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	05/01/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident in a census of 123 (Resident 2) received quality nursing care that was resident-centered and in accordance with her goals of care, as indicated in her Nursing Care Plan (a document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) when she experienced a Change of Condition (sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains; without intervention, the deviation could lead to clinically significant complications up to and including death) at approximately 8 a.m. on [DATE], but her responsible party (RP; individual with decision-making authority regarding the patient's care) was not notified until approximately 11 a.m.This failure caused an approximate 3-hour timespan between identification of Resident 2's medical emergency to notification of her RP, preventing him from consulting family and making timely treatment decisions for her. This in turn delayed Resident 2's transfer to the hospital and treatment of her urinary tract infection (infection in any part of the urinary system) and sepsis (life-threatening medical emergency caused the body's overwhelming response to an infection); she ultimately succumbed to her sepsis and died on [DATE]. Findings:A review of Resident 2's face sheet (front page of the medical record that contains a summary of basic information about the resident) indicated she was eighty-seven years old and admitted to the facility on [DATE] with diagnoses of unspecified dementia (progressive state of decline in mental abilities), hemiplegia (total or nearly complete paralysis on one side of the body), and Hemiparesis (weakness or paralysis on one side of the body, affecting daily activities and mobility) following a cerebral infarction (stroke).Review of Resident 2's nursing care plan, dated [DATE], with target date [DATE], indicated, It is very important for [Resident 2] . to have her son [name] involved in discussions about her care. The care plan goal indicated, [Resident 2] daily preferences will be respected daily over the next review date.Review of Resident 2's nursing care plan, dated [DATE], with target date [DATE], indicated, [Resident 2] has impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia .A review of Resident 2's physician orders, dated [DATE], indicated that Resident 2 did not have the capacity to make her own health care decision. The order further indicated, . The Surrogate decision maker [responsible party/RP] is: [son's name] .A review of Resident 2's POLST (Physician Orders for Life-sustaining Treatment; a medical order that specifies a seriously ill patient's treatment preferences in emergencies) indicated, Do not attempt Resuscitation/DNR. (DNR is a medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation - CPR: chest compressions, rescue breathing, and defibrillation to restart the heart] if a person's heart stops beating or they stop breathing). The POLST indicated potential medical interventions were, Comfort-focused treatment, with a goal of maximizing comfort. The POLST was signed by Resident 2's RP on [DATE].Review of Resident 2's medical record revealed a document titled, Change of Condition Assessment, dated [DATE] at 11 a.m., that indicated, 1. Triggering Event/Change. a. Mental Status Change. b.Family Reported Concern. 2. Describe. Unstable vital signs [clinical measurements of heart rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] . The document indicated Resident 2's vital signs on [DATE] (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11 a.m. were: . Blood pressure [BP]: 77/43 [normal BP is 120/80] . Pulse (heartrate): 109. Irregular [arrhythmia; heartrate is too fast, too slow or has an unsteady, erratic rhythm] . O2 [oxygen] sats [saturation] 81% [oxygen saturation levels - percent of oxygen in a person's blood; normal range is approximately 95% - 100%] on Room Air [oxygen level without supplemental administration of oxygen; breathing regular air] . The document indicated Resident 2's mental status at the time was, .d. Unresponsive [unconscious and does not react to external stimuli like voice, touch, or pain] . The document indicated, 10. Describe Change of Condition in Detail: Resident has unstable vital signs, out of regular limits. is sweating profusely and is lethargic [profound tiredness, sluggishness, and reduced alertness, often characterized by severe fatigue and diminished mental capacity] and unresponsive to verbal commands.Review of Resident 2's medical record revealed Licensed Nurse A (LN A) documented a nurse progress note (documentation of a resident's clinical status, response to treatment, and care updates), dated [DATE] at 11 a.m., that indicated, This morning around 0800 [8 a.m.] CNA [certified nurse assistant] reported to this nurse that resident [Resident 2] had a low blood pressure [BP]. This nurse checked vital signs, all were stable [within normal limits] except for BP(72/40). Resident was repositioned and encouraged to drink fluids and eat breakfast. After breakfast vital signs were reassessed. BP continued to be low and oxygen was now low as well. Vital signs: BP 77/43, HR [heartrate] 103. o2 [oxygen]: 81% . MD was notified for an order for supplemental oxygen. Resident was placed on 2L [oxygen rate of 2 liters per minute] of oxygen via nasal cannula [flexible tube with two prongs that fit into the nostrils]. Son. arrived for a visit. This nurse and son discussed residents' vital signs, and son made phone call to other family members. It was decided to send [Resident 2] to [local hospital name] . Paramedics arrived around 1100 (a.m.) and transferred resident.Review of Resident 2's ambulance trip sheet (formal record of a patient's encounter during an ambulance transport), dated [DATE], indicated an EMT (Emergency Medical Technician) and paramedic arrived on-scene and made contact with Resident 2 at 11:16 a.m. The document indicated Resident 2 was unable to answer questions, her skin was warm and diaphoretic (sweaty), her temperature was 103.1 F (Fahrenheit; normal is 98.6 F) and her oxygen saturation was 90% on 2 Liters of oxygen; at 11:18 a.m., her blood pressure was 94/29 and her heartrate was 159 (normal is 80 - 100). The EMT and paramedic documented Resident 2's RP and family stated Resident 2 was never