

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

Printed: 07/18/2026
Form Approved OMB
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 11/25/2025
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents' rights to confidentiality for a census of 142 residents, when residents' meal tickets containing personal and medical information were found in a kitchen trash can. This failure decreased the facility's potential to protect the residents' personal details and health information. Findings: During a concurrent observation and interview on 9/22/25 at 9:29 a.m. with the Dietary Services Supervisor (DSS) in the kitchen, a dietary aide was scraping food off breakfast plates into a large trash can. Numerous resident meal tickets were found in the trash can along with discarded food. Trash bags were then tossed into an unsecured dumpster behind the building. DSS stated the kitchen team had always discarded the meal tickets in the trash along with uneaten food, and this had been their practice for over a year. DSS also stated she was not aware that resident meal tickets' confidential information needed to be protected, nor was she familiar with the method of shredding meal tickets. DSS further stated this was a privacy issue for the residents and a violation of the Health Insurance Portability and Accountability Act (HIPAA - a U.S. federal law that sets national standards for the privacy and security of health information). During an interview on 9/25/25 at 10:27 a.m. with the Registered Dietician (RD), RD stated the practice of throwing out residents' meal tickets in the trash was a HIPAA violation on multiple counts, and the meal tickets should have been put through a paper shredder to protect residents' private information. A review of the facility's policy titled, Resident Rights, revised February 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . privacy and confidentiality. A review of the facility's policy titled, Confidentiality of Information and Personal Privacy, revised October 2017, indicated, The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records . Access to resident personal and medical records will be limited to authorized staff and business associates.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their medication storage policy and procedure (P&P) for a census of 142 residents, when multiple medications were not labeled and stored in a safe manner. This failure decreased the facility's potential to prevent unsafe medication administration to residents. Findings: During a concurrent observation and interview on [DATE] at 10 a.m. with Licensed Nurse 1 (LN 1), medication cart 2A was observed. The following findings were identified and confirmed by LN 1: 1. Budesonide inhaler (an inhaled respiratory medication) was found open with no open date; 2. Fluticasone/salmeterol Diskus (an inhaled respiratory medication) and a decongestant nasal spray were found with resident information on outer packaging only, not on the actual product; 3. Beclomethasone inhaler (an inhaled respiratory medication) was found with an expiration date of 8/25 and only a room number written on it; and 4. An unidentified peach oval shaped tablet was found loose in a drawer. During an interview on [DATE] at 9 am with the Director of Nursing (DON), DON stated she was aware of the labeling problems and expired inhaler and that was not her expectation. DON further stated expired non-controlled medications should have been placed in the white bins in the medication room, logged and destroyed. A review of the facility's P&P titled, Medication ordering and receiving from Pharmacy, Medication Labels, revised 1/18, indicated the Resident's name, at least, must be maintained directly on the actual product container and that resident specific non-prescription medications must be kept in the original container and identified with the resident's name. A review of the facility's P&P titled, Disposal of Medications and Medication- related Supplies, Medication Destruction for Non-Controlled Medications, revised 1/18, indicated unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to follow the recipe for a pureed diet (consists of foods that have been blended or mashed to a smooth, pudding-like consistency) for nine residents of a census of 142, when [NAME] 1 (C 1) did not add the correct amount of bread slices and broth cups while preparing pureed lunch for residents. This failure decreased the facility's potential to serve the right food consistency to residents with specific nutritional needs and dysphagia (difficulty swallowing). Findings: A review of the facility's menu, dated 9/24/25, indicated the lunch menu consisted of smothered pork chop, whipped potatoes, mixed vegetables, bread or roll with margarine, and lemon chiffon dessert. A review of the facility's recipe titled, Pureed Bread or Roll and Margarine (Pureed Diet Level 4 [PU4- a specialized dietary modification designed for individuals with severe dysphagia]), dated 2025, indicated the amount of white bread slices to add for 15 servings was seven and a half slices. A review of the facility's recipe titled, Pureed Smothered Pork Chop (PU4), dated 2025, indicated the amount of broth to add to 15 servings was one and a half cups. During a concurrent observation and interview on 9/24/25 at 10:30 a.m. with C 1 and the Dietary Services Supervisor (DSS), C 1 began preparing hot lunch items for residents with pureed diets. C 1 stated she was making 14 servings of the pureed food items. C 1 put 14 slices of white bread in a blender, followed by warm milk, and pureed it. C 1 then put 15 boneless pork chops into a food