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 04/16/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F600 The facility failed to ensure residents were free from physical abuse, including residentˆtoˆresident abuse, when it did not implement effective preventative resident abuse nursing care planned interventions to prevent three residentˆtoˆresident altercations for three of five sampled residents (Residents 2, 3, and 5). As a result, Resident 2 sustained head trauma to the right side and back of his head, with pain, swelling and redness; Resident 3 sustained abrasion with bleeding to his right ear, and Resident 5 sustained skin injury resulting in redness on his jaw. These failures resulted in abuse, pain, physical injuries and increased risk of psychosocial harm.A review of Resident 1's admission Record indicated he was admitted to the facility in 2017 and readmitted on [DATE] with severe mental illness disorder (a psychiatric condition characterized by significant disturbances in thinking, mood, behavior, or perception that profoundly affect a person's ability to function in daily life).A review of Resident 2's admission Record indicated he was admitted to the facility on [DATE] with a primary diagnosis of severe mental illness.A review of Resident 3's admission Record indicated he was admitted on [DATE] with a primary diagnosis of severe mental illness.During an interview with Licensed Nurse 1 (LN1) on 4/15/26 at 10:50 a.m., she stated that during the 5 p.m. medication pass on 3/20/26, Resident 1 suddenly began punching Resident 2's head and face with a closed fist. LN1 stated she was not surprised due to Resident 1's known history of aggression toward peers prior to his current admission.A review of Resident 2's nursing care plan on the focus area for skin integrity, dated 3/20/26, documented that he sustained slight swelling and redness to the back right side of his head after being hit by another resident. The goal stated the redness and swelling would decrease.During an interview with Resident 2 on 4/16/26 at 2:09 p.m., he recalled the incident and pointed to the area where he was struck, and relayed he felt pain on his head, at the time of the incident. When asked if he felt safe, he stated he wanted to be discharged .During an interview with unlicensed staff member 1 (US1) on 4/16/26 at 2:45 p.m., US1 stated that on 3/22/26 at approximately 2:45 p.m., he heard commotion on the patio and found Resident 1 kicking Resident 3 while Resident 3 was on the ground. Other staff who witnessed the entire event reported to him and the charge nurse that Resident 1 attacked Resident 3 without provocation, initially striking him on the head and then kicking him in the torso until staff intervened.A progress note dated 3/22/26 at 4:44 p.m. by Licensed Staff 2 (LS2) documented a headˆtoˆtoe assessment of Resident 3 after the assault on the patio. LS2 documented an abrasion with bleeding on the right ear, which was cleaned with normal saline. LS2 reported the injury to the physician and wound care nurse.A review of Resident 4's admission Record indicated an original admission in 2017 and a readmission on [DATE] for severe mental illness.A review of Resident 5's admission Record indicated he was admitted on [DATE] with a diagnosis of severe mental illness.A review of Resident 4's nursing care plan documented that on 3/26/26, Resident 4 struck Resident 5 on the chin and that Resident 4 had a known history of physical aggression.A review of Resident 4's, changeˆinˆcondition, assessment by Licensed Nurse (LN2) indicated that on 3/26/26 at 6 a.m., Resident 4 hit Resident 5 after becoming upset about not being able to shower first.A review of a report of alleged abuse document SOC-341 (a California form (continued on next page)

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

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 04/16/2026
NAME OF PROVIDER OR SUPPLIER Blue Oak Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Sonoma Ave Santa Rosa, CA 95404	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used by mandated reporters and others to officially document and report suspected abuse, neglect, or exploitation of elders and dependent adults to the appropriate authorities) dated 3/26/26, provided to the California Department of Public Health by the Administrator (ADM), indicated LN3 witnessed the 3/26/26 incident in which Resident 4 struck Resident 5 on the chin.A review of Resident 5's Medication Administration Record indicated he was administered pain medication, acetaminophen (an over-the-counter medication used to treat pain) at 6:44 a.m. on 3/26/26.A review of a 5-day-follow-up document dated 4/1/26 provided to the California Department of Public Health by the Administrator stated Resident 5 expressed frustration after being assaulted by Resident 4 and both residents were placed on monitoring every 15 minutes for safety checks.A review of Resident 5's nursing care plan for abuse and skin injury he sustained during the incident occurring on 3/26/26, indicated Resident 5 experienced abuse when struck on the chin, placing him at risk for emotional distress and psychosocial decline. A care plan focus area dated 3/26/26 was added, with a listed goal for the redness of the chin injury to heal by the review date.During an interview and concurrent record review of Resident 4's nursing care plan, with the Assistant Director of Nursing (ADON) on 4/16/26 at 3:02 p.m., the ADON acknowledged Resident 4's nursing care planned goal, created on 4/14/26, pertaining to the 3/26/26 focus area for the resident to resident altercation, in which Resident 4 exhibited abusive behavior towards Resident 5 indicated, The resident will not have emotional distress related to the allegation minimized and the entry was created late, 19 days after the abusive incident occurred back on 3/26/26. The ADON stated nursing care plans must be updated with appropriate residentˆspecific interventions during changes in condition timely, to protect all residents' safety. The ADON acknowledged that delayed or backdated documentation can place residents at risk for harm because staff may be unaware of current needs or events.During an interview with the Director of Nursing (DON) on 4/16/26 at 4 p.m., the DON stated the purpose of the nursing care plan is to provide individualized care and acknowledged the risk of harm to the resident for failure to implement effective interventions specific to the resident's individualized care plan.During an interview on 4/16/26, at 4:40 p.m., the Administrator (ADM), who served as the abuse coordinator, acknowledged residents' right to be free from abuse and neglect, and that all documentation concerning incidents of alleged abuse are required to be made timely, including in the medical record of the residents involved.A review of the facility policy titled, Abuse Reporting and Prevention, dated 2018, indicated, Assessment and Recognition. 4. The physician and staff will help identify risk factors for abuse within the facility; for example, significant numbers of residents/patients with unmanaged problematic behaviors. that might affect resident care. Cause Identification 1. The staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Treatment/Management 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.A review of the facility policy titled, Resident Rights, dated 2025, indicated, II. Resident Rights. a. Dignity, Respect and Freedom. iii. Be free from abuse, neglect.