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	05/28/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviews the facility failed to ensure a prompt resolution was provided for one out of three sampled residents (Resident 1), when Resident 1's Family Member (FM) filed a grievance for Resident 1's lost prescription glasses. This failure resulted in Resident 1's inability to see clearly.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in [DATE] with diagnoses which included vascular dementia (a cognitive decline caused by restricted or blocked blood flow to the brain) and combined forms of age-related cataracts (multiple types of cataracts affecting both eyes due to the natural aging process).During a review of Resident 1's Inventory of Personal Effects, dated [DATE], the inventory indicated Resident 1 had a pair of glasses.'A review of the Theft and Loss Log Year 2025 indicated Resident 1's eyeglasses were reported as lost/missing on [DATE].A review of the Theft and Loss Record, dated [DATE] by Licensed Nurse (LN) 1, LN 1 reported Resident 1's prescription eyeglasses with pink frames and eyeglass case were missing. A review of Resident 1's Progress Notes, Social Service Note indicated the following:1. [DATE] at 12:17 p.m.: the Social Services Assistant (SSA) indicated the morning LN reported Resident 1's eyeglasses were missing and were unable to be found.2. [DATE] at 12:30 p.m.: Family Member (FM) provided the facility with a copy of Resident 1's eye glass prescription, dated [DATE], which indicated the prescription was valid for two years. 3. Late entry on [DATE] at 1:53 p.m.: Interdisciplinary Team Meeting (IDT, a collaborative group of medical professionals from diverse specialties who work together to address a resident's complex needs) indicated, Resident 1 likes to do her word puzzles .Resident 1 wears eyeglasses.During a telephone interview on [DATE] at 12:37 p.m. with the FM, the FM indicated the facility has still not provided a resolution for Resident 1's prescription glasses that have been lost for over five months. The FM stated a copy of Resident 1's current glasses prescription, which expired in [DATE], was provided to the facility in [DATE]. The FM stated, I gave the facility a copy of [Resident 1's] current prescription, she [Resident 1] didn't need another eye exam. The facility should replace the glasses as requested, period. That facility has literally wasted months attempting to get authorization from [Resident 1's] insurance to cover the cost so they don't have to spend any money. The FM stated the receipt of purchase for the prescription glasses was provided to the facility and included the location where the glasses were purchased. The FM stated, Those eyeglasses should have been replaced months ago.During a telephone interview on [DATE] at 11:52 a.m. with the Long Term Care Ombudsman (LTCO), the LTCO stated he was aware that Resident 1's prescription eyeglasses and case were reported as missing/lost in [DATE]. The LTCO stated, The time it's taken for the facility to replace or reimburse the cost of [Resident 1's] glasses is inappropriate, especially since [FM] provided the facility with a current prescription months ago. The LTCO indicated the facility is expected to provide the resident or family member with prompt resolutions to grievances/complaints filed. The LTCO stated an expected and appropriate time frame for resolution is approximately one month. The facility should either replace or reimburse the cost of the lost item with something comparable, only after approval from the resident or family member. The LTCO stated, I didn't realize they [facility] still haven't (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replaced them [prescription eyeglasses and case] yet.During an interview on [DATE] at 1:14 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated when residents were admitted to the facility an inventory was taken of the resident's personal items and documented on the resident's inventory sheet. CNA 1 stated when items were reported as lost or missing the first thing to do was to search the resident's room and laundry room. CNA 1 indicated if the items were not found during the search the LN was notified and if a resident or family member continued to report additional items as lost/missing the complaint was elevated to the Social Services (SS) office. CNA 1 indicated only the items identified on a resident's inventory record would be investigated and reimbursed or replaced by the facility.During an interview on [DATE] at 1:42 p.m. with LN 1, LN 1 stated when items listed on the resident's inventory record were determined as lost or missing the items were reported directly to the SS office on a handwritten note. LN 1 further stated the resident or family member may file a grievance for lost items on a grievance form which was kept at the nursing station.During an interview on [DATE] at 2:11 p.m. with the Social Services Director (SSD) the SSD indicated staff, residents and family members were instructed to complete a grievance form when items were lost or missing. The SSD stated the SS office was responsible for the grievance/complaint process, which included an internal investigation and documented actions taken or proposed by the SS staff for the resolution of the filed grievance/complaint. The SSD indicated that the final report was submitted to the Admin and provided the determination and approval for resolution. The SSD indicated when the Admin approved the replacement or reimbursement for a lost/missing item from the resident's inventory the Admin will identify the approved actions to be taken to resolve the grievance/complaint, signed and dated the grievance/complaint form and returned the form to the SS office to carry out the steps identified as the approved resolution. The SSD confirmed Resident 1's glasses had still not been replaced or reimbursed since [DATE], and stated, No, these three to four months it has taken just to get [Resident 1's] glasses replaced is not appropriate. We [SSD and SSA] can only do so much, we must notify the Administrator who then makes the final decision about the outcome.During a concurrent interview and record review on [DATE] at 2:31 p.m. with the SSD and the SSA, Resident 1's grievance forms and inventory of personal effects were reviewed. The SSA and SSD confirmed Resident 1's grievance for her missing/lost prescription eyeglasses and case, filed in [DATE], still had not been resolved. The SSA and SSD reiterated, Whatever we do, it has to be approved by the Administrator. The SSA and SSD were unaware that a written summary of the investigation needed to be provided to the person who filed the grievance or complaint, and stated, We didn't know we had to do that. The SSD acknowledged the lack of timely resolutions for grievances/complaints, and stated, When residents or family members continue to file grievances or complaints that the facility doesn't resolve in a timely manner can cause residents and family members to really lose trust in our facility and processes.During an interview on [DATE] at 3:33 p.m. with the Director of Nursing (DON), the DON acknowledged the facility's responsibility to ensure the safety and security of a resident's personal belongings. The DON stated, The prompt investigation and resolution for grievances and complaints ensures the trust between the facility and residents or family members. It's all about communication and keeping the resident and family updated.A review of the facility's Filing Grievances/Complaints P&P indicated, The Administrator has delegated the responsibility of grievance and/or complaint investigation to [blank]. Upon receipt of a grievance and/or complaint [blank] will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. The resident, or person filing the grievance and/or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, or his or her designee, will make such reports orally within [blank] working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, and a copy will be filed in the business office.A review of the facility's P&P titled Personal Property revised [DATE], the P&P indicated, Residents are permitted to retain and use personal possessions, including furniture and clothing. Resident belongings are treated with respect by facility staff, regardless of perceived value.The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property.A review of the facility's P&P titled, Grievances/Complaints - Staff Responsibility revised [DATE], the P&P indicated, Staff members are encouraged to guide residents about where and how to file a grievance and/or complaint. Staff members will inform the resident or the person acting on the resident's behalf that he or she may file a grievance or complaint with the Administrator or other agencies as noted.