processor and added four cups of beef broth and pureed the mixture. The mixture was watery and sloshed around in its container when C 1 was handling it. C 1 stated she had finished making the pureed pork chop mixture and confirmed she did not follow the recipe. During a concurrent interview and record review on 9/24/25 at 11:03 a.m. with DSS, DSS confirmed C 1 did not follow the pureed recipe for the lunch meal. DSS stated because C 1 did not follow the recipe, residents might not receive the recommended daily allowance (RDA - the average daily intake level of nutrients sufficient to meet a person's dietary requirements) of nutrients they need, which could damage their health. DSS further stated watered down foods could lead to weight loss in vulnerable residents. A review of the facility's job description titled, Dietary Services-Head Cook, dated 2003, indicated one of the cook's responsibilities was to Prepare food for therapeutic diets in accordance with planned menus . Prepare food in accordance with standardized recipes and special diet orders. A review of the facility's dietary manual titled, Long Term Care Diet Manual - Pureed Diet, dated 2022, indicated, Weigh or measure the number of . portions required for the standardized recipe . Add measured amounts of hot liquid for cooked foods . and process until a smooth consistency is achieved.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to accommodate five residents' (Resident 119, Resident 14, Resident 43, Resident 44, and Resident 129) food allergies, intolerances, and preferences for a census of 142, when: 1. Resident 119 had lactose allergy and was served mashed potatoes with sour cream; and 2. Resident 14, Resident 43, Resident 44, and Resident 129's food preferences were not served as indicated on their meal tray tickets. These failures increased the residents' potential to sustain an allergic reaction and unmet nutritional needs. Findings: 1. A review of an admission record indicated Resident 119 was admitted to the facility in July 2022 with a diagnosis of lactose allergy. A review of Resident 119's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/4/25, indicated Resident 119 was cognitively intact. During an observation on 9/24/25 at 10:30 a.m., Prep [NAME] 1 (PC1) was preparing mashed potatoes per the facility's recipe which included sour cream. A review of the facility's recipe for mashed potatoes, dated 2025, indicated the recipe was not intended for residents with lactose allergy. During a concurrent observation and interview on 9/24/25 at 12:53 p.m. with the Dietary Services Supervisor (DSS), lunch tray line was observed. Resident 119 was served mashed potatoes. Resident 119's tray ticket indicated lactose allergy. DSS confirmed Resident 119 was plated mashed potatoes with sour cream and stated the followed recipe was not recommended to residents with lactose allergy. DSS further stated the mashed potatoes with sour cream should have not been plated and served to Resident 119. During an interview on 9/25/25 at 8:34 a.m. with Resident 119, Resident 119 stated if she ate foods containing lactose, her lips will double in size, she will get blisters in her mouth, and her throat will close up. During an interview on 9/25/25 at 9:48 a.m. with the Director of Nursing (DON), DON stated it would have been a problem if Resident 119 ate the food she was allergic to which might significantly affect her health. 2. During an observation of the lunch tray line on 9/24/25 at 12:06 p.m., four residents were not served their requested food items: - Resident 14's tray had no fruit and meal ticket indicated she requested fruit with her meal; - Resident 43's tray had no soup and meal ticket indicated she requested soup with her meal; - Resident 44's tray had one portion of protein and meal ticket indicated he requested double portions of protein with his meal; and - Resident 129's tray had no fruit and meal ticket indicated she requested fruit with every meal. During an interview on 9/24/25 at 2 p.m. with the DSS, DSS confirmed there were discrepancies in the four residents' plated foods and expected the cooks to follow the tray tickets' written requests during tray line. DSS stated meal ticket requests were not followed. DSS further stated it was important to serve residents the food they liked to eat because good nutrition might improve their overall quality of life. During an interview on 9/25/25 at 9:48 a.m. with DON, DON stated it could potentially be a problem if residents were not served food they like. DON further stated residents could potentially not eat the food served to them which could negatively affect their health and nutrition. A review of the facility's policy and procedure titled, Allergies and Intolerances, revised 8/17, indicated, Residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen(s).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to properly prepare and store food for a census of 142 residents, when:1. Food items were found undated, unlabeled, unsealed and expired;2. Food bins were stored on a corroded metal shelf;3. One cutting board had brown stains, another contained a sticky substance, one frying pan had an oily substance and brown residue on the inside, a steam warmer tray had brown residue on the outside;4. Two insect control machines were placed on walls above a food preparation area and a toaster;5. The inside of a ceiling ventilation fan had a thick, black substance; and6. The second step of the cool down log for cooked food items was incomplete from June to September 2025. These failures increased the facility's potential to serve contaminated food and cause foodborne illnesses among vulnerable residents. Findings:1. During a concurrent observation and interview on 9/22/25 at 9:04 a.m. with the Dietary Services Supervisor (DSS), the following items were found:- In the reach-in refrigerator: a container of fresh minced garlic with an expiration date of 9/21/25, an open jar of pickle relish with an expiration date of 9/18/25, and an unsealed bag of parsley containing yellowing sprigs with an open date of 9/8/25 and no expiration date.