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	12/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	555219	A. Building B. Wing	12/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on interview and record review, the facility failed to prevent an elopement (the act of leaving a facility unsupervised and without prior authorization) for one resident (Resident 5) of a census of 96, when Resident 5 was found by a family member walking down the street outside the facility and standing at a traffic light intersection.This failure decreased the facility's potential to maintain Resident 5's safety.Findings:A review of Resident 5's admission Record, indicated he was admitted to the facility in 2024 with diagnoses including moderate dementia (a decline in mental ability severe enough to interfere with daily life, involving memory loss and reasoning issues) with behavioral disturbance, post-traumatic stress disorder (PTSD-a mental health condition associated with experiencing an event that was traumatic, terrifying, or life-threatening), and difficulty in walking. The record further indicated Resident 5's spouse was his responsible party.A review of Resident 5's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/2/25, indicated Resident 5's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was four out of 15 with severe memory impairment. MDS further indicated a wander alarm device was not in use on Resident 5.A review of Resident 5's progress notes, dated 10/22/25 at 5:35 p.m., indicated Resident 5's family member notified a licensed nurse that she saw Resident 5 outside the facility walking down the street. The licensed nurse and an aide ran outside the facility to search for Resident 5. Resident 5 was found standing at the red light at an intersection and was escorted back to the facility. The facility's medical director was notified and a wander guard was placed on Resident 5's right foot.A review of Resident 5's Care Plan Report, revised on 10/22/25, indicated Resident 5 had an episode of elopement on 10/22/25 and was at risk for elopement related to dementia, forgetfulness, and PTSD.A review of Resident 5's Elopement and Wandering Risk Assessment, dated 4/7/25, indicated Resident 5 . has exhibited unsafe wandering [and] has made one or more attempts to elope . in the last year. The document further indicated a wander alarm was required for Resident 5.A review of the facility's Order Summary Report, dated 4/8/25, indicated the facility's physician ordered a wander guard for Resident 5 due to elopement risk.A review of Resident 5's nursing progress note, dated 4/19/25, indicated the wander guard order was discontinued and the device was removed.A review of Resident 5's Care Plan Report, revised on 8/28/25, indicated Resident 5's elopement risk and need for a wander guard were resolved.During an interview on 12/9/25 at 1:56 p.m. with the Director of Nursing (DON), DON stated on 10/22/25 Resident 5 left the premises until his family member spotted him on a road and alerted staff.During a concurrent interview and record review on 12/9/25 at 5:41 p.m. with the Administrator (ADM) and DON, Resident 5's care plan, elopement risk assessment, and MDS were reviewed. ADM and DON confirmed Resident 5 eloped from the facility on 10/22/25 and was at risk for elopement. DON stated Resident 5's care plan did not indicate the elopement risk between 8/28/25 and 10/22/25 and expected staff to prevent elopement incidents. ADM stated he did not know what time Resident 5 left the facility and for how long he was wandering outside the facility until a family member saw him. ADM and DON further stated Resident 5's elopement was a safety issue since he had dementia and PTSD which increased Resident 5' potential for injury if he fell or was hit by a vehicle.A review of the facility's policy titled, Wandering and Elopements, dated October 2024, indicated, If identified as at risk for wandering or elopement, the resident's care plan will include strategies and interventions that will be provided to maintain the resident's safety.