STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Rock Creek Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Racetrack Street Auburn, CA 95603	

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 interview and record review, the facility failed to ensure the transfer and discharge was appropriate for one of three sampled residents (Resident 1), when the resident was not provided with the required discharge notices when transferred to the hospital and was not permitted to return to the facility.This failure resulted in Resident 1's unnecessary admission in the hospital with no information on resident rights or how to file an appeal to remain in the skilled nursing facility (SNF), and had the potential risk of not attaining Resident 1's highest practicable physical, mental and psychosocial well-being.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in March 2026 with diagnoses which included unspecified sequelae of cerebral infarction (long-term complications that persist after a stroke which include cognitive challenges and emotional changes) and anxiety disorder (persistent, excessive fear or worry that interferes with daily life, functioning, and relationships).A review of the facility's Bed Hold Policy and Notification (BHPN), provided to Resident 1 upon admission, dated on 3/28/26, indicated, It is the policy of this facility to provide any resident that is transferred to a general acute care hospital the right to exercise the bed hold provision.A review of Resident 1's Minimum Data Set (MDS - Federally mandated resident assessment tool), dated 3/29/26, the MDS indicated Resident 1 had mild memory impairment and had not exhibited physical behavioral symptoms directed towards others.During a review of Resident 1's Baseline Care Plan (BCP, instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care), dated 3/29/26, the Social Services Director (SSD) documented Resident 1's psychosocial (psych) goals which included, The recognition and management of depression, anxiety, fear, developmental problems, disability, pain and limitations in daily living. These factors all contribute to resident psych well-being.During a review of the Social Service Note (SSN), dated 3/29/26 at 11:13 a.m., the SSD indicated Resident 1 will be sent out for further evaluation.During a review of the SNF/NF [SNF/nursing facility] to Hospital Transfer Form, dated 3/29/26 at 11:30 a.m., the form indicated, [Resident 1] was being transferred to the hospital for behavioral symptoms (e.g. agitation, psychosis), and the behavioral issues and interventions indicated, .restlessness, irritability, verbal/combative behavior and refusal of care.During a review of the Nurse's Notes (NN), dated 3/29/26 at 12:30 p.m., the NN indicated Resident 1 had been transferred to the (hospital name] emergency department (ED) for further evaluation and treatment.During a review of the Case Management Notes (CMN), dated 3/29/26 at 8:55 p.m., the CMN indicated Resident 1 was transferred directly from the facility to the ED by non-emergent transportation without paperwork or notification of the direct transfer. The CMN indicated during a phone call with the facility's admission Coordinator (AC), the AC stated the facility transferred Resident 1 to the ED because Resident 1 was aggressive and combative. The AC was notified that Resident 1 was agreeable to return to the facility. The AC stated the facility was at capacity and unable to place Resident 1 in a single room.A review of the facility census on 3/29/26 indicated there were four empty beds.During a review of the CMN, dated 3/30/26 at 8:43 a.m., the CMN indicated the facility was notified Resident 1 was ready to return to the facility.A review of the facility census on 3/30/26 indicated there were five empty beds.During a review of the CMN, dated 3/30/26 at 10 a.m., (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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NAME OF PROVIDER OR SUPPLIER Rock Creek Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Racetrack Street Auburn, CA 95603	