- In the dry goods storage room: multiple packages of open and unopened bread items were found unlabeled and undated. DSS stated expired bread could be moldy and served to residents, causing gastrointestinal problems.- In the walk-in refrigerator: sliced ham with use by date of 9/20/25. DSS confirmed the ham was past its expiration date and stated residents could get foodborne illnesses if they ingested the lunch meat. During a concurrent observation and interview on 9/23/25 at 8:41 a.m. with DSS, chopped parsley with yellow leaves was being prepared for the day's lunch. DSS ascertained it was the same parsley with an open date of 9/8/25 and it had not been removed from the reach-in refrigerator the day prior.2. During a concurrent observation and interview on 9/22/25 at 8:52 a.m. with DSS, a metal storage shelf housing plastic food bins had a reddish-brown substance on its bottom rack. DSS stated the material on the shelf looked like rust and it was inappropriate to store food bins there.3. During a concurrent observation and interview on 9/22/25 at 8:55 a.m. with DSS, a green cutting board was found to have several brown stains, and a blue cutting board had a sticky substance approximately 3 x 8 inches (a unit of measure) in area. DSS confirmed the presence of the stains and sticky residue and stated the cutting boards should not be used for food preparation due to the possibility of food contamination. During a concurrent observation and interview on 9/23/25 at 8:35 a.m. with DSS, a frying pan was found with an oily substance near the rim, in addition to a hard brown residue inside the pan. DSS confirmed the oily substance was cooking oil and stated it was no longer safe to use the pan. A steamer food tray was also found with two small areas of brown residue. DSS stated the brown residue in the frying pan and steamer tray could be dried on food.4. During a concurrent observation and interview on 9/22/25 at 9:39 a.m. with DSS, two electric insect control machines were found affixed to walls, one over a food preparation area, the other over a toaster. DSS stated placing the insect control systems above food preparation areas was problematic because flies could fall from the machines onto food surfaces.5. During a concurrent observation and interview on 9/22/25 at 9:25 a.m. with DSS, a ceiling ventilation fan with a thick layer of black substance on the inner casing and fan blades was found over a food preparation area. DSS stated the maintenance department was supposed to clean the fan on a scheduled basis and noted this fan was very dirty.6. During a concurrent interview and record review on 9/22/25 at 9:56 a.m. with DSS and Kitchen Supervisor (KS), the cool down logs (a record showing monitoring of temperatures during a two-step cooling process of hot foods prepared in advance) were not completed for June 2025 - September 2025. DSS acknowledged the log should have been filled out completely to reflect accurate cool down techniques. KS stated the dietary aides who filled out the log should have taken the food temperature during the second step to ensure a proper cool down technique, thereby keeping food safe and averting foodborne illness in residents. KS further stated if the food items were not at the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct temperatures, the food would need to be thrown away immediately. During an interview on 9/22/25 at 2:41 p.m. with Dietary Aide 2 (DA 2) and DSS, DA 2 explained he was not aware that the temperature should have been taken a final time during the second step of the process. DSS stated it was her duty to monitor the cool down log daily to ensure staff were correctly practicing the cool down method and since she was not aware of the full process of the cool down procedure's second step, the blank log entries of the missed step were unnoticed. DSS further stated food which had not been cooled down properly would possibly harbor toxic germs which could harm residents' health. During an interview on 9/25/25 at 10:27 a.m. with the Registered Dietician (RD), RD stated having unlabeled, undated, and expired kitchen food was considered unsafe. RD expressed concern about using oily or stained food preparation devices or rusty storage equipment due to possible food contamination. RD also stated dead insects could fall out of the wall-mounted insect control machines, and since they were above food preparation areas, they exposed the residents to unnecessary risks. RD further stated all kitchen staff should know the importance of documenting temperatures of the second step of the cool down process and all these issues could result in serious foodborne illnesses for many residents. A review of the facility's policy and procedure (P&P) titled, Food Preparation and Service, revised 2022, indicated, Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Cross-contamination can occur when harmful substances, i.e. chemicals or disease-causing organisms are transferred to food. A review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, indicated, All shelves and storage racks or platforms should be in accordance with state and federal regulations. Labels should be visible. All