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	06/10/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the care plan of one of five sampled residents (Resident 1) when the care plan for a toileting program was not carried out and Resident 1's noncompliance with the toileting program did not have a care plan. This failure had the potential to impede Resident 1's ability to regain her continence and delay her readiness for discharge home. During a phone interview on 6/8/26 at 2:54 p.m., Family Member (FM) stated she had spoken with five staff members regarding Resident 1's every-two-hour toileting program including two social services staff, the Director of Nursing, an occupational therapist, and one of Resident 1's nurses. FM stated the nurse had told FM that Resident 1 had been refusing to go to the toilet every two hours per the program. FM stated she told the nurse that they can call her any time, day or night, if Resident 1 refuses, and she (FM) will tell Resident 1 that if she complies with the toileting program she will get closer to going home to her cat. FM stated that Resident 1 really wants to see her cat, and if she says that to her, she can get Resident 1 to comply. FM stated she has not gotten one phone call to tell her Resident 1 was refusing to go to the toilet and that they needed her to encourage Resident 1 to comply. FM stated Resident 1 had been continent prior to falling and breaking her arm. FM stated she needed Resident 1 to regain her continence before she came home, and also because using incontinence briefs was causing Resident 1 to develop urinary tract infections. Review of Resident 1's face sheet indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including a fracture of the left humerus (a break in the bone of the upper arm), schizophrenia, and dementia. Review of Resident 1's care plan revealed a focus area [Bowel and Bladder] Incontinence Program [related to] frequently incontinent, dated 3/25/26. Review of the focus area's interventions included prompted toileting program every two hours and at bedtime, dated 5/11/26. Further review of the care plan revealed there was no focus area regarding noncompliance or refusal of care. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 4/3/26, indicated Resident 1 had moderate cognitive impairment, no rejection of care, was able to walk 10 feet using a walker with supervision, and needed substantial assistance with toileting. Review of Resident 1's SLUMS (St. Louis University Mental Status) examination (a test for approximating global cognitive functioning), dated 3/31/26, indicated severe dementia. During an observation and concurrent interview on 6/9/26 at 10:40 a.m., Resident 1 was lying in bed. When queried, Resident 1 stated staff did not help her to the bathroom. Resident 1 stated, I don't get up, so that's a stupid question. During an interview on 6/9/26 at 2:32 p.m., Certified Nursing Assistant A (CNA A) stated that when a resident was on an every-two-hour toileting program, it showed in her tasks for that resident. CNA A stated she charted in the resident's record every time she helped the resident to the toilet. CNA A verified she did not chart once per shift that she took the resident to the toilet every two hours. During a record review and concurrent interview on 6/9/26 at 4:08 p.m., Director of Staff Development (DSD) reviewed the CNA's documentation for Resident 1 of the task titled, Prompted toileting program [every two hours] and at bedtime dated 5/12/26 through 6/9/26. DSD verified the CNAs had documented toileting Resident 1 four times per day between 5/12/26 and 6/4/26 and three documented refusals between (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/12/26 and 6/9/26. DSD stated, We could do better. DSD stated it was his expectation that the CNAs chart every time they took the resident to the toilet so they could document that the order to toilet the resident every two hours was followed. DSD stated that the goal of the toileting program was to regain continence and success would be if the resident was not incontinent in her brief and voided in the toilet. DSD verified that if the resident was non-compliant with the toileting program, the family should be involved to encourage the resident to be compliant. DSD stated the family knew the resident best so we should always try to involve the family. During an interview on 6/10/26 at 9:42 a.m., CNA B stated Resident 1 was on her regular resident assignment. CNA B stated Resident 1 was on an every-two-hour toileting schedule but she refused most of the time. CNA B stated that if Resident 1 refused to get up to the toilet there was nothing she could do except to tell the nurse that Resident 1 refused. CNA B stated Resident 1 was compliant with the toileting schedule all day long on Saturday (6/6/26) and stayed dry all day. During an interview on 6/10/26 at 10:27 a.m., Licensed Nurse C (LN C) stated Resident 1 was on her regular resident assignment. LN C stated they tried their best to get Resident 1 to comply with the toileting program but Resident 1 could be very defensive and often refused to get up to the toilet. LN C verified that if Resident 1 was refusing to comply with the toileting program, a care plan for noncompliance should be developed. LN C stated developing the care plan was the responsibility of us nurses or the DSD, and verified it should be developed with input from Resident 1's family. LN C stated the potential outcome to the resident if she did not comply with toileting every two hours was Resident 1 could develop a urinary tract