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	10/03/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) accurately reflected the resident's current condition for one of 25 sampled residents (Resident 92), when the discharge MDS indicated the resident was discharged to an acute hospital. This failure resulted in Resident 92's MDS inaccurate assessment data submitted to CMS (Centers for Medicare-Medicaid Services). Findings: Resident 92 was admitted to the facility in the middle 2024 with multiple diagnoses which included heart failure and difficulty in walking. During a review of Resident 92's Physician Orders (PO), dated 8/20/24, the PO indicated, Discharge to home with medications . During a review of Resident 92's Nurse's Note (NN), dated 8/21/24 at 10:17 a.m., the NN indicated, Pt [patient] is discharging to home today . During a review of Resident 92's Nurse Practitioner Note (NPN), dated 8/21/24 at 3:04 p.m., the NPN indicated, .resident noted to be discharging to go home today . During a review of Resident 92's MDS, dated [DATE], the MDS titled, Discharge Status, indicated, . Short-Term General Hospital . During a concurrent record review and interview on 10/2/24 at 11:50 a.m. with the MDS Coordinator (MDSC) in the facility conference room, the MDSC verified Resident 92's MDS on 8/21/24 indicated the resident was discharged to short-term general hospital, and stated, .I don't know why .It should've been coded correctly . During an interview on 10/2/24 at 12:20 p.m., with the Director of Nursing (DON) in the facility conference room, when asked about the MDS coding expectation, the DON stated, .make sure it's accurate . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Resident Assessments, revised 10/23, the P&P indicated, .Required Assessments are federally mandated, and therefore must be performed for all residents .assessments include: Discharge Assessment (return anticipated and return not anticipated) .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. During a review of the undated Resident Assessment Instrument (RAI), the RAI indicated, The RAI process is a means of ensuring that residents receive the highest quality of care and can maintain the highest quality of life .This assessment is completed initially and periodically and is comprehensive, accurate, and standardized.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on interview and record review, the facility failed to ensure comprehensive care plans were developed or implemented for three out of 25 sampled residents (Resident 36, Resident 148, and Resident 85), when: 1. Resident 148 had no care plan for a newly ordered respiratory treatment; 2. Resident 36's respiratory treatment and oxygen (O2) therapy care plan was not implemented; and 3. Resident 85's O2 therapy care plan was not implemented. These failures increased the potential risk to result in the residents not attaining their highest practicable physical, mental and psychosocial well-being. Findings: 1. Resident 148 was admitted in late 2024 with diagnoses which included pulmonary edema (fluid in the lungs causing cough with extreme difficulty of breathing), muscle weakness and swallowing difficulty. During a review of Resident 148's Physician Orders (PO), dated [DATE], the PO indicated, Ipratropium-Albuterol Solution [combination medication used to treat obstructive lung disease] .3 ml [milliliter, volume measure] inhale orally every 6 hours for productive cough for 10 days. During a concurrent observation and interview on [DATE] at 10:23 a.m. in Resident 148's room, an unlabeled and undated hand held nebulizer (HHN) was found on top of Resident 148's wheelchair. Resident 148 was in bed, awake, alert and verbally responsive, and stated, That is mine. I don't know why they put that in my face. I am breathing fine. They did not tell me why they are giving me breathing treatment. During a concurrent observation and interview on [DATE] at 10:30 a.m. in Resident 148's room with Certified Nursing Assistant (CNA) 11, CNA 11 verified the HHN on top of the wheelchair, and stated, The stuff is hers . She usually uses it a couple of times a day. Resident 148 stated, That's my thing. I'm blowing at it but I don't know why. During a review of Resident 148's Minimum Data Set (MDS, an assessment tool), dated [DATE], the MDS indicated Resident 148 had no memory impairment, and required assistance with activities of daily living (ADLs). During a review of Resident 148's care plans (CP) on [DATE], there was no documented evidence a comprehensive care plan was developed or initiated on the nebulizer treatment for the productive cough. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 8:20 a.m. with Licensed Nurse (LN) 7, LN 7 verified the respiratory treatment was ordered on [DATE], and stated, [Resident 148] is alert and oriented. The order for the breathing treatment was related to her productive cough. LN 7 verified the medical record for the newly ordered medication, and stated, I don't see any care plan for the nebulizer treatment .There should have been a care plan for that. During an interview on [DATE] at 8:35 a.m. with the Director of Nursing (DON), the DON stated, .On any new medication order added, I would expect the nurses to develop a care plan and follow those interventions . 2. Resident 36 was admitted in late 2024 with diagnoses which included asthma exacerbation (the lung airways become inflamed, narrow and swell making it difficult to breath), respiratory failure with hypoxia (low levels of O2 in the blood). During a review of Resident 36's PO, dated [DATE], the PO indicated, Ipratropium-Albuterol inhalation Solution .1 unit inhale orally three times a day for SOB [shortness of breath]/Wheeze r/t [related to] asthma . Run over 15 minutes. During a review of Resident 36's CP, dated [DATE], the CP indicated, [Resident 36] has asthma with acute exacerbation .Give nebulizer treatments and oxygen therapy as ordered. During a review of Resident 36's CP, dated [DATE], the CP indicated, [Resident 36] has shortness of breath due to .chronic respiratory failure with hypoxia .oxygen therapy as ordered. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 had no memory impairment, required assistance with activities of daily living, and needed O2 therapy. During a concurrent observation and interview on [DATE] at 11:03 a.m. in Resident 36's room, Resident 36 was in bed, awake, alert and verbally responsive in his own language, and stated, No speaking English. I speak and understand a little bit. On top of the nightstand were an unlabeled and undated nasal cannula (nasal tubing delivering O2) connected to the nebulizer machine dated [DATE], a disconnected HHN with liquid medication left in the chamber and dated [DATE], and an undated disconnected O2 mask coiled and parts of the tubing touching the floor. During a concurrent observation and interview on [DATE] at 11:05 a.m. in Resident 36's room with CNA 9, CNA 9 verified the nasal cannula, HHN and mask at the bedside, and stated, So, that's [DATE] on the machine. Today is [DATE], so it has been 10 days. The [nasal] tubing is dated [DATE]. There's no date on the other tubing .The other one that is touching the floor has no labeled date. During a concurrent observation and interview on [DATE] at 11:10 a.m. in Resident 36's room with LN 7, LN 7 verified the dates of the nasal tubings, and stated, This one here should have a date on. We change the O2 tubing weekly so that's expired and should have been changed. This one has still medication on it and the process is that they are supposed to finish it for 15 minutes .if there is something left, then they're not getting the medication. We are supposed to come and check it and I didn't. The nebulizer mask are supposed to be in a bag, labeled and dated, and these bags are not dated. When asked what happened if medication was not administered and the tubes were not changed weekly, LN 7 stated, They're not getting their medicine. When they are not changed every week, they get respiratory infections. It's all about infection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on [DATE] at 1:22 p.m. in a hallway near the front lobby, Resident 36 