food will be dated - month, day, year. P&P further indicated, Food in unlabeled, rusty, leaking, broken containers or cans. shall not be retained or used. A review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines within this section. A review of the facility's document titled, Storing Produce, dated 2023, indicated, When storing vegetables that should remain crisp, such as fresh herbs. they will stay fresher longer if [placed] in a sealed bag or container. A review of the facility's guide titled, Dry Goods Storage, dated 2023, indicated opened or unopened bread should be stored 5-7 days. A review of the facility's guide titled, Refrigerated Storage, dated 2023, indicated luncheon ham should be stored in the refrigerator 5 days before discarding. A review of the facility's guide titled, Produce Storage, dated 2023, indicated parsley should be stored in the refrigerator for 2-3 days and diced garlic should be kept 3 days. A review of the facility's policy titled, Pot and Pan Washing, dated 2023, indicated, Pots and pans will be properly sanitized. A review of the facility's procedure titled, Shelves, Counters, and Other Surfaces, dated 2023, indicated, Remove any large debris. A review of the facility's document titled, Hoods, Filters, and Vents, dated 2023, indicated, Vents must be free of dust and dirt. A review of the facility's P&P titled, Cooling and Reheating of Potentially Hazardous Food (PHF): the Two Stage Method, dated 2023, indicated, When cooked PHF food will not be served right away it must be cooled as quickly as possible. P&P also indicated, Cool cooked food from 140 F [degrees Fahrenheit; a unit of measure] to 70 F within two hours. Then cool from 70 F to 41 F or less in an additional four hours for a total cooling time of six hours. When writing in the cool down log, staff are to, Note menu item, date, temperature, and cook's initials on the cool down log used. P&P further indicated corrective action to be taken when the cool down procedure is performed incorrectly: Discard cooked hot food immediately when the food is: above 70 F and more than 2 hours into the cooling process, or above 41 F and more than 6 hours into the cooling process.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented for a census of 142 residents, when:1. Two washing machines in the behavioral unit were found closed while not in use with moisture inside and the washing machine in station B had black spots around the door seal;2. Licensed Nurse 2 (LN 2) did not perform proper hand hygiene prior to medication preparation; and3. Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce the spread of multidrug-resistant organisms [MDRO]) were not followed for Resident 5, Resident 135, and Resident 4.These failures had the potential to spread infection among residents, staff, and visitors.Findings: 1.During a concurrent observation and interview on 9/25/25 at 9:05 a.m. with Director of Environmental Services (DES) in station A's laundry room in the behavioral unit, the washing machine was found not in use with the door closed and with visible moisture inside the washer. DES confirmed the washer was closed with moisture inside and stated staff were supposed to leave the washing machine door open after use for infection prevention and to prevent the washing machine from acquiring a smell. During a concurrent observation and interview on 9/25/25 at 9:11 a.m. with DES in station B's laundry room in behavioral unit, the washing machine was found not in use with the door closed, with visible moisture inside the washer, and with black spots around the door seal. DES confirmed the washing machine was closed, with visible moisture and with black spots. DES stated the black spots were mold. DES further stated the residents' washed clothes in the washing machine would not be considered clean and mold could affect the residents' health. During an interview on 9/25/25 at 10:09 a.m. with Infection Preventionist (IP), IP stated closing the washing machines with moisture inside while not in use could cause bacteria build-up and could contaminate the residents' clothes. A review of the facility's policy titled, Departmental (Environmental Services) & Laundry and Linen, revised January 2014, indicated, Leave washing machine doors open when not in use . 2.During an observation on 9/23/25 at 8:10 a.m., LN 2 blew his nose using a tissue paper and proceeded to prepare medications without performing hand hygiene. During an interview on 9/23/25 at 10 a.m. with LN 2, LN 2 confirmed that he forgot to perform hand hygiene after blowing his nose and before preparing medications. During an interview on 9/25/25 at 10 a.m. with the Director of Nursing (DON), DON stated nurses should perform proper hand hygiene to prevent the spread of infections and protect residents. A review of the facility's policy titled, Handwashing/Hand Hygiene, revised in 2023, indicated, This facility considers hand hygiene the primary means to prevent spread of healthcare-associated infection . All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3.A review of Resident 5's admission record, indicated Resident 5 was admitted to the facility in July 2025. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 5's Order Listing Report, dated 9/25/25, indicated Resident 5 was on EBP for left foot wound and urinary catheter (a small, flexible tube that is inserted into the bladder to drain urine) and staff to wear personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing care for Resident 5. During an observation on 9/22/25 at 9:38 a.m. outside Resident 5's room, two staff members entered Resident 5's room wearing gloves without a gown. During an interview on 9/22/25 at 9:40 a.m. with Wound Nurse (WN), WN stated she was in Resident 5's room with Physician Assistant (PA) to assess Resident 5's wound. A review of Resident 135's admission Record, indicated Resident 135 was admitted to the facility in August 2025. A review of Resident 135's Order Listing Report, dated 9/25/25, indicated Resident 135 was on EBP for left heel blister (a small, fluid-filled sac that forms on the outer layer of the skin) and staff to wear PPE when providing care for Resident 135. During an observation on 9/22/25 at 9:47 a.m. in Resident 135's room, PA entered the room wearing gloves. PA then removed Resident 135's dressing on the left foot and told Resident 135 a wound debridement (removal of dead or damaged tissue and foreign objects from a wound to promote healing) was needed. During an observation on 9/22/25 at 9:49 a.m. in Resident 135's room, PA was performing wound debridement on Resident 135's left heel. WN was assisting PA by holding Resident 135's leg. Both PA and WN were observed without a gown. During an interview on 9/22/25 at 9:52 a.m. with WN, WN stated she performed the wound dressing on Resident 135's left foot and PA did the wound debridement. During an interview on 9/24/25 at 4:13 p.m. with IP, IP stated PA and WN should have worn a gown and gloves when they assessed Resident 5's wound and when they debrided and dressed Resident 135's wound. IP further stated it was her expectation for staff to follow EBP to prevent the residents from acquiring infection and to prevent the spread of infection among residents and staff. A review of Resident 4's admission Record, indicated Resident 4 was admitted to the facility in April 2025 with a diagnosis of gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During an observation on 9/23/25 at 8:53 a.m., Certified Nursing Assistant 1 (CNA 1) was observed changing the linens on Resident 4's bed. CNA 1 was wearing gloves but no gown. An EBP sign was observed on Resident 4's open door. During an interview on 9/23/25 at 8:54 a.m. with CNA 1, CNA 1 confirmed Resident 4 was on EBP and stated she was not wearing a gown while changing the linens and should have been. CNA 1 further stated it was important to follow EBP precautions to protect the residents from spread of infection. During an interview on 9/25/25 at 8:16 a.m. with DON, DON stated it was her expectation for staff to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow EBP to prevent the spread of infection and for resident safety. DON further stated a gown and gloves should be worn for any personal care for residents with a G-tube. A review of Resident 4's care plan, dated 4/21/25, indicated, Resident [4] on Enhanced Barrier Precautions (EBP) . wear gown and gloves for high contact resident care activities such as . changing linens. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated August 2022, indicated, EBPs employ targeted gown and glove use during high contact resident care activities . examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . changing linens . EBPs are indicated . for residents with . indwelling medical devices [e.g. urinary catheter] regardless of MDRO colonization .		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call systems (an electronic communication network that allows residents to alert staff when they need assistance) were provided for 46 residents out of a census of 142, when the residents' rooms and bathrooms in the behavioral unit (a specialized area that provides focused care for residents who have mental health disorders, substance use disorders, or complex behaviors) were found without a functioning call system. This failure decreased the facility's potential to maintain residents' safety. Findings: A review of Resident 102's admission Record, indicated Resident 102 was admitted to the facility in February 2025 with a diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 102's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/13/25, indicated Resident 102'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) score was 14 out of 15 with good memory. During a concurrent observation and interview on 9/22/25 at 10:25 a.m. with Resident 102, no call button was observed in the room. Resident 102 confirmed there was no call button in the room and stated if he needed help, he would go to the nurses' station to ask for help. A review of Resident 105's admission Record, indicated Resident 105 was admitted to the facility in May 2024 with a diagnosis of bipolar type schizoaffective disorder (a chronic mental condition where a person experiences symptoms of both schizophrenia and a mood disorder simultaneously). A review of Resident 105's MDS, dated [DATE], indicated Resident 105's BIMS score was 15 out of 15 with no memory impairment. During a concurrent observation and interview on 9/22/25 at 1:09 p.m. with Resident 105, no call button was observed in the room. Resident 105 confirmed there was no call button in the room and stated he would make a noise, bang the wall, and yell for help if he needed help. During an interview on 9/23/25 at 11:48 a.m. with the Psychiatric Technician 1 (PT 1), PT 1 confirmed residents' rooms and bathrooms in the behavioral unit did not have a call system and stated the call system in the unit had not worked for years. During an interview on 9/24/25 at 2:58 p.m. with the Program Director (PD), PD confirmed behavioral unit did not have a call system and stated it was important to have a call system to add a level of safety for the residents. A review of the facility's policy titled, Call System, Residents, dated September 2022, indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor . The resident call system remains functional at all times .		