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the CMN indicated the AC refused to readmit Resident 1.During a review of Resident 1's Notice of Proposed Transfer/Discharge (NPTD), dated 3/30/26 at 10:40 a.m., the NPTD indicated Resident 1 was discharged and not expected to return.A review of the facility census on 3/31/26 indicated there were four empty beds.A review of the fax confirmation of the NPTD to the Long Term Care Ombudsman (LTCO) dated 3/31/26, the NPTD indicated the facility notified the LTCO office of the proposed transfer/discharge for Resident 1 on 3/31/26 at 1:03 p.m.A review of the CMN, dated 3/31/26 at 2:22 p.m., the CMN indicated the facility had been notified that Resident 1 was ready to return to the facility. The facility indicated they would file an exchange of care for Resident 1 to be transferred to a different facility.A review of the CMN, dated 4/2/26 at 1:39 p.m., the CMN indicated the facility was notified that Resident 1 was ready to return to the facility. Resident 1 had been taking all of his medications, was calm and cooperative and family had been involved in his care and at his bedside. The CMN indicated the facility was notified to either readmit Resident 1 or notify Resident 1's insurance of non-readmittance and cancel the authorization for skilled care. The facility indicated they would not readmit Resident 1 and would cancel the authorization.During a telephone interview on 4/14/26 at 4:57 p.m. with the Case Manager (CM) 1, CM 1 stated Resident 1 was a direct transfer from the facility to the ED on 3/29/26. CM 1 stated Resident 1 sat in the ED waiting room without paperwork or information from the facility regarding the reason for Resident 1's direct transfer. CM 1 stated when the facility was notified of Resident 1's return, the facility refused to readmit Resident 1 because they did not feel comfortable having him return to a three-person room.During a telephone interview on 4/14/26 at 5:25 p.m. with the Transportation Company Manager (TCM), the TCM stated, We typically don't transport to the ER (emergency room) since we are a non-emergent transportation company. The TCM stated the majority of facilities provide a transfer packet or paperwork for a resident who is transferred to the ER or medical appointment. The TCM confirmed the facility did not provide transfer documents or instructions at the time of Resident 1's transfer. During a concurrent interview and record review on 4/15/26 at 12:12 p.m. with the DON and Assistant Director of Nursing (ADON), Resident 1's medical record was reviewed. The DON acknowledged the documentation in Resident 1's chart and did not support Resident 1's transfer to the ER and confirmed there was no documentation that indicated the facility had contacted Resident 1's family, emergency contacts or physician prior to transferring Resident 1 to the ER. The DON stated the Business Office Manager (BOM) or AC should have contacted the resident or resident's responsible party to inquire if Resident 1 would like a bed hold and documented the conversation in Resident 1's medical record. The DON and ADON confirmed there was no documentation to indicate Resident 1 had been offered a bed hold. The DON stated the facility did not readmit Resident 1 due to concerns over his behaviors and an assessment of Resident 1's status and needs at the time of the proposed return to the facility from the ER had not been completed. The DON confirmed the required documentation, transfer or discharge notices and bed hold policy prior to the transfer, and the subsequent discharge from the facility had not been provided to Resident 1.During a concurrent telephone interview and record review on 4/16/26 at 2:19 p.m. with the LTCO, the LTCO reviewed Resident 1's NPTD received on 3/31/26 and indicated the notice should be provided at the time of the transfer or discharge. The LTCO stated, The facility should have accepted this resident back at the facility.A review of the facility's policy and procedure (P&P) titled, Transfer or Discharge revised October 2025, the P&P indicated, Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record.3. Each resident is permitted to remain in the facility, and not be transferred or discharged unless: a. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; b. the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by this facility; c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. the health of individuals in the facility would otherwise be (continued on next page)

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	055446	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Creek Care Center	260 Racetrack Street Auburn, CA 95603

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	endangered.Transfer or Discharge Documentation in the Medical Record: 1. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: a. The basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; h. Disposition of medications; i. Others as appropriate or as necessary; and j. The signature of the person recording the data in the medical record. 2. If the basis for the transfer or discharge is that the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility, the resident's physician (or provider) documents: a. the specific resident needs that cannot be met; b. this facility's attempt to meet those needs; and c. the receiving facility's service(s) that are available to meet those needs.4. In situations where the facility determines the resident's clinical or behavioral status endangers the safety or health of individuals in the facility, the documentation regarding the reason for the transfer or discharge is provided by a physician or provider (but not necessarily the resident's physician or provider). Resident Refusal of Treatment as a Basis for discharge: 5. A resident's refusal of treatment is not grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. a. If a resident's refusal of care poses a risk to the health or safety of the resident or others in the facility, the administrator, director of nursing, and the medical director may choose to conduct an ethics review with legal consultation to determine whether discharge is appropriate. b. Documentation includes that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others. Transfer or Discharge Appeals: 1. Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including: a.The name, address, email, and telephone number of the entity which receives such requests; b. information about how to obtain, complete, and submit an appeal form; c. how to get assistance completing the appeal process; and d. the facility bed-hold policy.