sat in a wheelchair calling staff for help and pointed at the O2 tank hanging behind his wheelchair. Resident 36 indicated his O2 tank was empty, and stated, I'm okay, but short of breath. The O2 tank was checked and the indicator was on the red mark which indicated the tank was empty. During a concurrent observation and interview on [DATE] at 1:23 p.m. in a hallway near the front lobby, with LN 8, LN 8 verified the O2 tank was empty, and stated, We check them out as needed and every day when the staff comes in or when the resident takes the O2 around. LN 8 verified and confirmed the tank was zeroed out, and stated, [Resident 36] is alert and oriented but he speaks a different language but understands English. He can be short of breath without the oxygen. During an interview on [DATE] at 8:20 a.m. with LN 7, LN 7 stated, Because [O2 tank] was empty, we're supposed to be checking it each shift whenever he gets out of the room .This is the first time that it was empty, but we should have checked it. During an interview on [DATE] at 8:35 a.m. with the DON, the DON stated, We usually check [O2 tanks], like if a resident is on a chair, we check intermittently to make sure that the tank has O2 on it. There's no monitoring like every day to check the tank. When the nurses come in every shift, all they want to know is the resident is using the O2 tank. The resident could potentially have respiratory distress. 3. Resident 85 was admitted in the middle of 2024 with diagnoses which included lung cancer, pulmonary fibrosis (scarred lung tissue over time causing shortness of breath), and chronic obstructive pulmonary disease (COPD). During a review of Resident 85's CP, dated [DATE], the CP indicated, [Resident 85] has pulmonary fibrosis . oxygen therapy as ordered. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 had no memory impairment and needed O2 therapy. During an observation on [DATE] at 11:30 a.m. in Resident 85's room, Resident 85 was in bed and received O2 via nasal cannula at 4L/min (Liters/minute). During a review of Resident 85's PO, dated [DATE], the PO indicated, Oxygen - @3 Liters/Min Via Nasal Cannula (Routine/Continuous) .Goal to Maintain 02 Sats [saturation, level of O2 in the blood] greater than 90% .Monitor O2 Sats .every shift. During a concurrent interview and review of Resident 85's PO on [DATE] at 3:25 p.m. with LN 3, LN 3 verified the PO was O2 at 3L/min, and stated, It is important to follow the doctor's order .specially for residents with COPD . During an observation on [DATE] at 1:40 p.m. in Resident 85's room, Resident 85 was in bed and received O2 via nasal cannula which remained at 4 L/min. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1:42 p.m. with LN 4, LN 4 confirmed Resident 85 continuously received 4L/min. LN 4 verified the order at 3L per minute and titrate for O2 sat above 90% and check saturation every shift. When asked if she had checked the O2 sat on her shift, the LN stated, I have not checked the O2 saturation on my shift. When asked to check the care plan, LN 4 confirmed the intervention to administer the medication as ordered. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive, revised , d+[DATE], the P&P indicated, A comprehensive care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview, and record review, the facility failed to ensure care and services in accordance with acceptable professional standards of quality were provided for four of 25 sampled residents (Resident 143, Resident 144, Resident 36, and Resident 85), when: 1. Medication and ointments were left at the nightstand of Resident 143; 2. Medication, hazardous liquids and ointments were left at the bedside of Resident 144; 3. A medication was not administered completely and left at the bedside, and oxygen tank was empty while in use for Resident 36; and 4. The oxygen (O2) saturation levels were not monitored for Resident 85. These failures had the potential risks to negatively affect the residents' health status. Findings: 1. Resident 143 was admitted in late 2024 with diagnoses which included peripheral vascular disease [decreased blood flow to the arms and legs], communication deficit, difficulty walking, and lack of coordination. During a review of Resident 143's Baseline Care Plan (BCP), dated [DATE], the BCP indicate Resident 143 had baseline confusion but able to make needs known. During a review of Resident 143's Physician Orders (PO), dated [DATE], the PO indicated, Miconazole [treatment for fungal infection] External powder .Micatin Cream .apply under breast topically . During a concurrent observation and interview on [DATE] at 9:55 a.m. in Resident 143's room, on top of the nightstand were two unlabeled plastic medicine cups half-filled with white paste-like consistency and an ointment tube. Resident 143 sat in a wheelchair, awake, alert and verbally responsive, and stated, I don't know what they are, but I think those are for me. They left it there for me. During a concurrent observation and interview on [DATE] at 9:57 a.m. in Resident 143's room with Certified Nursing Assistant (CNA) 9, CNA 9 verified the findings of the leftmedicine cup and the ointment tube, and stated, I don't know what they are. I will tell the nurse. During a concurrent observation and interview on [DATE] at 9:59 a.m. in Resident 143's room with License Nurse (LN) 7, LN 7 verified the medications on top of the night stand of Resident 143, and stated, [The medications] are not supposed to be here. They are not labeled and dated. I don't know when they left them here. 2. Resident 144 was admitted in late 2024 with diagnoses which included right arm fracture, difficulty in walking and lack of coordination. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 144's Minimum Data Set (MDS, an assessment tool), dated [DATE], the MDS indicated Resident 144 had mild memory impairment, hard of hearing, and needed assistance with activities of daily living. During a concurrent observation and interview on [DATE] at 9:44 a.m. in Resident 144's room, Resident 144 sat on a wheelchair, awake, alert and verbally responsive but hard of hearing. On top of the bedside table was a labeled medication inside a plastic bag with another resident's name (Resident 143). Resident 144 indicated the medication was not hers. Another opened and unlabeled container of mentholatum ointment (product use to relieve itching, minor muscle or joint pain) was on top of the bedside table, and Resident 144 stated, That's mine. I brought that from home and I use it. On top of the night stand was another unlabeled and opened large plastic container of mouthwash rinse, and Resident 144 stated, My friend gave me that. During a concurrent observation and interview on [DATE] at 9:52 a.m. in Resident 144's room, CNA 9 verified the plastic container was a medication, and stated, [The medications] are not supposed to be at the bedside. It's a prescription medication and that's not even hers. The mouth rinse should not be here, it should be placed in the bathroom and the other one is hers. Those things would be risky for the resident. I will report to the nurse. I don't understand why the medication is there. During a concurrent observation and interview on [DATE] at 9:59 a.m. in Resident 144's room with LN 7, LN 7 verified the medication on top of bedside table of Resident 144, and stated, The medication is labeled with another name [Resident 143] and that's not hers. I'm not sure if they forgot to take it, but no medications should be left at bedside because they can ingest it or give it to somebody else or someone else can come in and take it. LN 7 verified the mentholatum ointment and the big plastic bottle of mouthwash, and stated, When they receive medications from home, they're supposed to check in with the nurse and the nurse is supposed to get an order, then we're supposed to put it on our locked cart or inside our medicine cabinet or send these home with the family members. 3. Resident 36 was admitted in late 2024 with diagnoses which included asthma exacerbation (the lung airways become inflamed, narrow and swell making it difficult to breath), respiratory failure with hypoxia (low levels of O2 in the blood). During a review of Resident 36's PO, dated [DATE], the PO indicated, Ipratropium-Albuterol inhalation Solution .1 unit inhale orally three times day for SOB [shortness of breath]/Wheeze r/t [related to] asthma . Run over 15 minutes. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 had no memory impairment and required assistance with activities of daily living and needed O2 therapy. During a concurrent observation and interview on [DATE] at 11:03 a.m. in Resident 36's room, Resident 36 was in bed, awake, alert and verbally responsive in his own language, and stated, No speaking English. I speak and understand a little bit. On top of the nightstand were an unlabeled and undated nasal cannula (nasal tubing delivering O2)connected to the nebulizer machine dated [DATE], a disconnected HHN with liquid medication left in the chamber and dated [DATE], and an undated disconnected O2 mask coiled and parts of the tubing touching the floor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 11:05 a.m. in Resident 36's room with CNA 9, CNA 9 verified the nasal cannula, HHN and mask at the bedside, and stated, So, that's [DATE] on the machine. Today is [DATE], so it has been 10 days. The [nasal] tubing is dated [DATE]. There's no date on the other tubing .The other one that is touching the floor has no labeled date. During a concurrent observation and interview on [DATE] at 11:10 a.m. in Resident 36's room with LN 7, LN 7 verified the dates of the nasal tubings, and stated, This one here should have a date on. We change the O2 tubing weekly so that's expired and should have been changed. This one has still medication on it and the process is that they are supposed to finish it for 15 minutes .if there is something left, then they're not getting the medication. We are supposed to come and check it and I didn't. The nebulizer mask are supposed to be in a bag, labeled and dated, and these bags are not dated. When asked what happened if medication was not administered and the tubes were not changed weekly, LN 7 stated, They're not getting their medicine. When they are not changed every week, they get respiratory infections. It's all about infection. During a concurrent observation and interview on [DATE] at 1:22 p.m. in a hallway near the front lobby, Resident 36 sat in a wheelchair calling staff for help and pointed at the O2 tank hanging behind his wheelchair. Resident 36 indicated his O2 tank was empty, and stated, I'm okay, but short of breath. The O2 tank was checked and the indicator was on the red mark which indicated the tank was empty. During a concurrent observation and interview on [DATE] at 1:23 p.m. in a hallway near the front lobby, with LN 8, LN 8 verified the O2 tank was empty, and stated, We check them out to as needed and every day when the staff comes in or when the resident takes the O2 around. LN 8 verified and confirmed the tank was zeroed out, and stated, [Resident 36 is alert and oriented but he speaks a different language but understands English. He can be short of breath without the oxygen. During an interview on [DATE] at 8:20 a.m. with LN 7, LN 7 stated, Because [O2 tank] was empty, we're supposed to be checking it each shift whenever he gets out of the room .This is the first time that it was empty, but we should have checked it. During an interview on [DATE] at 8:35 a.m. with the DON, the DON stated, We usually check [O2 tanks], like if a resident is on a chair, we check intermittently to make sure that the tank has O2 on it. There's no monitoring like every day to check the tank. When the nurses come in every shift, all they want to know is the resident is using the O2 tank. The resident could potentially have respiratory distress. 4. Resident 85 was admitted in the middle of 2024 with diagnoses which included lung cancer, pulmonary fibrosis (scarred lung tissue over time causing shortness of breath), and chronic obstructive pulmonary disease (COPD). During a review of Resident 85's NCPs, dated [DATE], the NCP indicated, [Resident 85] has pulmonary fibrosis .oxygen therapy as ordered. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 had no memory impairment and needed oxygen therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 11:30 a.m. in Resident 85's room, Resident 85 was in in bed and received O2 via nasal cannula at 4L/min. During a review of Resident 85's PO, dated [DATE], the PO indicated, Oxygen - @3 Liters/Min Via Nasal Cannula (Routine/Continuous) .Goal to Maintain 02 Sats [saturation, O2 levels in the blood] great than 90% . Monitor O2 Sats .every shift. During a concurrent interview and review of Resident 85's PO on [DATE] at 3:25 p.m. with LN 3, LN 3 verified the PO was O2 at 3L/min, and stated, It is important to follow the doctor's order .specially for residents with COPD . During an observation on [DATE] at 1:40 p.m. in Resident 85's room, Resident 85 was in bed and received O2 via nasal cannula which remained at 4 L/min. During a concurrent interview and record review on 1:42 p.m. with LN 4, confirmed Resident 85's was continuously receiving 4L/min. LN 4 verified the order at 3L per minute and titrate for O2 sat above 90% and check saturation every shift. When asked if she had checked the O2 sat for her shift, the LN stated, I have not checked the oxygen saturation in my shift. When asked to check the care plan, LN 4 confirmed the intervention to administer the medication as ordered. During a review of facility's policy and procedure (P&P) titled, Oxygen Administration, revised ,d+[DATE], the P&P indicated, Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter .The Oxygen tubing is changed at least weekly, labeled with the date it was changed, and stored in anti-microbial bag which is changed at least every 30 days. During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regiment . ordered by and within the scope of licensure of a physician .as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46995 Based on observation, interview, and record review, the facility failed to ensure residents were assisted with activities of daily living (ADL, tasks related to personal care, such as eating, grooming, dressing, hygiene) to maintain good nutrition and personal hygiene for four out of 25 sampled residents (Resident 20, Resident 29, Resident 44, and Resident 83), when: 1. Nail care was not performed for Resident 83, Resident 44, and Resident 20; and 2. Resident 29 did not have one to one assistance with her meals as ordered. These failures increased the potential for infection, weight loss, and a diminished sense of dignity. Findings: 1. Resident 83 was admitted to the facility in mid-2024 with diagnoses which included Huntington's Disease (hereditary disorder that includes coordination problems). During a review of Resident 83's Minimum Data Set (MDS, an assessment tool), dated 6/24/24, the MDS indicated Resident 83 required partial/moderate assistance for personal hygiene (washing/drying hands). During a concurrent observation and interview on 10/1/24 at 9:27 a.m. with Licensed Nurse (LN 6), and the Minimum Data Set Coordinator (MDSC) of Resident 83's fingernails, Resident 83's fingernails were long, with thick dark substance underneath them. LN 6 stated sometimes Resident 83 feeds herself with her fingers. The MDSC agreed Resident 83's fingernails were not clean. Resident 44 admitted to the facility in early 2020 with diagnoses which included cognitive impairment, lack of coordination and muscle weakness. During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44 needed substantial/maximum assistance with personal hygiene. During a concurrent observation and interview on 9/30/24 at 9:08 a.m. with the Infection Preventionist (IP) in Resident 44's room, Resident 44 had long fingernails with chipped pink nail polish and thick dark matter under the nails. Resident 44 stated, I eat with my fingers. The IP confirmed the dark substance under Resident 44's nails. During a concurrent observation and interview on 10/1/24 at 9:35 a.m. with the MDSC of Resident 44's nails, there was thick dark dry substance under her nails. The MDSC confirmed the findings and stated, .hand hygiene is important. Hands and nails should be kept clean . Resident 20 was admitted to the facility in late 2023 with diagnoses which included lack of coordination, and dementia (memory loss). (continued on next page)

