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	04/02/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews and record reviews, the facility failed to fully implement one out of four sampled residents (Resident 3) fall care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) when Resident 3's bed was not in the lowest position as indicated on his fall CP.This failure put Resident 3 at increased risk for falls and fall related injuries.Findings:A review of Resident 3's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date to the facility on 3/4/26 with diagnoses of difficulty walking and muscle weakness.A review of Resident 3's Fall CP, dated 3/31/26, indicated Resident 3 had an unwitnessed fall and one of the interventions indicated his bed was to be put in the lowest position.During a concurrent observation and interview on 4/2/26 at 3:38 p.m., sitter D and Licensed Nurse (LN) E were present in Resident 3's room. LN E confirmed Resident 3's bed was expected to be in the lowest position. Sitter D confirmed Resident 3's bed was not in the lowest position.During an interview on 4/2/26 at 3:40 p.m., sitter D stated it was important Resident 3's bed was put in the lowest position to ensure Resident 3 did not hurt himself in case he fell. Sitter D acknowledged she forgot to put Resident 3's bed in the lowest position earlier.During an interview on 4/2/26 at 3:42 p.m., LN E stated Resident 3's fall CP indicated his bed should be placed in lowest position because he was at high risk for falls. LN E stated Resident 3 already had multiple falls and added, placing the bed in lowest position decreased the risk of Resident 3 sustaining an injury when he falls. LN E stated staff should follow care plan interventions and explained not following a care plan intervention put the resident at risk for injuries.During a concurrent interview and record review with the Director of Nursing (DON) on 4/2/26 at 4:08 p.m., Resident 3's Fall CP, dated 3/31/26, was reviewed. The DON verified Resident 3's Fall CP indicated Resident 3 had an unwitnessed fall and one of the interventions indicated bed in lowest position. The DON stated fall CP interventions were put in place for a reason and must be followed. The DON stated she expected Resident 3's bed to be in the lowest position, unless staff were performing care with him. The DON confirmed Resident 3 was a high fall risk, had poor safety awareness, and placing the bed in its lowest position decreases Resident 3's risk for injury in case he falls.A review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated .in conjunction with the attending physician, staff will identify and implement relevant interventions (.as applicable) to try to minimize serious consequences of falling.

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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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and record reviews, the facility failed to ensure their call light system (communication devices/system that allows residents to instantly alert nursing staff, aiding in safety, fall prevention, and resident-centered care) allowed residents to be able to directly communicate with staff when they needed assistance for two out of three sampled residents (Residents 1 and 2) when:1. Resident 1's call light volume was too low to be heard, and2. the light outside Resident 2's room, by their door, failed to illuminate upon call light use.These failures put the residents at risk for delayed provision of care and unmet needs.Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date to the facility in 9/2025 with diagnoses of Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and Malaise (general, vague feeling of being unwell, uncomfortable, or lacking energy).A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 3/12/26, indicated Resident 1's score was 15 representing no memory issues. A review of Resident 2's face sheet indicated an admission date to the facility in 11/2025 with diagnoses of difficulty walking and muscle weakness.A review of Resident 2's BIMS, dated 3/3/26, indicated Resident 2's score was 12, representing having moderate cognitive impairment (may need extra assistance with daily activities).During a concurrent observation and interview on 4/2/26 at 9:57 a.m., in Resident 1's room, Resident 1 pressed her pendant type of call ight button to alert staff she was requesting assistance. After waiting for about 21 minutes, Resident 1 stated see, I told you no one will come.During an observation on 4/2/26 at 10:05 a.m., outside Resident 1's room in hallway 1, there was no alert noise that could be heard in the hallway indicating Resident 1 had pressed her call light. However, there was a faint audible beep that could be heard at Nursing station 1 that indicated Resident 1 had pressed the call light. Licensed Nurse A (LN A) was seen in hallway 1 but did not respond to Resident 1's call light alert.During an interview on 4/2/26 10:18 a.m., the Director of Staff Development (DSD) verified when Resident 1 pressed the call light, the beep was faint and if there were no staff near or at nursing station 1, staff would not be alerted Resident 1 pressed her call light. The DSD stated it was important that the facility had an effective call light system to ensure resident needs were met.During a concurrent observation and interview on 4/2/26 10:21 a.m., outside Resident 2's room in hallway 1, Resident 2 had pressed her call light but the light above Resident 2's door, that is supposed to illuminate when the call light is pressed, was not illuminated. Resident 2 stated staff did not answer her call light last night nor this morning. Resident 2 stated she waited and waited but no staff came. During an interview on 4/2/26 at 10:35 a.m., the DSD verified when Resident 2 pressed her call light, the light above Resident 2's door, that is supposed to illuminate when the call light is pressed, was not illuminated which indicated Resident 2's call light was not working. The DSD stated it was important that call light was effective and in good working conditions to allow residents to request assistance if they needed it and to prevent accidents and injuries.During a concurrent observation and interview on 4/2/26 at 10:34 a.m., the Maintenance Director (MD) verified Resident 1's call light had a faint beep that could only be heard at nursing station 1 and was a risk for Resident 1's safety as staff would not be able to hear Resident 1's call for assistance once they were away at nursing station 1. MD also verified Resident 2's call light was broken. MD stated it was important that call lights were effective and in good working conditions for residents' safety.During an interview on 4/2/26 at 10:49 a.m., LN A confirmed Resident 1's call light when pressed emitted a faint beep at nursing station 1. LN A stated not hearing Resident 1's call light earlier when in hallway 1 and Resident 1's call light was alerting faintly at nursing station 1. LN A stated there was a big chance no one would come to answer Resident 1's call for assistance because staff could not hear it. LN A stated staff have been aware that Resident 1's call light was not audible if away from nursing station 1. LN A verified she did (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not report this issue to the supervisor or MD. LN A stated it was important to have an effective and working call light because residents used it to call staff when they needed assistance. LN A stated if call lights were ineffective or were broken, then there would be no way for residents to call for assistance which was a safety risk.During an interview on 4/2/26 at 4:08 p.m., the Director of Nursing (DON) stated call light must be effective and in good working condition as call lights allow residents to notify staff of their immediate needs, which is very important for emergency situations.A review of the facility's policy and procedure (P&P) titled Call lights: Accessibility and Timely Response, undated, the P&P indicated .the purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance.staff will report problems with a call light or call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions.