STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056410	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Oaks Care Center	3529 Walnut Avenue Carmichael, CA 95608

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure resident rights were respected and honored for one of three sampled residents (Resident 1) when Licensed Nurse (LN) 1 did not initiate interventions to allow Resident 1 to go safely out on pass with a family member.This failure had resulted in Resident 1 not able to go out and have dinner on thanksgiving weekend with her family, and had the potential to negatively impact residents' psychosocial well-being.Findings:During a review of Resident 1's clinical record, Resident 1 was admitted to the facility in late 2024 with multiple diagnoses which included major depressive order and general anxiety. Resident 1's clinical record indicated Resident 1 had no memory impairment.Resident 1 submitted a complaint via email to California Department of Public Health on 11/30/25 at 4:29 a.m., which indicated Resident 1 had planned on going out with her son to celebrate thanksgiving dinner but was denied by the facility. During a review of Resident 1's Nurse's note dated 11/29/2025 at 1:59 p.m., indicated, Noted resident's son. bringing a wheelchair in the facility.he planned on taking resident out to eat Thanksgiving dinner. Resident did not have an LOA (Leave of absence) order, no progress notes regarding LOA for today, confirmed with.Nurse. (Son) was educated that there needs to be an LOA order from the doctor in advance in order to leave the facility, or else it will be considered AMA (against medical advice) if the resident leaves. Resident was also educated of this information and started yelling at this RN Supervisor stating, YOU CAN'T KEEP ME HERE. IF I WANT TO LEAVE I'M GOING TO BUT YOU CAN'T TELL ME I CAN'T COME BACK I WAS NEVER TOLD THAT I NEED A DOCTOR'S NOTE FOR AN LOA, I WANT THIS IN WRITING!During an interview on 12/10/25 at 1:51 p.m., LN 1 confirmed that Resident 1 did not go out to Thanksgiving dinner. LN 1 stated no further intervention was made and no attempt was made to call a doctor because I was told not to call the doctor on weekends because it is not favorable [to the doctor] . LN 1 acknowledged that she did not follow through to get an LOA order and other interventions so that Resident 1 can go to Thanksgiving dinner with son safely. During a review of Resident 1's care plan, dated 9/15/25, indicated, .Psychosocial- Well-being:.is at risk for psychosocial well-being concerns. Will minimize risk for decline in mood and behavior/psychosocial well-being. The care plan further indicated, Social Isolation: Resident is at risk for social isolation due to prefers to stay in room. Will be active on her own. Educate on the importance of social interaction. Encourage socialization.During an interview on 12/10/25 at 4 p.m., the Director of Nursing (DON) acknowledged that LN 1 should have attempted to call the doctor [to get an LOA order]. The DON further confirmed that Resident 1 was not included in facility preparation to get LOA orders from the doctor prior to the holiday weekend.During a review of facility's policy and procedure titled, Resident Rights-Quality of Life, revised March 2017, indicated The resident has a right to a dignified existence, self determination.and access to, persons and services inside and outside of the Facility.The resident has the right to exercise his or her rights as Resident of the Facility.The resident has the right to be free of interference, coercion.or reprisal from exercising his or her rights.The Resident has a right to be fully informed in advance about care and treatment that may affect the Resident's well being.No facility policy and procedure was provided for obtaining a Leave of Absence or Out on Pass doctor orders for the residents when requested.