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	555219	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Oaks Care Center	3400 Bell Road Auburn, CA 95603

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 required partial/moderate assistance for personal hygiene (washing/drying hands) . During an observation on 10/1/24 at 2:40 p.m. of Resident 20, Resident 20 had long fingernails with thick brown/black dried substance under the nails. During a concurrent observation and interview on 10/1/24 at 2:45 p.m. with Certified Nursing Assistant (CNA 4) of Resident 20's fingernails, CNA 4 confirmed Resident 20 had long nails with dark dry substance under them and stated, . I would not consider them clean .it's important to clean them, sometimes they eat with their hands, it could be cross contamination . During an interview on 10/2/24 at 2:28 p.m. with the Director of Staff Development (DSD), the DSD stated, .I expect staff to clean the nails of residents .nails should be kept clean .for several reasons; resident safety, prevent bacterial growth if they scratch themselves with dirty nails . 48860 2. Resident 29 was admitted to the facility in early 2024 with diagnoses which included spinal stenosis (narrowing of the spinal canal in the lower part of the back), dysphagia (difficulty swallowing foods or liquids), and unspecified dementia (loss of memory, language, problem-solving and other thinking abilities). During a review of Resident 29's MDS, dated [DATE], indicated Resident 29's cognition as moderately impaired. The MDS reflected that Resident 29 required supervision, verbal cues, and touching/steadying assistance when eating. During a review of Resident 29's care plan (CP), dated 8/5/24, the CP indicated Resident 29 was on, 1:1 assist and needs encouragement and sometimes feeding assist .Eats in dining room for most meals. During a dinning observation on 9/30/24 at 12:50 p.m. Resident 29 did not receive 1:1 assistance after the staff placed her meal in front of her. During a review of Resident 29's meal ticket, dated 9/30/24, the meal ticket indicated Resident 29's assist instruction which included 1:1 assist. During an interview on 9/30/24 at 2 p.m. with the Registered Dietitian (RD), the RD confirmed Resident 29 was on 1:1 assist and that staff should encourage and assist her during meals. During an interview on 10/2/24 at 10:18 a.m. with the Director of Nursing (DON), the DON stated, .staff should be sitting with the patient during meals and assisting them. The DON confirmed that Resident 29 was on 1:1 assist during meals. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living [ADL], dated 5/24, the P&P indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Fingernails/Toenails, Care of, dated 5/24, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 38528 Based on observation, interview and record review, the facility failed to ensure physician's orders were followed in accordance with professional standards for two of 25 sampled residents (Resident 85 and Resident 71), when: 1. Resident 85's oxygen (O2) was not administered as ordered and O2 saturation level was not monitored; and 2. Resident 71's insulin medication was administered outside of physician ordered parameters. These failures increased the potential risk for the decline in the residents' health status and well-being. Findings: 1. Resident 85 was admitted in the middle of 2024 with diagnoses which included lung cancer, pulmonary fibrosis (scarred lung tissue over time causing shortness of breath), and chronic obstructive pulmonary disease (COPD). During a review of Resident 85's Care Plan (CP), dated 8/21/24, the CP indicated, [Resident 85] has pulmonary fibrosis .oxygen therapy as ordered. During a review of Resident 85's Minimum Data Sets (MDS, an assessment tool), dated 8/27/24, the MDS indicated Resident 85 had no memory impairment and needed O2 therapy. During an observation on 9/30/24 at 11:30 a.m. in Resident 85's room, Resident 85 was in in bed and received O2 via nasal cannula (nasal tubing that delivers O2) at 4 liters/minute (L/min). During a review of Resident 85's Physician Orders (PO), dated 8/21/24, the PO indicated, Oxygen - @3 Liters/Min Via Nasal Cannula (Routine/Continuous) .Goal to Maintain 02 Sats [saturation, O2 levels in the blood] greater than 90% .Monitor O2 Sats .every shift. During a review of Resident 85's O2 Sats Summary for 9/26/24, 9/28/24 and 9/30/24, the O2 sats were only monitored two times per day, and on 9/29/24, the O2 sat was only monitored once the whole day. During a concurrent interview and record review of Resident 85's PO on 9/30/24 at 3:25 p.m. with LN 3, LN 3 verified the PO was O2 at 3L/min, and stated, It is important to follow the doctor's order .specially for residents with COPD . During an observation on 10/1/24 at 1:40 p.m. in Resident 85's room, Resident 85 was in bed and received O2 via nasal cannula which remained at 4 L/min. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/1/24 at 1:42 p.m. with LN 4, LN 4 confirmed Resident 85's continuously received 4L/min. LN 4 verified the order at 3L/min and titrate for O2 sat above 90% and check saturation every shift. When asked if she had checked the O2 sat for her shift, LN 4 stated, I have not checked the oxygen saturation in my shift. LN 4 confirmed the intervention to administer the medication as ordered. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 5/24, the P&P indicated, Verify that there is order for this procedure Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter . 46995 2. Resident 71 was readmitted to the facility in mid-2024 with diagnoses which included diabetes (disease that results in too much sugar in the blood). During a review Resident 71's, PO, dated 8/11/24, the PO indicated, Insulin Glargine [Insulin, lowers the levels of sugar in the blood. Glargine, long-acting type of insulin] .Inject 25 units [type of measurement] . HOLD FOR BLOOD SUGAR LESS THAN 151 . During a review of Resident 71's CP, undated, the CP indicated, [Resident 71] has a DX [diagnosis] of Diabetes .Diabetes medication as ordered by doctor . During a review of Resident 71's medication administration record (MAR), dated 9/1/24-9/30/24, the MAR indicated, Insulin Glargine .Inject 25 units .HOLD FOR BLOOD SUGAR LESS THAN 151 . On 9/13/24, Resident 71's blood sugar reading was 110, and on 9/27/24, Resident 71's blood sugar reading was 136. The MAR indicated Insulin Glargine was administered on both dates. During a concurrent interview and record review on 10/2/24 at 9:28 a.m. with the Director of Nursing (DON) of Resident 71's MAR, the DON confirmed the Insulin Glargine was marked as administered on 9/13/24 and 9/27/24. The DON confirmed the medication was given outside of the range ordered, and stated, My expectation for insulin is to follow the medication order .parameters are supposed to be followed. During an interview on 10/3/24 at 11:27 a.m. with Licensed Nurse (LN 7), LN 7 stated, Insulin orders have parameters .it will tell you what to give .I would not give insulin if the blood sugar was outside the parameter . blood sugar would drop too fast .we follow the doctor orders. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 10/23, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . During a review of facility's P&P titled, Conformity with Laws and Professional Standards of Care, revised 5/24, the P&P indicated, Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48175 Based on observation, interview, and record review, the facility failed to provide the residents with a safe and comfortable environment free of accident hazards when four out of ten residents' bathroom faucets had water temperatures above 120 degrees Fahrenheit (F, scale for measuring temperature). This failure could potentially place residents at risk of accidental scalds or burns from hot water. Findings: During a concurrent observation and interview on 9/30/24 at 8:56 a.m. with Certified Nurse Assistant (CNA) 6 in Resident 1's bathroom, CNA 6 confirmed the faucet water temperature to be 120.2 F. Resident 1 stated, The water is always very hot, and at times I am scared the water might burn or scald me . During a concurrent observation and interview on 9/30/24 at 11:02 a.m. with Housekeeper (HK) 1 in Resident 22 and 7's bathroom, HK 1 confirmed the faucet temperature to be 122.2 F. HK 1 stated that the water was very hot and could burn or scald the resident's skin since they were fragile. During a concurrent observation and interview on 9/30/24 at 11:11 a.m. with CNA 7 in Resident 13's bathroom, CNA 7 confirmed the faucet temperature to be 120.9 F. Resident 7 stated, I make sure the nurse is present before turning on the water because it is always scorching . During a concurrent observation and interview on 9/30/24 at 12:11 p.m. with the Maintenance Director (MD) in Resident 59's bathroom, the MD confirmed the faucet temperature to be 120.9 F on the surveyor's thermometer. The MD's thermometer read 120.5 F. Resident 59 stated, I know better than to turn the water to the left because it gets very hot, and I don't want to burn . During a review of the facility's policy and procedure (P&P) titled, Water Temperatures, Safety of, dated 5/24, the P&P indicated, .Water heaters .bathrooms .areas shall be set to temperatures of 105 degrees Fahrenheit to 120 degrees Fahrenheit .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 48175 Based on interview and record review, the facility failed to complete annual performance evaluations (PEs) for three of five sampled certified nursing assistants (CNAs; CNA 3, CNA 4, and CNA 5), for a census of 95. This failure increased the risk of residents receiving poor-quality care from the CNAs. Findings: During a concurrent interview and record review on 10/2/24 at 2:48 p.m. with the Director of Staffing Development (DSD) and the Consultant of Director of Staffing Development/Infection preventionist (CDSD/IP), the DSD and CDSD/IP reviewed CNA 3, CNA 4, and CNA 5's employee's files and found the following: CNA 3 was hired on 7/30/19, CNA 4 was hired on 12/26/20, and CNA 5 was hired on 8/31/09. All the CNAs files reviewed had no documented evidence the annual PEs were done. The DSD stated, I have not completed any employee's performance evaluations PEs in 2023 to 2024 . During a concurrent interview and record review, on 10/3/24 at 9:15 a.m. with the Administrator (ADM) and the Director of Nursing (DON), the DON stated, The PEs are completed by the DSD and are used to identify areas for improvement of residents' care and evaluate if care has been provided the correct way. The ADM stated, I found out yesterday and confirmed that no PEs were completed for 2023 to 2024. The ADM stated that if the PEs were not completed annually, the staff skills could be decreased, affecting the CNAs' competency in caring for the residents. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, dated 5/24, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 Based on observation, interview and record review, the facility failed to ensure: 1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted for on the medication administration record (MAR) and the Controlled Drug Record (CDR) for four of five randomly selected residents (Residents 3, 22, 75 and 78); and 2. An antibiotic emergency kit (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) was replaced timely after being opened and medications were removed. These failures resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. Findings: 1. Resident 3 had a physician's order dated 9/16/24, for hydrocodone/acetaminophen (a medication to treat pain) 5/325 milligrams (mg, a unit of measurement), one tablet every eight hours around the clock and one tablet every four hours as needed for pain. The CDR indicated 1 tablet was removed on 9/26/24 at 11:31 p.m. , but the respective administration was not documented on the MAR. Resident 22 had a physician's order dated 9/11/24, for tramadol (a medication to treat pain) 50 mg, one tablet every eight hours for pain management. The MAR indicated 1 tablet was administered to Resident 22 on 9/18/24 at 3 a.m. but the removal was not documented on the CDR. Resident 75 had a physician's order dated 8/28/24, for lorazepam (a medication to treat anxiety) 0.5 mg, half tablet every four hours as needed for anxiety. The CDR indicated half a tablet was removed on 9/18/24 at 8:24 p.m. but the respective administration was not documented on the MAR. Resident 78 had a physician's order dated 7/12/24, for hydrocodone/acetaminophen 5/325 mg, one tablet every 4 hours as needed. The MAR indicated 1 tablet was administered on the following dates and times, but their removal was not documented on the CDR: 8/8/24 at 10:16 a.m., 8/8/24 at 4:02 p.m., and 8/9/24 at 3:42 p.m. During an interview on 9/30/24 at 2:14 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated whenever a controlled medication was administered to a resident, the removal of the medication was to be documented on the CDR and the administration in the MAR. She stated nursing staff checked the MAR to know when a resident was last given a medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 10:34 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to document the administration of controlled medications on both the CDR and the MAR. She stated documentation in the CDR and MAR allowed nursing staff to know what was removed from the medication cart and when a dose was last given. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications, revised 10/2022, the P&P indicated, Procedures . 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose, completed after the medication is actually administered. 2. During a concurrent interview and inspection on 9/30/24 at 10:52 a.m. of Medication Storage room [ROOM NUMBER] with the Assistant Director of Nursing (ADON), an e-kit with a red plastic tie (indicating it had been opened) was identified. Inside the e-kit were seven e-kit logs indicating what medications had been removed. The e-kit logs indicated medications were removed on the following dates: 9/14/24, 9/19/24, 9/20/24, 9/21/24, 9/26/24, and 9/27/24. ADON confirmed the finding and stated nursing staff were expected to request a replacement e-kit as soon as it was opened and used to ensure all doses of each medication were on hand and available for use when needed. During a review of the facility's P&P titled, Emergency Kits, revised 10/2023, the P&P indicated, Procedures . 7 . opened kits are replaced with sealed kits within 72 hours of opening.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 Based on interview and record review, the facility failed to develop and implement a process to ensure clinical rationale was documented when no changes were made to medications in response to identified irregularities and recommendations by the pharmacy consultant (PC) for one of 25 sampled residents (Resident 83). This failure had the potential to result in medication-related problems, errors, or irregularities identified and reported by the PC, and the potential for unnecessary medications (such as prolonged use, excessive dose, unmonitored use, duplication, etc.) for the resident. Findings: A review of Resident 83's medical record indicated she was admitted to the facility on [DATE] with multiple diagnosis including Huntington's disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down and die), anxiety, insomnia, dementia, high blood pressure, depression, and repeated falls. A review of the Resident 83's medical record indicated she had physician's orders for the following medications: aripiprazole (a medication to treat Huntington's disease), trazodone (a medication to treat insomnia), sertraline (a medication to treat depression), tetrabenazine (a medication to treat Huntington's disease), lamotrigine (a medication to prevent seizures), lorazepam (a medication to treat anxiety), and carvedilol (a medication to treat high blood pressure). During an interview on 10/1/24 at 2:59 p.m. with Director of Nursing (DON), DON stated the PC's monthly drug regimen reviews (MRR) were given to the provider for review. She stated the provider was to assess the risk versus benefit for any recommendations and to document clinical rational if they did not agree with them. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/1/24 at 3:03 p.m. with DON the PC's MRR dated 7/11/24 for Resident 83 was reviewed. The MRR indicated, Resident's medications were reviewed for possible adverse effects or drug interactions which may have contributed to her recent falls . Combination therapy of aripiprazole sertraline, trazodone, tetrabenazine, and lamotrigine increases risk of CNS depression. Combination therapy of aripiprazole, sertraline, trazodone and tetrabenazine can increase risk of serotonin syndrome (a serious and potentially life-threatening condition that occurs when there is too much serotonin in the body); use of aripiprazole and tetrabenazine can increase risk of neuroleptic malignant syndrome (a life-threatening condition that can occur as a reaction to certain drugs used to treat mental illness) and increased risk of extrapyramidal symptoms (a group of side effects that cause involuntary movements and other motor issues that can occur as a result of taking medications used to treat mental illness). Would recommend evaluating regimen and assessing risk vs. benefits of therapy and if appropriate can consider dose reductions. She receives lamotrigine ER (extended release) 25 mg twice a day. Lamotrigine ER (extended release) is typically dosed once a day. Would recommend assessing appropriateness/necessity for resident to receive lamotrigine ER twice a day as she may be experiencing adverse effects of therapy, which may be contributing to her falls . consider changing ER therapy to once-a-day dosing or change to IR (immediate release) formulation . DON confirmed the MRR indicated the provider marked disagree with the PC's recommendations however the clinical rationale was not documented. During a concurrent interview and record review on 10/1/24 at 3:10 p.m. with DON, the PC's MRRs for Resident 83, both dated 7/12/24 were reviewed. The MRRs indicated, Resident has an order for lamotrigine ER 25 mg scheduled twice a day. Lamotrigine ER (extended release) is typically dosed once a day . should dose be changed to ER 50 mg daily? Or changed to the IR (immediate release) formulation for twice a day dosing? The DON confirmed the MRR indicated the provider marked disagree with the PC's recommendations but did not document the rationale. The second MRR dated 7/12/24 indicated, Resident is on 2 antidepressants . although combination therapy may be clinically appropriate, use of 2 antidepressants may appear as duplicate therapy. Please review the orders to assess appropriateness/necessity for resident to be on 2 antidepressant therapies as this can increase risk of adverse effects/toxicity. The DON confirmed the MRR indicated the provider disagreed with the PC's recommendations but did not provide clinical rationale. During an interview on 10/1/24 at approximately 4 p.m. with DON, a facility P&P addressing the facility's process for reviewing and acting upon the PC's MRRs was requested. The facility was unable to provide the requested P&P.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43258 Based on observation, interview, and record review, the facility failed to ensure expired medications were not available for resident use, medications with shorter expiration dates after use were labeled with an open date, single-use medications were discarded after use, medications were labeled with a pharmacy label, and medications in medication carts were stored in a clean, safe and orderly manner in accordance with the facility's policy and procedure (P&P). These failures had the potential for residents to receive medications with unsafe or reduced potency from being used past their expiration date or improper storage, and diversion or misuse of medications from not being safely stored. Findings: During an inspection on 9/30/24 at approximately 11 a.m. of the Central Supply, alongside Assistant Director of Nursing (ADON), three tubes Skintegrity Hydrogel (a topical used for wound care) expired 2/2024 and two vials EvenCare G3 blood glucose test strips (used to test blood sugar) expired 6/2024 were identified. ADON confirmed the finding and stated expired items were to be removed from facility stock. During an inspection of Medication Cart Station 2 Front on 9/30/24 at approximately 12 p.m. with Licensed Nurse 2 (LN 2), one open vial Assure Platinum blood glucose test strips was identified. LN 2 confirmed the manufacturer's labeling on the package indicated they expired six months after opening. Inspection of the cart also identified four loose tablets in the drawers, one partially used bottle sterile normal saline (used to moisten wound dressing) 0.9%, and three partially used bottles acetic acid irrigation 0.25% irrigation (used to flush tubing to prevent infection). LN 2 confirmed the loose tablets should not have been available in the cart and needed to be disposed. She acknowledged the manufacturer's labeling on the normal saline and acetic acid solutions indicated single use and agreed any unused portion was to be discarded after opening the bottles. A review of the manufacturer's labeling for acetic acid 0.25% irrigation, dated 8/2023, the labeling indicated, Description . contains no preservatives . Precautions . Use only if solution is clear and container and seal are intact . Unused portions should be discarded and a fresh container of appropriate size used for the start up of each cycle or repeat procedure . A review of the manufacturer's package labeling for sterile 0.9% normal saline indicated, Caution . No antimicrobial or other substance added . Contents sterile unless container is opened . During an inspection of Medication Cart Station 2 Back on 9/30/24 at approximately 12:40 p.m. with LN 1, three loose tablets in the drawers were identified with one vial nitroglycerin (a medication used to treat chest pain) 0.4 milligram (mg, a unit of measurement) sublingual (under the tongue) tablets in a clear, unlabeled plastic bag were identified. LN 1 confirmed the loose tablets should have been disposed of and all medications provided by the pharmacy needed labeling to identify which resident it was for. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Storage of Medications, revised October 2023, the P&P indicated, Policy Interpretation and Implementation . 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Discontinued, outdated, or deteriorated drugs or biologicals are placed on designated appropriate bins for destruction. During a review of the facility's P&P titled, Medication Labeling, revised October 2023, the P&P indicated, Policy Interpretation and Implementation . 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with . currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum . d. expiration date as determined by the manufacturer e. resident's name . During an inspection of Medication Cart 2 Back on 10/1/24 at 9:57 a.m. with LN 4, two bags containing injectable medications along with a third bag containing topical patches for separate residents were identified stored with oral medications. LN 4 stated medications that required different routes of administration should have been stored separately. During an inspection of Medication Cart 2 Front on 10/1/24 at 10:04 a.m. with LN 5, one bag of transdermal patches was identified in a drawer with oral medications. LN 5 stated topical medications should have been stored separately from oral medications. During an interview on 10/1/24 at 10:46 a.m. with the Director of Nursing (DON), DON stated medications that required different routes of administration should have been stored in separate compartments in the medication carts. She stated nurses were expected to inspect their carts between shifts for loose tablets and dispose of them. DON stated medications provided by the pharmacy should have all had a resident specific label on them to correctly identify who it was for. She stated single-use medications should have been discarded after the first use since there was a risk of contamination. During a review of the facility's P&P titled, Storage of Medications, revised October 2023, the P&P indicated, Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation . 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview, and record review, the facility failed to ensure resident food preferences were accommodated for four of 25 sampled residents (Resident 51, Resident 60, Resident 82, and Resident 20), when the residents' meal choices were not served. This failure increased the potential risk for the residents not attaining their highest practicable mental, physical and psychosocial well-being. Findings: 1. Resident 51 was admitted in late 2020 and readmitted in the middle of 2021 with diagnoses which included malnutrition, adult failure to thrive (condition where the individual's organs specifically the digestive tract are not absorbing required nutrients), and swallowing difficulty. During a review of Resident 51's care plan (CP), dated 9/2/24, the CP indicated, At risk for Altered Nutritional Status, Malnutrition - 9/2/22, revised 7/4/24 - Food preferences to be honored; Baseline food preferences - 10/26/22, revised 7/7/24 - Food preferences to be honored at time of service. During a review of Resident 51's Physician Orders (PO), dated 9/1/22, the PO indicated, Regular Diet, Mechanical [Mech] Soft Ground [Grnd]Texture, Thin Liquid consistency .dated 6/9/24, Ensure Plus .dated 4/13/24, Snacks between meals. During a review of Resident 51's Minimum Data Set (MDS, an assessment tool), dated 9/4/24, the MDS indicated Resident 51 had severe memory impairment, required set-up with meals, and needed mechanically altered and therapeutic diet. During a concurrent observation and interview on 9/30/24 at 1:06 p.m. in the dining room, Resident 51 had a lunch meal and appeared confused about what she got on her meal tray. The meal tray contained one piece of sandwich and the meal ticket indicated a regular diet order. Resident 51 stated, I don't know why they gave me just a sandwich. During a concurrent observation and interview on 9/30/24 at 1:07 p.m. in the dining room with the Infection Preventionist (IP), the IP confirmed the sandwich on the meal tray, and stated, Let me check. IP came back and stated, She wants sandwiches for her lunch. That's what they told me. 2. Resident 60 was admitted in the middle of 2024 with diagnoses which included weakness and enterocolitis (inflammation of the digestive tract caused by bacteria), and depression. During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60 had mild memory impairment, required set-up with meals, and needed mechanically altered and therapeutic diet. During a concurrent observation and interview on 9/30/24 at 9:27 a.m. in Resident 60's room, Resident 60 was in bed, awake and alert, verbally responsive, and stated, Food is not great. They don't give me what I want. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/24 at 10:02 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated, [Resident 60] is alert and oriented from time to time and aware of what's going on. During a concurrent observation and interview on 10/1/24 at 1:20 p.m. in Resident 60's room, Resident 60 was in bed, awake and alert and the bedside table was empty, and stated, I didn't like the food they served me. They gave me pasta and I can't eat it. It is not what I asked. I didn't like the food. It's not healthy. They took the tray and they didn't ask me if I need a replacement. During a concurrent observation and interview on 10/1/24 at 1:21 p.m. with Licensed Nurse (LN) 7, LN 7 checked Resident 60's meal tray on the meal cart and confirmed the meal tray contained a pasta, and the meal ticket indicated, Heart healthy diet. Dislikes: Bread, Pasta, Rice. LN 7 stated, [Resident 60] didn't tell us. I'll checked if she wants a replacement. She didn't say she was hungry. 3. Resident 82 was admitted in the middle of 2024 with diagnoses which included adult failure to thrive. During a review of Resident 82's CP, dated 6/5/24, the CP indicated, Malnutrition: [Resident 82] is at risk for malnutrition due to anemia (low red blood cells) .Cater to food preferences. During a review of Resident 82's PO, dated 8/30/24, the PO indicated, CCHO [consistent carbohydrate, eating the same amount of carbohydrate to help manage blood sugar levels) diet, Chopped Meat Texture, Thin Liquid Consistency. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 had no memory impairment, required therapeutic diet, and needed partial assistance with eating. During an interview on 10/01/24 at 10:49 a.m. at the resident council meeting, Resident 82 stated, They put gravy in your meat. I don't like gravy in my meat because it just adds a taste to the meat. I told them that and they keep on putting gravy on the meat. During a concurrent observation and interview on 10/1/24 at 1:10 p.m. in the dining room, Resident 82 was upset and pushed his meal plate on the side, and stated, I cannot stand the red sauces put in the food. It's like gravy except it's red. I already told them that and still it's in my plate. I don't like sauce and spices in my food. Resident 82's meal ticket indicated, dislikes, Spicy .Salsa, Enchilada Sauce. During a concurrent observation and interview on 10/1/24 at 1:11 p.m. in the dining room, the Assistant Director of Nursing (ADON),verified the meal plate with sauce on the food, and stated, Let me get a replacement .What would you like to have? Resident 82 answered, Anything without sauce in it. I don't like any sauce. 4. Resident 20 was admitted in late 2024 with diagnoses which included malnutrition and depression. During a review of Resident 20's PO, dated 11/16/21, the PO indicated, Regular Diet /Mech Soft/Grnd Texture/Thin Liquid Consistency. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had moderate memory impairment and needed assistance with ADLs. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/1/24 at 1:08 p.m. in the dining room, Resident 20's meal plate contained a single piece of sandwich. Resident 20 appeared dissatisfied with what she got in her plate, and stated, I am not sure why they just gave me a sandwich. I like sandwich but we are having lunch. The other residents who were in the same table had regular food from the menu served. The meal ticket for the Resident 20 indicated, Regular Diet/Mech Soft/Grnd Texture/Thin Liquid Consistency .Likes: Soup, P.B. J. [peanut butter and jelly] Sandwich, Veggies . During a concurrent observation and interview on 10/1/24 at 1:09 p.m. in the dining room with the Infection Preventionist (IP), the IP verified Resident 20's meal plate, and stated, I am not sure why both [Resident 20 and Resident 51] received the same sandwich. I don't know who decides that. During an interview on 10/2/24 at 10 a.m. with the Registered Dietitian (RD), the RD stated, A patient on a regular diet is under no diet restrictions. I expect them to read out the tray ticket and the preferences and the diet order and the cook will plate their food. During a review of an undated facility's policy and procedure (P&P) titled, Food Preferences, the P&P indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods dislike will be given the appropriate food group. Condiments such as salt, pepper, and sugar are available at each meal unless contraindicated by the diet order .Food preferences can be obtained from the resident, family, or staff members. Updating of food preferences will be done as the resident's needs change and/or during the quarterly review.