supposed to be comfort care (as indicated on the POLST); the trip sheet indicated they requested she remain DNR with full treatment; they wanted all possible treatment for Resident 2 except CPR.Review of Resident 16's hospital History and Physical Examination (comprehensive clinical evaluation of a patient's health history and physical examination), dated [DATE], indicated she arrived in the Emergency Department (ED), she had a low BP, temperature of 105 F and normal oxygen level while receiving supplemental oxygen. The physician's assessment indicated Resident 2 presented (came to the ED) with altered mental status (change in awareness, cognition, or behavior) and septic shock (a life-threatening condition characterized by dangerously low blood pressure and organ dysfunction due to a severe infection) due to a urinary tract infection; she was admitted to the Intensive Care Unit (unit in hospitals that provides round-the-clock monitoring and treatment for people with serious illnesses).Review of Resident 16's hospital Discharge Death Summary (documentation in a patient's medical record when a patient dies during or after a hospital stay), signed on [DATE], indicated Resident 2 died on [DATE] at 9:07 p.m. Her Cause of Death was identified as septic shock. due to urinary tract infection .During a confidential telephone interview on [DATE] at 3:10 p.m., Confidential Family Members B (CFM B) stated they visited Resident 2 regularly and she had been fine during a visit the week prior to [DATE]. CFM B stated they arrived for a visit on [DATE] around 11:30 a.m. but Resident 2 was not responsive and they could not wake her up. CFM B stated they spoke to the nurse (LN A) and she told them Resident 2's vital signs were low and her oxygen level was 81%. CFM B stated they then called a family member; they decided to call 911 (medical emergency service) and transfer Resident 2 to the hospital. CFM B stated paramedics (emergency responders) arrived and took Resident 2 to the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital, where she later died.During the same confidential interview on [DATE] at 3:10 p.m., CFM B stated the facility had not notified them that Resident 2's vital signs were not okay and her oxygen was low. They stated, how did she get that bad without a call? CFM B stated they were Resident 2's decision maker (responsible party) and she was not on Hospice (comfort-focused end of life care). CFM B stated they were not sure exactly what her POLST indicated, but they wanted her to be No CPR (no chest compressions), to receive treatment if necessary, and to be comfortable. CFM B stated Resident 2 had had a UTI (urinary tract infection) in the past while at the facility and had received treatment (and recovered). During a concurrent interview and medical record review on [DATE] at 1:50 p.m., LN A reviewed Resident 2's medical record. LN A stated before breakfast on [DATE], a CNA reported to her that Resident 2 had, low vital signs. LN A stated she double-checked the vital signs and her BP was low. She stated she encouraged fluids (encourage consumption of beverages) and instructed the CNA to try and feed her breakfast. LN A stated after breakfast at approximately 8:30 a.m., Resident 2 was still not well; her blood pressure was low, her heartrate was elevated and her oxygen saturation was decreased to 81%. She stated she checked Resident 2's POLST, called the physician, and gave Resident 2 supplemental oxygen (oxygen delivered via plastic tubing placed at the base of the nostrils) per the physician's orders. She stated Resident 2's family member (the RP) arrived after the supplemental oxygen was started. LN A stated she discussed the POLST with the RP after he arrived and the RP called another family member; after the call, the RP told her to send Resident to the hospital. She stated she called 911 at 11 a.m. LN A stated she had not called the RP prior to his arrival; she stated she told him about Resident 2's deteriorating condition after he arrived at the facility, not earlier in the morning when it was identified.During a follow-up confidential telephone interview on [DATE] at 2:22 p.m., CFM B stated they were not sure how long Resident 2's BP and oxygen were low the morning of [DATE]. CFM B stated he was not aware her blood pressure and oxygen levels were low at approximately 8 a.m. CFM B stated had they known about Resident 2's condition earlier, they, would have come in right away. CFM B stated staff should have called him; they stated staff sometimes called another family member with updated/information about Resident 2, but that family member had not been called, either. During a concurrent interview and record review on [DATE] at 3:40 p.m., the Director of Nursing (DON) reviewed Resident 2's electronic medical record. The DON confirmed Resident 2's blood pressure had been low at 77/43 and her oxygen was low at 81%. When asked if staff should have notified the RP as soon as possible when her unstable vital signs were identified at approximately 8 a.m., the DON stated, yes. The DON stated it was her expectation that family be notified when a Resident experienced a Change of Condition.Review of facility policy titled, Resident Rights, subtitled Procedure/Guidelines, dated [DATE], indicated, II. Resident Rights. c. Participation in care: i. Be fully informed about their health status and treatment options. ii. Participate in . treatment choices.Review of facility policy titled, Resident Participation - Assessment/Care Plans, subtitled, Policy interpretation and Implementation, revised 11/2025, indicated, 3. The resident's/representative's right to participate in the . implementation of the plan of care includes the right to: . f. participate in the type. of care. h. be informed. of changes to the plan of care. i. request changes to. care of treatment offered or proposed.Review of facility policy titled, Acute Condition Changes - Clinical Protocol, subtitled, Assessment and Recognition, revised 3/2018, indicated, 1. The physician will help identify individuals with a significant risk for having acute changes of condition. for example, and individual with. unstable vital signs (blood pressure, heartrate) . Under subtitle, Treatment/Management, the policy indicated, 2. The physician and staff will identify relevant resident/patient wishes.