STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056090	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Oak Post-Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to provide the State Survey Agency (California Department of Public Health [CDPH]) written investigation reports (an investigation conducted by the facility following the allegations of abuse) of two facility reported abuse allegations within five calendar days, for four of four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4).This failure decreased the facility's potential to ensure relevant interventions were in place and implemented to prevent further abuse and psychosocial (a combined influence of psychological [the mental and emotional state of a person] factors and the surrounding social environment on physical, emotional, and/or mental wellness) harm for Resident 1, Resident 2, Resident 3, and Resident 4.A review of a facility document dated 12/18/25, and received by CPDH on 12/18/25, indicated an allegation of suspected dependent adult/elder abuse had been made related to a resident-to-resident altercation between Resident 1 and suspected abuser [left blank .Resident 2]. A review of a facility document dated 12/23/25, and received by CPDH on 12/23/25, indicated an allegation of suspected dependent adult/elder abuse had been made related to a resident-to-resident altercation between Resident 3 and Resident 4.During an interview on 1/05/26 at 1:20 p.m., the Administrator (ADM) stated her first day as ADM at the facility was 1/01/2026. The ADM stated she could not locate the facility files [which generally include the facility's five-day investigation report] for either abuse allegation.During an interview on 1/05/26 at 2:05 p.m., the ADM confirmed she could not locate the facility's five-day investigation reports or provide evidence that they were sent to CDPH.During an interview on 1/05/26 at 4:20 p.m., the ADM stated it was their policy to submit the five-day investigation reports to CPDH within five days of the reported abuse allegations.During an interview on 1/07/26 at 12:12 p.m., with the Director of Nursing (DON), she stated she did not know if the facility's investigation reports for both abuse allegations were completed. The DON stated the purpose of the facility's investigation reports was to ensure the facility investigated what happened and what interventions were implemented to provide resident safety. The DON further stated it was a regulatory requirement to provide the five-day investigation report to CDPH.A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 11/2023, indicated, All allegations are thoroughly investigated.The administrator initiates investigations.Within five business days of the incident, the administrator will provide a follow-up investigation report.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure resident care met professional standards of practice for two of six sampled residents (Resident 1 and Resident 2) when:1: A skin assessment was not completed following the report of bruising/discoloration sustained to Resident 1's right arm after an abuse allegation, and;2: The facility did not conduct 72-hour monitoring every shift (morning [AM], evening [PM] and night shift [NOC]) following Resident 2's change of condition (COC).These failures resulted in inaccurate documentation and monitoring of Resident 1's injuries and decreased the facility's potential to ensure that consistent monitoring and safety measures were provided to Resident 2.1: A review of Resident 1's admission record indicated she was admitted to the facility in July 2025 with medical diagnosis which included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 10/25, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 13, which indicated her cognition was intact (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact).A review of Resident 1's order summary report dated as of 11/01/25 indicated no orders for blood thinning medications (medications that are known to increase the risk of bruising and bleeding).A review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, a communication technique used in healthcare to facilitate clear and concise information) - COC progress note dated 12/18/25 at 7:46 a.m., indicated, [Resident 1] Reported alleged physical abuse with skin discoloration on RFA (right forearm).Skin discoloration on RFA was present. No swelling and denies pain.A review of Resident 1's progress notes, type Skin/Wound Note, dated 12/21/25 at 4:38 p.m., indicated, Continue to monitor for discoloration or bruises on right forearm. The skin is intact.During an observation and concurrent interview on 1/05/26 at 2:09 p.m., Resident 1 stated she had bruises on her right arm. Resident 1 further stated a man came into her room and grabbed her right arm. Resident 1 removed one of her shirts to expose both arms. Resident 1 had a bruise on the lateral (situated at or on the side) aspect of her right upper arm below the deltoid (a large muscle forming the contour of the shoulder). The bruise was oblong with purple discoloration lining the outskirts and yellow discoloration inside. The bruise measured approximately 2.5 inches (in.- a unit of measurement) in length and 2 in. wide. Resident 1 had another bruise on the lateral aspect of her right lower arm below the elbow. The bruise was purple and measured approximately 2 in. by 2 in. No other bruises or discoloration was observed on Resident 1's right arm.During an interview and concurrent record review on 1/07/26 at 12:12 p.m. with the Director of Nursing (DON), she confirmed Resident 1's SBAR report indicated skin discoloration to RFA. The DON stated she expected a more detailed skin-wound assessment given the findings following an allegation of abuse. The DON further stated Resident 1 is missing a skin integrity assessment and excepted it to be completed at the time of the SBAR. The DON stated the skin integrity assessment is an extra tool used to describe the wound in detail based on discoloration, size, location, and so forth. The DON verified a skin/wound note for Resident 1 was completed on 12/21/25, and she expected it to be completed on 12/18/25, when the bruising was first reported.A review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revision dated 2/2021, indicated, .the nurse will make detailed observations and gather relevant and pertinent information.A review of the facility's document, Charge Nurse- Job (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Descriptions, dated 2003, indicated, [The licensed nurse is to] Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures.2: A review of Resident 2's admission record indicated he was admitted to the facility in December 2016 with medical diagnosis which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), vascular dementia with behavioral disturbances (when damaged blood vessels reduce blood flow and oxygen to the brain, impairing thinking, memory, and function) and major depressive disorder. A review of Resident 2's MDS dated 11/25, indicated his BIMS score was 13, which indicated his cognition was intact.A review of Resident 2's SBAR - COC progress note dated 12/17/25 at 6:19 p.m., indicated, Resident [Resident 2] observed with increased agitation, physically aggressive behaviors, wandering around other station and walked to other resident's room.Placed on 72-hr (hour) monitoring.A review of Resident 2's care plan dated 12/18/25, indicated, The resident [Resident 2] is exhibiting adverse behavior resulting in: impaired physical well-being, impaired safety, aggressive behavior toward staff and other resident.72-hr monitoring initiated.A review of Resident 2's progress notes showed no evidence that 72-hr monitoring was completed by nursing staff every shift on 12/18/25. There also was no evidence that 72-hr monitoring was completed AM, PM, and NOC shift on 12/19/25, and NOC shift on 12/20/25.During an interview on 1/05/26 at 2:54 p.m. with Licensed Nurse 1 (LN 1), she stated 72-hr monitoring is expected to be completed every shift on both residents for safety purposes following abuse allegations. During an interview and concurrent record review on 1/07/26 at 12:12 p.m., the DON stated her expectation for 72-hr monitoring is that it was completed every shift by licensed nursing staff. The DON further stated she expected nine nurse progress notes total through the 72-hr monitoring period. The DON verified 72-hr monitoring notes were completed on 12/20/25 at 9:05 a.m. and 9:07 p.m. only. The DON confirmed monitoring was only completed two out of the nine expected times. The DON stated, It [72-hr monitoring] should have been more consistent. The DON further stated the importance of 72-hr monitoring is to ensure Resident 2 and other residents were safe. A review of the facility's P&P titled, Charting and Documentation, revision dated 7/2017, indicated, All services provided to the resident.shall be documented in the resident's medical record.A review of the facility's document, Charge Nurse- Job Descriptions, dated 2003, indicated, Ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan. Ensure that nurses' notes reflect that the care plan is being followed.