STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555219	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Oaks Care Center	3400 Bell Road 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43247 Based on observation, interview, and record review, the facility failed to ensure confidentiality was maintained for one of four sampled residents (Resident 2) when Resident 1 received Resident 2's labeled medication cards upon discharge by mistake. This failure resulted in Resident 2's confidential information being provided to an unauthorized recipient. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in September 2024 with multiple diagnoses including orthopedic aftercare for fusion of spine (surgery to connect two or more bones in the spine) and spinal stenosis (narrowing of the spaces in the spinal canal). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility in September 2024 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- blood flow to the brain is blocked). A review of Resident 1's Discharge Summary, dated 9/24/24, indicated .All medications reviewed including route, time, dose and indication with no questions asked .Current Reconciled Medications List was provided to Resident/Family/Caregiver at Discharge? .Yes . A review of Resident 1's Progress Note, social services note, dated 9/23/24, indicated .Resident is scheduled for discharge on 9/24/24 to home w/ [with] daughter and medications . A review of Resident 1's Progress Note, nurse's note, dated 9/24/24, indicated .Pt [patient] discharging home today with daughter .present at bedside for transport. All medications and ppwk [paperwork] reviewed, signed and sent with resident and dtr [daughter] with no questions at this time .Pt and dtr left facility approx [approximately] 12:30 [12:30 p.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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(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 - Few	During a telephone interview on 10/10/24 at 8:52 a.m. with Resident 1's Family Member (FM), the FM stated Resident 1 was discharged from the facility on 9/24/24. The FM stated she noticed after she left the facility, Resident 1 was discharged with her own Norco (narcotic pain medication) but also had roommate's (Resident 2) medications. The FM was told that medications for both roommates (Resident 1 and Resident 2) were in the same drawer and Resident 2's medications were scooped up by mistake. During an interview on 10/10/24 at 10:46 a.m. with the Director of Nursing (DON), the DON stated for a scheduled discharge the medication cart nurse or desk nurse reviews medications with the resident or Responsible Party (RP). Medications that are left are given to the resident upon discharge. The DON stated on 9/24/24, the wrong medications were pulled for Resident 1. Resident 1 was given her roommate's (Resident 2) medications. The DON stated, It was a mistake from nursing. Need to verify and make sure medications are correct. During an interview on 10/10/24 at 11:39 a.m. with Licensed Nurse (LN) 1, LN 1 stated the medication cart nurse pulls the medications for discharged residents from the medication cart, places in bag, and gives to the desk nurse. LN 1 stated the medication cart nurse pulled Resident 1 roommate's (Resident 2) medications by mistake upon discharge of Resident 1. LN 1 was the desk nurse that day. LN 1 stated she briefly went through the bag and used Resident 1's Norco medication card from the bag to review with Resident 1. LN 1 stated, Did not notice the rest of meds. Did not check rest of meds to see if they were correct. During an interview on 10/10/24 at 11:53 a.m. with LN 2, LN 2 stated Resident 1 received her roommate's (Resident 2) medications at discharge. During a telephone interview on 10/10/24 at 2:13 p.m. with LN 3, LN 3 stated for resident discharges she usually obtains the medication list from the desk nurse, goes over the medications, collects the medications from the medication cart, places medications in a bag, and gives to the desk nurse. LN 3 stated when Resident 1 was discharged , Did not do this. Didn't have the list. LN 3 stated she pulled Resident1's Norco cards from the second left drawer, then picked up roommate's (Resident 2) medications from second right drawer and gave then to LN 2. LN 3 stated, Didn't look at the medications either. LN 3 stated Resident 1's FM was angry and anxious at the time of discharge, so she hurried and got the medications. LN 3 stated, Was in a hurry. LN 3 was notified later Resident 1 had been given the wrong medications. During a concurrent observation and interview on 10/10/24 at 1:35 p.m. with LN 2, observed Resident 2's medication card in the medication cart. The medication card was labeled with Resident 2's name, medication, dosage, instructions, prescription number, and expiration date. During an interview on 10/10/24 at 1:21 p.m. and a subsequent interview on 10/10/24 at 2:33 p.m. with the Director of Nursing (DON), the DON stated, Nurses need to go over medications. The DON stated the confidentiality breach was not reported to the state as far as she knows. The DON stated Resident 1 and FM were aware of incident, but the family of Resident 2 was not notified of incident. Requested policy and procedure for confidentiality breach process. The DON stated she could not find the policy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled Confidentiality of Information and Personal Privacy, revised 10/23, indicated .Our facility will protect and safeguard resident confidentiality and personal privacy .The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .The facility will strive to protect the resident's privacy regarding his or her .medical treatment . A review of the facility's P&P titled Resident Rights, revised 10/23, 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 .The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues .

