STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Blvd. Fair Oaks, CA 95628

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to investigate a complaint of mistreatment for one of five sampled residents (Resident 1), when Resident 1's Family Member (FM) notified facility staff of Resident 1's complaint and facility did not conduct an investigation including resident and staff interviews and, staff education.This failure had the potential to place Resident 1 and other residents at risk for mistreatment leading to psychosocial distress. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in August 2025 with multiple diagnoses including malignant neoplasm of the cauda equina (a cancerous tumor affecting nerves at end of the spinal cord), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe), neuromuscular dysfunction of the bladder (nerves and muscles that control bladder function are impaired), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety or fear that interfere with daily life). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 8/28/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's MDS, Functional Abilities, dated 8/28/25 indicated Resident 1 required maximal assistance for toileting hygiene. Further review of Resident 1's MDS, Bladder and Bowel, dated 8/28/25, indicated Resident 1 was always incontinent of bowel.A review of Resident 1's Bowel and Bladder Elimination Task document indicated Resident 1 had a bowel movement on 8/25/25 at 1:58 p.m. A review of Resident 1's Nursing Daily Skilled Charting, dated 8/25/25 at 3:39 p.m., indicated .Pt [patient] A&0 [alert and oriented] x 4 [person, place, time, situation], no changes in LOC [level of consciousness] . Able to make needs known .Call light within reach . A review of Resident 1's Nursing Daily Skilled Charting, dated 8/25/25 at 9:50 p.m., indicated .Compliant with care. Cooperative with staff .Call light within reach .A review of Resident 1's Nursing Daily Skilled Charting, dated 8/26/25 at 11:13 p.m., indicated . Call light within reach and personal items within reach . A review of Resident 1's Nursing Daily Skilled Charting, dated 8/27/25 at 5:21 p.m., indicated .Call light and personal items in reach . Care staff Assisted with ADL'S [Activities of Daily Living] .A further review of Resident 1's nursing daily skilled charting and progress notes did not reflect any documentation that Resident 1 or Resident 1's FM reported concerns regarding inappropriate or rough handling of Resident 1 to staff. During an interview on 9/5/25 at 12:21 p.m. with Licensed Nurse (LN) 1, LN 1 stated she was familiar with Resident 1 but had not heard about any complaints she had regarding rough treatment by staff. During an interview on 9/5/25 at 12:26 p.m. with LN 2, LN 2 stated she was familiar with Resident 1 but was not aware of any complaints of rough treatment by a CNA (Certified Nursing Assistant).During an interview on 9/5/25 at 1:10 p.m. and a subsequent interview on 9/5/25 at 1:30 p.m. with the Director of Nursing (DON), the DON stated she was not aware of any complaint from Resident 1 or Resident 1's FM regarding rough treatment by a CNA. The DON stated she had not heard anything from the staff or Resident 1's FM. During an interview on 9/5/25 at 1:28 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she manages the wing where Resident 1 was. The ADON stated she had not heard of any reports of rough treatment to Resident 1. During a telephone interview on 9/3/25 at 2:27 p.m. with CNA 2, CNA started she had worked with Resident 1 and does not recall her reporting any incidents with other CNAs. CNA 2 stated she works the night shift. During a telephone interview on 9/9/25 at 11:03 a.m. with Resident 1's FM1, FM 1 stated she visited Resident 1 on 8/27/25 and Resident 1 reported to her that she had been handled roughly on 8/25/25 by a staff member when being cleaned up after a bowel movement. FM 1 stated Resident 1 reported incident to CNA 2 on 8/25/25 or early morning 8/26/25. FM 1 stated that CNA 2 said she would report the incident. FM1 stated she reported the incident to the Social Services Director (SSD) on 8/27/25. FM 1 stated she reported the incident to the RN Case Manager (CM) on 8/29/25. The CM notified FM 1 that the CNA would not be working with Resident 1 again. During a telephone interview on 9/9/25 at 11:28 a.m. with Resident 1's FM 2. FM 2 stated she visited Resident 1 on 8/25/25. FM 2 stated she pushed call button between 2 p.m. and 3 p.m. to call CNA after Resident 1 had a bowel movement. FM 2 stated CNA was rough turning Resident 1, turned her hard, yanked the blanket, and lifted her legs. FM 2 stated CNA was very rough with [Resident 1]. FM 2 stated she did not notify any staff of the incident. During an interview on 9/10/25 at 10:10 a.m. with the SSD, the SSD stated Resident 1's FM 1 reported that Resident 1 did not like one of the CNAs and FM 1 did not want that CNA to work with Resident 1. The SSD stated she does not recall what day she spoke with FM 1. The SSD stated she notified FM 1 that the CNA would not be working with Resident 1. The SSD stated she