infection. During an interview on 6/10/26 at 10:44 p.m., Assistant Director of Nursing (ADON) stated one of the reasons it was important to involve family in the development of the resident's care plan was to set the resident up for success after their discharge. During an interview on 6/10/26 at 11:29 a.m., ADON verified it was her expectation that if Resident 1 was regularly refusing to comply with her toileting program, Resident 1 should have a care plan to address the noncompliance so that her caregivers could see what interventions worked and did not work to encourage compliance. ADON also stated that the CNAs should be documenting Resident 1's refusal to go to the toilet when prompted. Review of facility policy and procedure Care Plans, Comprehensive Person-Centered, dated 12/5/25, indicated, The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: . receive the services and/or items included in the plan of care .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility Social Services Director (SSD) failed to make a medical appointment for one of five sampled patients (Resident 1) when Resident 1 was admitted to the facility with a physician order for a neurosurgery appointment that was never carried out for eleven weeks. This failure potentially prolonged a spinal condition that caused Resident 1 to have difficulty walking, and may have been surgically corrected had Resident 1 been able to see the neurosurgeon.During a phone interview on 6/8/26 at 2:54 p.m., Family Member (FM) stated Resident 1 had an MRI (magnetic resonance imaging, a noninvasive medical imaging test that produces highly detailed, 3D cross-sectional images of the inside of the body) of her back that showed a narrowing in her spinal cord that is causing Trendelenburg gait (an abnormal walking pattern where the pelvis drops on the unsupported side when lifting one leg to step) and that Resident 1 needed a neurology consult. FM stated she had been asking about the status of this consult since Resident 1 had been admitted but no appointment had been made yet. FM stated she was concerned Resident 1 may not be able to make enough progress in physical therapy to be able to come home if the issue with Resident 1's spinal cord was not addressed. Review of Resident 1's face sheet indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including a fracture of the left humerus (a break in the bone of the upper arm), spinal stenosis of the lumbar region (a significant narrowing of the spinal canal in the lower back, causing intense compression of the nerves that control your legs), difficulty in walking, falling, and weakness. Review of Resident 1's document Hospitalist Discharge summary, dated [DATE], indicated Resident 1's discharge diagnoses included weakness and severe lumbar stenosis with the comment to follow up with neurosurgery as outpatient. Review of Resident 1's document Skilled/Intermediate Facility Instructions/Orders, dated 3/25/26, indicated, Discharge Instructions: . Please obtain a referral for a neurosurgeon within 2 weeks for lumbar spinal stenosis - [patient] can followup at [hospital system named] with one of our surgeons - [three surgeons named]. Review of Resident 1's facility history and physical note dated 3/25/26 indicated, She also [sic] significant weakness, MRI showed severe lumbar stenosis . outpatient followed [sic] up recommended by neurosurgery. During a record review and concurrent interview on 6/9/26 at 2:57 p.m., when queried, Social Services Director (SSD) stated she had no documentation that a neurosurgery appointment had been made for Resident 1 because they had not yet found a provider to send Resident 1 to. SSD reviewed Resident 1's History and Physical dated 3/25/26 and verified that it indicated Resident 1 had severe lumbar stenosis with a recommendation for follow up with neurosurgery. SSD reviewed Resident 1's document Skilled/Intermediate Facility Instructions/Orders, dated 3/25/26, and stated she had never seen that order before to obtain a referral for a neurosurgeon within two weeks with the names of three potential neurosurgeons for Resident 1 to see. SSD verified the date on the discharge instructions was 3/25/26. SSD stated it was her responsibility to review the discharge orders for patients being admitted to the facility from the hospital and to let the scheduler know about any appointments that need to be made. SSD stated the potential outcome to a resident if she did not get her follow up appointments was her health could deteriorate. SSD also stated that the sooner the appointment was made, the better, because these specialties were impacted and getting seen could take three to four months. SSD stated getting all the paperwork in place to make an appointment with a specialist took about five to seven days to complete. During an interview on 6/10/26 at 10:44 a.m., Assistant Director of Nursing stated that the potential outcome to Resident 1 not having this appointment with neurosurgery could affect whether it is safe for her to go home or not and could delay her discharge plan. During an interview on 6/10/26 at 11:29 a.m., Administrator verified SSD reported directly to her. Administrator stated it was her expectation that SSD began the process for making the follow up appointments for newly admitted residents as soon as possible. Review of facility job description Director of Social Services, last (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 7/2024, indicated under Duties and Responsibilities, Plan, develop, organize, implement, evaluate and direct the social service programs of the facility.