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure two of 31 sampled residents (Resident 28 and Resident 140) were free from abuse, when both residents were subjected to offensive language and profanity during an argument as witnessed by staff. This failure decreased the facility's potential to maintain Resident 28's and Resident 140's highest practicable physical, mental, and psychosocial well-being. Findings: A review of an admission record indicated Resident 28 was admitted to the facility in December 2024 with a diagnosis of recurrent depressive disorder. A review of Resident 28's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/16/25, indicated Resident 28 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 with intact cognition. A review of an admission record indicated Resident 140 was admitted to the facility in February 2024 with a diagnosis of adjustment disorder (behavioral reaction to a stressful life event leading to impairment in daily functioning) with depressed mood. A review of Resident 140's MDS, dated [DATE], indicated a BIMS score of 14 out of 15 with no memory impairment. During an observation on 9/22/25 at 2 p.m. by station 1, Resident 140 was seen talking with a staff member about a disagreement with her roommate over a television remote. Resident 28's visiting son was also observed requesting staff to address Resident 140's accusation against Resident 28 being a thief. During an interview on 9/24/25 at 2:10 p.m. with Licensed Nurse 5 (LN 5), LN 5 stated on 9/22/25 around 2:15 p.m. she observed Resident 140 outside her room verbally upset with her roommate. LN 5 attempted to calm Resident 140 who insisted on returning to her room. LN 5 confirmed that once inside the room, Resident 140 expressed her frustration by saying Assholes . fuck you both directed at Resident 28 and Resident 28's visiting son. During an interview on 9/24/25 at 2:20 p.m. with the Director of Staff Development (DSD), DSD stated on 9/22/25 around 2:30 p.m., Resident 28's son was visiting and got angry with Resident 140, when Resident 140 called Resident 28 (his mom) a thief. DSD stated Resident 28's son told Resident 140 I'm going to kick your ass and Fuck you. During an interview on 9/24/25 at 3:30 p.m. with the Administrator (ADM), ADM confirmed the verbal altercation between the two residents and Resident 28's son and stated abusive behaviors of residents and visitors were not tolerated. ADM acknowledged the facility's responsibility to make sure residents feel protected, safe and secure while at the facility. A review of the facility's policy titled, Abuse Prevention Program, revised in 2016, indicated, . residents had the right to be free from abuse . protect the residents from abuse by anyone including staff and other residents.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess the nutritional status for one of 31 sampled residents (Resident 127), when a Minimum Data Set (MDS; an assessment tool) quarterly review indicated Resident 127 had no weight loss. This failure decreased the facility's potential to identify Resident 127's severe weight loss. Findings: A review of an admission record indicated Resident 127 was admitted to the facility in December 2016 with a diagnosis of type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During an observation on 9/22/25 at 9:59 a.m. in Resident 127's room, Resident 127 was observed lying in bed on his side facing away from an untouched meal tray. A review of Resident 127's medical record (MR), indicated Resident 127's weight was 193.8 pounds (a unit of measure) on 1/1/25 with a severe weight loss of 16.82 percent (%; a unit of measure) in six months. MR further indicated Resident 127's weight was 171.2 pounds on 6/15/25 and 161.2 pounds on 7/15/25 with a severe weight loss of 5.84 % in one month. A review of Resident 127's MDS, dated [DATE], indicated Resident 127 had no Weight Loss . Loss of 5% or more in the last month or loss of 10% or more in the last 6 months. During a concurrent interview and record review on 9/24/25 at 3:01 p.m. with Dietary Services Supervisor (DSS), Resident 127's MDS, dated [DATE], was reviewed. DSS stated she did not complete Resident 127's assessment accurately and she should have answered Yes to weight loss. DSS further stated without an accurate assessment, Resident 127's care plan was not updated accordingly and Resident 127 could continue to lose weight without it being caught. During an interview on 9/25/25 at 8:16 a.m. with Director of Nursing (DON), DON stated it was important to complete the MDS assessment as accurately as possible because it was a tool used for resident care planning. During a concurrent interview and record review on 9/25/25 at 8:53 a.m. with the MDS Coordinator (MDSC), Resident 127's MR and MDS were reviewed. MDSC confirmed Resident 127's MDS, dated [DATE], was marked No for weight loss and stated it was important to complete the MDS assessment accurately because MDS was used for care planning. MDSC further stated an inaccurate weight loss MDS assessment might not trigger a Care Area Assessment (CAA) notifying the facility to update Resident 127's care plan. A review of the facility's policy and procedure (P&P) titled, Comprehensive Assessment and the Care Delivery Process, dated December 2016, indicated, Comprehensive assessments will be conducted to assist in developing person-centered care plans. A review of the facility's P&P titled, Resident Assessments, dated March 2022, indicated, All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.		