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation, interview, and record review, the facility failed to provide a safe discharge home for one of four sampled residents (Resident 1), when Resident 1 was discharged home with another resident's (Resident 2) medications. This failure had the potential for Resident 1 to take the wrong medications causing adverse effects. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in September 2024 with multiple diagnoses including orthopedic aftercare for fusion of spine (surgery to connect two or more bones in the sine) and spinal stenosis (narrowing of the spaces in the spinal canal). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility in September 2024 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- blood flow to the brain is blocked). A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 9/13/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated she was cognitively intact. A review of Resident 1's MDS, Functional Abilities and Goals, dated 9/13/24, indicated Resident 1 was independent for self-care and indoor mobility and required some assistance for stairs upon admission. A review of Resident 1's Discharge Summary, dated 9/24/24, indicated .All medications reviewed including route, time, dose and indication with no questions asked .Current Reconciled Medications List was provided to Resident/Family/Caregiver at Discharge? .Yes . A review of Resident 1's Order Summary Report, indicating medication list for discharge was signed by Resident 1 on 9/24/24. A review of Resident 1's Progress Note, social services note, dated 9/23/24, indicated .Resident is scheduled for discharge on 9/24/24 to home w/ [with] daughter and medications . A review of Resident 1's Progress Note, nurse's note, dated 9/24/24, indicated .Pt [patient] discharging home today with daughter .present at bedside for transport. All medications and ppwk [paperwork] reviewed, signed and sent with resident and dtr [daughter] with no questions at this time .Pt and dtr left facility approx [approximately] 12:30 [12:30 p.m.] . A review of Resident 1's Progress Note, nurse practitioner note, dated 9/24/24, indicated .[Resident 1] was seen in her room this morning with her daughter at bedside. They were waiting for her discharge papers and as soon as they received them, they left. Patient and daughter said they had no needs at the time of discharge . (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Progress Note, nurse practitioner note, dated 9/25/24, indicated . [Resident 1] was discharged [DATE] in stable condition .meds reconciled . During a telephone interview on 10/10/24 at 8:52 a.m. with Resident 1's Family Member (FM), the FM stated Resident 1 was discharged from the facility on 9/24/24. The FM stated she noticed after she left the facility, Resident 1 was discharged with her own Norco (narcotic pain medication) but had roommate's (Resident 2) medications. Resident 1 did not have her other medications upon discharge. The FM stated she was asked by the facility to bring back Resident 2's medications but was unable to do so until the next day as she was in the emergency department with Resident 1. The FM stated Licensed Nurse (LN) 1 and LN 2 brought Resident 1's medications to the emergency department that day. The FM was told that medications for both roommates (Resident 1 and Resident 2) were in the same drawer and Resident 2's medications were scooped up by mistake. During an interview on 10/10/24 at 10:46 a.m. with the Director of Nursing (DON), the DON stated for a scheduled discharge the medication cart nurse or desk nurse reviews medications with the resident or Responsible Party (RP). Medications that are left are given to the resident. The DON stated on 9/24/24, the wrong medications were pulled for Resident 1. Resident 1 was given Resident 2's medications. The DON stated, it was a mistake from nursing. Need to verify and make sure medications are correct. The DON stated Resident 1's medications were delivered to her the same day and Resident 1's FM brought in Resident 2's medications the next day. During an interview on 10/10/24 at 11:39 a.m. with LN 1, LN 1 stated the medication cart nurse pulls the medications for discharged residents from the medication cart, places in bag, and gives to the desk nurse. LN 1 was the desk nurse that day. LN 1 stated the medication cart nurse pulled Resident 1 roommate's (Resident 2) medications by mistake. LN 1 stated she briefly went through the bag and used Resident 1's Norco medication card from the bag to review with Resident 1. LN 1 stated, Did not notice the rest of meds. Did not check rest of meds to see if they were correct. Observed with LN 1 medication cart, 1 Front. Observed second left drawer contained medication cards for narcotics in order by resident, no dividers. Observed second right drawer with medications separated by dividers labeled with room number. LN 1 stated she delivered Resident 1's medications to her that same day in the emergency room . When asked what the consequences may be of resident discharged with wrong medications, LN 1 stated, Potentially allergies, side effects. During an interview on 10/10/24 at 11:53 a.m. with LN 2, LN 2 stated Resident 1 received her roommate's (Resident 2) medications at discharge. LN 2 stated medications are pulled by the medication cart nurse, checked against the medication list, and given to the desk nurse. The desk nurse gives the discharge instructions. LN 2 stated that he went with LN 1 to deliver Resident 1's medications in the emergency department. When asked what the outcome might be if resident given wrong medication, LN 2 stated, Family may not have checked medication, can cause harm, allergic reactions, side effects. May be given the wrong dose. All sorts of consequences with wrong medications. Should be double or tripled checked, read card two times. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/10/24 at 2:13 p.m. with LN 3, LN 3 stated for resident discharges she usually obtains the medication list from the desk nurse, goes over the medications, collects the medications from the medication cart, places medications in a bag, and gives to the desk nurse. LN 3 stated when Resident 1 was discharged , Did not do this. Didn't have the list. LN 3 stated she pulled Resident1's Norco cards from the second left drawer, then picked up Resident 2's medications from second right drawer and gave then to LN 2. LN 3 stated, Didn't look at the medications either. LN 3 stated Resident 1's FM was angry and anxious at the time of discharge, so she hurried and got the medications. LN 3 stated, Was in a hurry. LN 3 was notified later Resident 1 had been given the wrong medications. A review of the facility's Policy and Procedure (P&P) titled Discharging the Resident, revised 10/23, indicated .If the resident is being discharged home, ensure that resident and/or responsible party receives discharge instructions . A review of the facility's P&P titled Medication Regimen Review, revised 4/23, indicated .The resident's medication regimen shall be consistent with an individual's plan of care .