The DBH stated the incident would make the resident feel fearful, concerned about retaliation, and humiliated.A review of the facility's 5-day summary report, dated 11/25/25, indicated CNA A admitted to her actions and stated she was trying to teach Resident 1 a lesson. The report further indicated Unlicensed Staff C confirmed the incident to be true. A review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, stipulated, residents have the right to be free from abuse, including verbal abuse and mental abuse and the facility has a commitment to prevent resident abuse by anyone.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to ensure an abuse allegation was properly investigated when the facility did not interview other residents as part of its investigation. This failure prevented the facility from identifying other residents who could have been affected. Findings: A review of the facility document titled, 5- day summary report, dated 11/25/25, indicated Resident 1 was the only resident interviewed related to the abuse allegation. During an interview on 12/10/25 at 3:36 p.m., with the Director of Behavioral Health (DBH), the DBH stated she had not interviewed other residents during the investigation, and everything that had been done during the investigation was documented on the 5-day summary report. During an interview on 12/11/25 at 3:30 p.m., with the Administrator (ADM), the ADM stated they had not interviewed other residents during the investigation. The ADM further stated, interviewing other residents was part of the policy and in principle, they should have to make sure no other residents were affected. A review of the facility policy titled, Abuse Investigation, dated 2/08, indicated the individual conducting the investigation, would, as a minimum, interview the resident's roommate and other residents to whom the accused employee provides care or services.</p>