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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. Based on observation, interview, and record review, the facility failed to ensure professional standards of care were followed for enteral feeding and medication administration for one of 31 sampled residents (Resident 132), when:1. Resident 132's physician's order for enteral (involving or passing through the intestine, either naturally via the mouth and esophagus, or through an artificial opening) feeding was incomplete, without start and stop times, and lacked medication administration and flushing instructions; and2. Licensed Nurse 3 (LN 3) did not follow the facility's policy during medication administration through a gastrostomy tube (G-tube; a surgical opening fitted with a device to allow feedings to be administered directly into the stomach, common for people with swallowing problems).This failure increased Resident 132's risk for inconsistent enteral feeding times, increased residual, and potential tube clogging.Findings:A review of Resident 132's admission Record, indicated Resident 132 was admitted to the facility in October 2012 with diagnoses including enterocolitis due to Clostridium difficile (a condition where the bacteria, often triggered by antibiotic use, infects and inflames the colon and small intestine), acute gastric ulcer with hemorrhage (a break in the lining of the stomach that causes bleeding) and aphasia (a disorder that makes it difficult to speak) following a stroke.1.A review of Resident 132's Order Listing Report, dated 8/25/25, indicated Resident 132 was on enteral feeding at 60 milliliters (ml- a unit of measurement) per hour for 20 hours per day and tube feeding could be stopped for activities of daily life and other resident activities. The report did not indicate the start or stop times for Resident 132's feeding and did not provide instructions for medication administration or flushing.2. During an observation on 9/23/25 at 8:20 a.m. in Resident 132's room, LN 3 was observed administering medications through Resident 132's G-tube using cool tap water measuring 30 ml to dilute each crushed medication prior to medication administration, between medications, and after the last medication was delivered.During a concurrent interview and record review on 9/23/25 at 3 p.m. with LN 3 the facility's policy for proper administration of medications through a G-tube was reviewed. LN 3 confirmed he did not follow the facility's policy when he flushed Resident 132's G-tube with 30 ml of cool tap water in between medications which can lead to complications.During an interview on 9/25/25 at 9 a.m. with the Director of Nursing (DON), DON stated she expected enteral orders to be personalized and include type, rate of administration, stop and start times, and flushing or other specific instructions. DON also stated if flushing was not specified, then the nurse should have followed the facility's policy. DON further stated an incomplete order could result in excess volume or if too little it could clog or slow tubing.A review of the facility's policy and procedure titled, Administering Medications through an Enteral Tube, revised in 11/18, indicated tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing, to use warm purified water for diluting medications and for flushing, and to use 15 ml between medications and 15 ml again when the last medication begins to drain from the tubing.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an enteral feeding (a method of providing nutrition directly into the stomach through a surgically placed tube) was administered as per physician's order for one of 31 sampled residents (Resident 33), when Resident 33's feeding pump was observed off during scheduled feeding times. This failure increased Resident 33's potential for malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and dehydration (occurs when the body uses or loses more fluid than it takes in). Findings: A review of Resident 33's admission record indicated he was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and a gastrostomy tube (g-tube, a device to allow feedings to be administered directly to the stomach, common for people with swallowing problems). During an observation on 9/23/25 at 9:24 a.m. with Resident 33 in his room, Resident 33's tube feeding pump was turned off, and the feeding tube was detached from Resident 33's g-tube and wrapped around the pump. A review of Resident 33's Enteral Feed Order, dated 10/7/24, indicated a strict NPO [not by mouth] diet with tube feeding 18 hours a day on and six hours off, totaling 1530 cubic centimeter (a unit of measure) of feeding to run 4 p.m. to 10 a.m. During an interview on 9/23/25 at 10:12 a.m. with Licensed Nurse 2 (LN2), LN2 stated, this was me. I did not turn it back on after I gave meds. I gave meds around 8:20 am; Resident will be missing 1 hour 40 minutes of his feeding. LN2 stated the potential impact of missing the feeding was Resident 33 might had malnutrition and dehydration. During an interview on 9/25/25 at 9:40 a.m. with the Director of Nursing (DON), DON stated, This is not good. DON further stated missing the enteral feeding could have a negative effect on Resident 33's health and nutrition. A review of the facility's policy and procedure titled, Administering Medications through an Enteral Tube, revised November 2018, indicated, when medication administration is complete . reconnect to feeding formula.