

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/29/2026
NAME OF PROVIDER OR SUPPLIER Blue Oak Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews and record review, the facility's Social Services Department failed to ensure the discharge planning process was documented for one resident (Resident 1) of five sampled residents when the facility planned to discharge Resident 1 from the facility to a shelter without having documented: that the shelter could meet Resident 1's medical needs, Resident 1's involvement in the discharge process, and without preparing Resident 1 to transfer to the new facility. This failure decreased the facility's potential to ensure Resident 1 had a safe discharge and prevent Resident 1's readmission to the hospital. Cross Reference F628Findings: A record review of Resident 1's admission record indicated admission to the facility on 6/2/21 with a diagnosis of Type II Diabetes Mellitus (DM- a medical condition characterized by poor blood sugar control and poor wound healing) and had a history of Traumatic Brain Injury (damage caused to the brain by a forceful bump, blow, or jolt). A review of Resident 1's comprehensive nursing care plan, dated 2/16/22, indicated Resident 1 wished to remain in the facility for long term care due to the inability to care for self or in home care settings. No revisions or additions were noted on this care plan to support a transition to a lower level of care nor a pending discharge. A review of Resident 1's Interdisciplinary Team's (a group of people with different areas of expertise collaborating towards a common goal) Care Conference note, dated 6/4/26, indicated Resident 1 had no change in his discharge plans; however, the Social Services Department (a group of people who evaluate a resident's safety, coordinates care, and provides people resources to obtain basic life needs like food, housing, and medical care) indicated applications for a place Resident 1 could transfer or discharge to were waiting for approval. Resident 1 was not listed as an attendee at this meeting. No evidence of additional documentation regarding Resident 1's discharge could be located in Resident 1's medical record. A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 6/8/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation and judgment status of a resident) score of 15 which indicated intact cognition (the mental process of acquiring knowledge, and understanding through thought, experience and the senses). A further review of Resident 1's MDS indicated Resident 1 required a walker or wheelchair for mobility, needed supervision for toileting and tub/shower transfers and moderate/partial assistance (the helper completed less than half of task by either lifting, holding or supporting the trunk or limbs) for showering or bathing. During an interview on 7/29/26 at 8:48 a.m. in Resident 1's room, Resident 1 stated someone from the Social Services Department came into his room during the week of 7/20/26 and told him he was being discharged to a shelter in the Upper Northern California area. Resident 1 stated he was initially surprised to learn he was being discharged in two days. Resident 1 stated he had not requested a discharge and became fearful about being sent to a facility that did not provide 24-hour nursing care, explaining that nurses (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056090
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have administered his insulin twice a day. Resident 1 stated he was afraid he would fall, become ill, require hospitalization, or die if he was discharged to a setting that was unable to meet his medical needs. Most recently, Resident 1 stated he was told that because the facility was no longer a long-term care facility and he had no skilled nursing needs, a discharge to a lower level of care was appropriate. Resident 1 further stated he had not received any education on how to manage his diabetes through insulin administration and diet, both skills he would need to safely prepare himself to live in a lower level of care. Resident 1 denied having received a written notice of discharge prior to being informed he was being discharged. Resident 1 stated he spoke with someone from the shelter and was told the shelter could only provide a bed, a room, a shower, laundry services, and transportation to and from medical appointments. The shelter would not be able to provide assistance with insulin administration or assistance to shower or bathe. During an interview at the nurse's station on 7/29/26 at 9:13 a.m., Licensed Nurse 1 (LN 1) stated if Resident 1 were to be discharged, he would need medication education which included safe insulin injections, how to recognize the signs and symptoms of hyperglycemia (very high blood sugar levels) and hypoglycemia (very low blood sugar levels), and how to treat both of them. LN 1 stated a diabetic diet was a very important aspect of DM care, so a dietitian would likely need to be involved in part of the DM training as well. LN 1 stated the amount of resident education would require a minimum of one week of introduction, constant reinforcement, and persistent return demonstration to determine competency and safety with all medications and needles. During an interview on 7/29/26 at 12:49 p.m. in the Social Services Director's (SSD) office, the SSD stated that after the change in ownership, the facility's focus shifted to the care of short-term residents. As a result, she began working on transitioning long-term, stable residents whenever possible. The SSD explained there was no formal discharge meeting; instead, information about long-term residents was gathered during various other meetings to help her team understand potential discharge needs. The SSD acknowledged she did not document discharge planning processes or progress in the resident's medical record and instead tracked information on an internal document stored on her computer. The SSD further stated that the Social Services team informally met outside of structured care planning processes, and these discussions were not incorporated into, or documented in, residents' medical records or comprehensive care plans. This included any progress on individual discharge plans for residents. The SSD stated the shelter in Upper Northern California had an opening for Resident 