

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Auburn Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>Based on observation, interview, and record review, the facility failed to obtain an informed consent for a dental procedure from one of three sampled residents (Resident 1's) Responsible Party (RP) in a census of 96. This failure compromised the resident's right to make informed decision regarding their care and resulted in Resident 1 receiving a dental procedure they had not agreed to or fully understood. Findings: Resident 1 was readmitted to the facility in the winter of 2026 with diagnoses which included subarachnoid hemorrhage (a type of stroke), cognitive communication deficit (a communication problem) and encephalopathy (any disease, damage, or malfunction that alters brain function which causes mental state changes, such as confusion, and memory loss) and long term use of anticoagulants (blood thinning medication). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/5/26, the MDS indicated Resident 1 had moderate memory impairment. During a review of Resident 1's face sheet, the Responsible Party was indicated as Family Member (FM) 1. During a review of the physician's orders (PO), the PO indicated Resident not capable. During a review of Resident 1's Nurse Practitioner Note (NPN), dated 3/31/26, the NPN indicated She is awake, has periods of confusion. During a review of the DENTIST VISIT LIST [DVL], dated 4/7/26, the DVL indicated Resident 1 was scheduled for surgical extraction requiring bone removal [of teeth number] 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 21, 28, 29, 30, 31. During a review of the Post-Operative Instructions for Extractions, dated 4/7/26, indicated Oral Surgery Date Completed: April 7, 2026. During a telephone interview on 4/15/26 at 9:19 a.m. with FM 1, FM 1 said, I am her RP. They did not ask my consent for taking out [Resident 1's] teeth. They took out 21 in the facility. They said they got consent from [Resident 1] but she's confused at times. During an observation of Resident 1 on 4/15/26 at 1:37 p.m., when questioned, Resident 1 had a memory problem and could not answer all questions asked by the Nurse Surveyor. During a concurrent interview and record review on 4/15/26 at 3:35 p.m. with the Director of Nursing (DON), the DON was asked her expectations for getting RP consent for dental extractions and said, According to the face sheet, [FM 1] is the RP. For any procedure that requires consent, [FM 1] should have been contacted and consent obtained. We go by the physician's order that shows capacity. Her capacity fluctuates. The DON verified the PO indicated Resident 1 had no capacity and that a consent from the RP for the extraction of 21 teeth could not be found. During a telephone interview on 4/15/26 at 4:25 p.m. with the Registered Dental Hygienist (RDH), the RDH said, If they have an RP, we normally call the RP. We didn't realize it had changed. I've never actually spoken to [FM 1]. If it's a patient who is not her own RP, we definitely have a signature for those patients. A facility policy and procedure was requested but not provided.</p>

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