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care services according to professional standards of quality for one of 31 sampled residents (Resident 28), when Resident 28's administered oxygen was not consistent with the physician's order. This failure decreased the facility's potential to follow the physician's order when providing respiratory services. Findings: A review of an admission record indicated Resident 28 was admitted to the facility in December 2024 with a diagnosis of chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). A review of Resident 28's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/16/25, indicated Resident 28 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 with intact cognition. During a concurrent observation and interview on 9/22/25 at 10:33 a.m. with Resident 28, Resident 28 was observed in bed receiving oxygen at 2.5 liters per minute (L/min, unit of measurement) via nasal cannula. Resident 28 stated she needed more oxygen than the delivered amount and typically she required three L/min. During a concurrent interview and record review on 9/22/25 at 3 p.m. with Licensed Nurse 6 (LN 6), Resident 28's Order Summary Report was reviewed. LN 6 stated Resident 28 had been using oxygen continuously at two L/min since admission. LN 6 further stated she could not find Resident 28's oxygen order. A review of Resident 28's hospital transfer orders, dated 12/18/24, indicated an order for oxygen at three L/min continuous for COPD. During an interview on 9/25/25 at 10 a.m. with the Director of Nursing (DON), DON stated nurses should follow the doctor's order to safely provide care to residents and to prevent health complications. A review of the facility's policy titled, Oxygen Administration, revised in 2010, indicated, . for safe oxygen administration . verify that there is a physician's order . review the physician's order . adjust oxygen delivery . so that it is comfortable for the resident and the proper flow of oxygen is being administered . observe the resident upon set-up and periodically thereafter to be sure oxygen is being tolerated. A review of the facility's policy titled, Medication and Treatment Orders, revised in 2016, indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure accurate documentation, disposition, and storage of controlled medications for one of 31 sampled residents (Resident 135), when: 1. Resident 135's controlled drug was found in a sealed plastic bag stored inside a general medication drawer in the medication cart; and 2. Resident 135's Controlled Drug Record (CDR-a paper log of controlled drug removal for administration to residents) did not match the actual medication count. These failures had the potential to contribute to unsafe controlled medication handling and/or risk of controlled drug diversion. Findings: 1. A review of Resident 135's admission record indicated she was admitted to the facility on 8/25 with diagnoses including closed fracture (break in the bone) and an anxiety disorder. A review of Resident 135's Order Listing Report, dated 9/25/25, indicated an order for clonazepam (a controlled medication for anxiety) 0.5 milligrams (mg- a unit of measurement), give two tablets one time a day and one tablet at bedtime. During a concurrent observation and interview on 9/24/25 at 10 a.m. with Licensed Nurse 1 (LN1), Medication cart-2A was inspected. A sealed plastic bag full of medications for Resident 135 was found in the general medication compartment. A bottle of clonazepam 0.5 mg was found inside the sealed plastic bag. LN 1 stated the bag of medications was brought in by Resident 135 on admission and should have been locked with other controlled medications. 2. During a concurrent observation, interview, and record review on 9/24/25 at 10 a.m. with LN 1, the controlled medication compartment was inspected, and the CDR was reviewed. Resident 135's bubble pack of clonazepam 0.5 mg was checked with a count of eight, and the CDR indicated the tablet count was 10. LN 1 confirmed the actual count of tablets in the bubble pack and stated the count on the CDR did not match with the bubble pack. During an interview on 9/25/25 at 9 a.m. with the Director of Nursing (DON), DON stated nurses should have created a CDR when a controlled medication was received, then should have reconciled and signed out the medication when passing it and at shift change. DON further stated her expectation was the CDR should have matched the actual medication count and controlled medications should have been in a locked drawer that only nurses had access to. A review of the facility's policy and procedure titled, Controlled Substances, revised on 4/19, indicated controlled substances are stored in a locked container, separate from containers for any non-controlled medications and should be reconciled upon receipt, administration, disposition, and at the end of shift.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose garbage for a census of 142 residents, when a kitchen garbage dumpster was found to have two warped lids. This failure had the potential to produce unsanitary conditions for residents due to easy access for rodents and other pests. Findings: During a concurrent observation and interview on 9/22/25 at 9:17 a.m. with the Maintenance Director (MD) at the kitchen dumpsters, one garbage dumpster's lids were separated at the midline, leaving a one inch (a unit of measure) gap between the lids. Three flies were hovering at the gap. MD stated it was a pest problem because insects and rodents could access the dumpster. A review of the facility's document titled, Garbage and Trash, dated 2023, indicated, Adequate, clean, vermin-proof areas must be provided for storage of garbage . and that the lids are closed.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain record of Coronavirus disease 2019 (COVID-19) vaccination status for one of two sampled staff (Certified Nursing Assistant 2; CNA 2), when CNA 2 was not provided an education regarding COVID-19 vaccination and the refusal of the vaccine was not documented. This failure decreased the facility's potential to assess staffs' vaccination status against infectious disease. Findings: During a concurrent interview and record review on 9/25/25 at 11:02 a.m. with Director of Staff Development (DSD), CNA 2's employee record was reviewed. DSD confirmed CNA 2 did not have COVID-19 vaccination record on file. DSD stated COVID-19 vaccine was offered to CNA 2 and CNA 2 declined. DSD further stated education regarding COVID-19 vaccination was not provided and CNA 2's refusal of vaccine was not documented. A review of the facility's policy titled, Employee Infection and Vaccination Status, revised January 2024, indicated, Employees are provided with educational materials to make informed decisions for . vaccinations. If declined, a declination form is completed and placed in the employee's health record .		