1. Resident 1 had a phone interview with administration at that building on 7/21/26 and was accepted. Discharge to the shelter was planned for 7/23/26. During an interview in the Training Room on 7/29/26 at 1:29 p.m., the Assistant Director of Nursing (ADON) stated DM education required 48-72 hours at a minimum due to the complexity of the disease and the multiple important topics needing reinforcement and return demonstration of self-administration of insulin. The ADON stated time was needed to ensure the education stays with the resident. It is important for them to be safe at home. A review of the facility's job duties for the position of Social Worker, revised July 2024, indicated the social worker would Participate in the development of a resident centered care plan for each resident. Involve the resident/family in planning individualized objectives and goals for the resident. Ensure the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. A review of the facility's policy titled Discharge Planning and Transitions of Care, dated 1/14/26 indicated, The facility shall implement coordinated discharge planning and transitions of care processes to ensure safe, appropriate and person-centered transitions that meet each resident's medical, psychosocial and functional needs in accordance with federal and state regulations. Discharge planning shall be a collaborative, interdisciplinary process that includes the (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and/or the resident's representative. The interdisciplinary team shall assess each resident's potential discharge needs, including medical, functional, psychosocial and environmental considerations. Social Services shall assess psychosocial factors, support systems, preferences, and available community resources. Discharge planning information shall be incorporated into the resident's comprehensive care plan. Residents shall be informed of discharge options and actively involved in discharge planning decisions. Education shall be provided in a manner the resident can understand. Planned discharges shall be conducted in accordance with resident's rights, notice requirements, and facility policy. Social Services shall assist the residents and families in understanding the discharge processes and available appeal rights when applicable. All planned discharges shall be documented in the medical record. All discharge planning assessments, resident communications, referrals, coordination activities and transitions of care shall be documented accurately, timely and in accordance with facility documentation standards.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility's Social Services Department failed to provide the Ombudsman (an independent official who mediates disputes between residents and the facility) and one resident (Resident 1) of five sampled residents with the required written discharge notice when the Social Services Department informed Resident 1 that he was going to be discharged with two days notice.This failure led to Resident 1 experiencing fear from not understanding the reason for his discharge, not knowing where he was being discharged to, and the prevention of the Ombudsman from performing mandated oversight of Resident 1's right to be informed of his rights regarding the discharge process. Cross Reference F627Findings:During a phone interview on 7/28/26 at 10:01 a.m., the Ombudsman (OM) stated she did not receive a notice of discharge nor was contacted for any discharge planning for Resident 1. The OM stated she became aware of the attempted discharge after receiving a phone call from Resident 1's family member. The OM further stated the Administrator (ADM) and the Social Services Director (SSD) both stated they were unaware of the need to notify the OM's office during the discharge process.During an interview on 7/29/26 at 8:48 a.m. in Resident 1's room, Resident 1 stated someone from the Social Services Department came into his room during the week of 7/20/26 and told him he was being discharged to a shelter in the Upper Northern California area. Resident 1 stated he was initially surprised to learn he was being discharged in two days. Resident 1 denied receiving a written notice of discharge prior to being informed he was being discharged . During a review of Resident 1's electronic medical record, no evidence was found showing the facility issued a written discharge notice or any other required discharge documentation to Resident 1 or the Ombudsman.During an interview on 7/29/26 at 12:49 p.m. in the SSD's office, the SSD stated she was unaware written notices must be provided to both the resident and the Ombudsman at least 30 days prior to a discharge. The SSD admitted she had never issued written discharge notices and had not documented any discharge planning progress in the resident's medical record. The SSD stated discharge information was tracked informally on a spreadsheet stored on her personal computer and Social Services discussions regarding discharge occurred informally outside of structured care planning processes. These discussions were not incorporated into residents' care plans or records.During an interview on 7/29/26 at 2:55 p.m., the ADM acknowledged the SSD had not completed necessary tasks and documentation as per facility policy regarding discharge processes. A review of the facility's policy titled Discharge Planning and Transitions of Care dated 1/14/26, indicated, The purpose of the Social Services Manual is to establish standardized policies and procedures that ensure residents receive.support consistent with applicable federal.regulations.It is the responsibility of representatives of the social services department to ensure appropriate discharge planning and transitions of care processes remain in place.Planned discharges shall be conducted in accordance with resident's rights, notice requirements, and facility policy. Social Services shall assist the residents and families in understanding the discharge processes and available appeal rights when applicable. All planned discharges shall be documented in the medical record. All discharge planning assessments, resident communications, referrals, coordination activities and transitions of care shall be documented accurately, timely and in accordance with facility documentation standards.		