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48860 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a total of 95 residents who received facility prepared foods, when: 1. Proper food labeling was not followed; 2. Expired foods were not discarded; 3. Undated box of loose bananas with dark brown to black discoloration and leaking fluids were stored in the walk-in refrigerator; and 4. Several wet steam table pans were found stacked at the clean and ready-to-use storage areas. These failures had the potential to cause food-borne illnesses. Findings: 1. During the initial kitchen tour on [DATE] beginning at 8:40 a.m. the following items were observed not having proper labeling: Inside the dry storage: Unlabeled and opened clear plastic bag of coconut flakes with no opened or used date. Inside the walk-in refrigerator: Opened resealable plastic bag of diced onion with no opened or used by date; and Unlabeled and opened clear plastic bag of cut celery sticks with no opened or used by date. During a concurrent observation and interview on [DATE] at 9:04 a.m. with the Registered Dietitian (RD) in the dry food storage room in the kitchen, the RD confirmed the observed item did not have the proper labels and removed it from the shelf. During a concurrent observation and interview on [DATE] at 9:53 a.m. with the RD in the walk-in refrigerator in the kitchen, the RD confirmed the observed items did not have the proper labels and removed it from the shelf. During an interview with the RD on [DATE] at 10 a.m. the RD stated that food items stored in dry storage and walk-in refrigerator, should be labeled and dated before it gets in. The RD expects the staff to label the food items correctly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility Policy and Procedure (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated, . Labels should be visible .All foods will be dated- month, day, year. 2. During an observation on [DATE], within the initial kitchen tour beginning at 8:40 a.m. the following expired items were observed: Inside the dry storage room: Carton of .Oat Milk expired on of [DATE]; Box of .salad dressing packets expired on [DATE]; Box of .chocolate baking chips expired on [DATE]; and Box of .[pie] Crust Expired on [DATE]. Inside the walk-in refrigerator: Clear plastic bag with four peeled hard-boiled eggs with opened date of [DATE]. Inside the front refrigerator: Opened carton of .Soy Milk expired on [DATE]. During a concurrent observation and interview on [DATE], at 9:04 a.m. with the RD in the dry storage area of the kitchen, the RD confirmed the observations of expired products in the dry storage, and stated, Those should have been thrown away. During a concurrent observation and interview on [DATE], at 9:36 a.m. a pack of four peeled hard-boiled eggs with an open date of [DATE] were stored on a shelf in the walk-in refrigerator. The RD confirmed the observation, and stated, It should've been dumped by staff. During a concurrent observation and interview on [DATE] at 10 a.m. an opened carton of Soy Milk with an expiration date of [DATE] was found inside the front refrigerator. The RD confirmed the observation. During an interview on [DATE] at 10 a.m. with the RD, the RD indicated she expected the staff to regularly check the expirations or the use-by date and to discard expired items immediately. During a review of the facility P&P titled, Storage of Food and Supplies,dated 2023, the P&P indicated, .No food will be kept longer than the expiration date on the product. During a review of the U.S Food and Drug Administration (FDA) document titled, FOOD FACTS, Egg Safety: What You Need To Know, dated ,d+[DATE], The document indicated, Storing .Use or eat hard-cooked eggs (in the shell or peeled) within 1 week after cooking. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of the US FDA (Food and Drug Administration) Food Code 2022, ,d+[DATE].17 (A) (B) (C) (D) discusses required food labeling and dating. The FDA code indicated, The day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. 3. During a concurrent observation and interview on [DATE] within the initial kitchen tour at 9:32 a.m. a box of undated loose bananas with dark brown to black discoloration and leaking fluids were stored on the bottom shelf of the rack inside the walk-in refrigerator. Both the RD and the Dietary Manager (DM) confirmed this observation. The DM stated that the bananas would not be served to the residents. During an interview with the RD on [DATE] at 10 a.m. the RD stated that produce stored in the kitchen should be properly sealed and labeled with the received, opened, and used-by dates. The RD also expected staff to make sure the produce remains fresh and discard any overripe produce. During a review of the facility P&P titled, STORING PRODUCE, dated 2023, the P&P indicated, Check boxes of fruit and vegetables for rotten, spoiled items .Bananas should be stored at room temperature. When fully ripe, bananas may be stored in the refrigerator for five days . 4. During a concurrent observation and interview on [DATE], within the initial kitchen tour at 8:53 a.m. several steam table pans were found stored wet. The RD and DM confirmed the observation. During an interview with the RD on [DATE] at 10 a.m. the RD stated that pans and other utensils should be air dried for sanitation reasons. During a review of the facility P&P titled, DISHWASHING, dated 20123 [sic], the P&P indicated, Dishes are to be air dried in racks before stacking and storing. During a review of the US FDA 2022 Food Code, Annex ,d+[DATE].11, titled, Equipment and Utensils, Air-Drying Required, [DATE] version, the FDA code indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program for four of 25 sampled residents (Resident 148, Resident 36, Resident 1 and Resident 3), when: 1. A hand held nebulizer (HHN, breathing treatment device) and a nasal cannula (tubing that delivers oxygen) were unlabeled and undated for Resident 148; 2. A nasal cannula and HHN with expired dates were found at the nightstand of Resident 36; 3. Resident 1's oxygen (O2) tubing and face mask was not labeled or dated; and 4. Resident 3 O2 tubing and face masks were not labeled or dated and the antimicrobial bag was labeled with an expired date. These failures increased the potential risk for respiratory infection. Findings: 1. Resident 148 was admitted in late 2024 with diagnoses which included pulmonary edema (fluid in the lung causing cough with extreme difficulty of breathing), muscle weakness and swallowing difficulty. During a concurrent observation and interview on [DATE] at 10:23 a.m. in Resident 148's room, a HHN on top of the wheelchair with no date and label was found. Resident 148 was in bed, awake, alert and verbally responsive, and stated, That is mine. On top of the nightstand was another nasal cannula tubing with no date, and a nebulizer bag dated [DATE]. During a concurrent observation and interview on [DATE] at 10:30 a.m. in Resident 148's room with Certified Nursing Assistant (CNA) 11 and Resident 148, CNA 11 verified the HHN on top of the wheelchair belonged to Resident 148, and stated, The stuff is hers .I hadn't had a chance to clean up these stuff .Sorry, the tube is a little tangled up with her. I don't see a label on this one .There's a label on that one at the nightstand but the nebulizer has no label and the bag has a label but both are dated more than a week. 2. Resident 36 was admitted in late 2024 with diagnoses which included asthma exacerbation (the lung airways become inflamed, narrow and swell making it difficult to breath), respiratory failure with hypoxia (low level of O2). During an observation on [DATE] at 11:03 a.m. in Resident 36's room, Resident 36 was in bed, awake, alert and verbally responsive in his own language. On top of the night stand were an unlabeled and undated nasal cannula connected to the nebulizer machine which was dated [DATE], a disconnected nebulizer chamber with liquid medication dated [DATE], and an undated disconnected O2 mask coiled with parts of the tube touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 11:05 in Resident 36's room with CNA 9, CNA 9 verified the findings on top of Resident 36's nightstand, and stated, So, that's labeled [DATE] on the machine. Today is [DATE], so it has been 10 days. The tube is dated [DATE]. There's no date on the other tubing .The other one that is touching the floor has no labeled date. During a concurrent observation and interview on [DATE] at 11:10 a.m. in Resident 36's room with LN 7, LN 7 verified the dates of the tubing, and stated, This one here should have a date on. We change the oxygen tubing weekly so that's expired and should have been changed .The nebulizer mask are supposed to be in a bag, labeled and dated, and these bags are not dated .When they are not changed every week, they get respiratory infections. It's all about infection. 48175 3. Resident 1 was admitted to the facility in early 2012 with a diagnosis that included quadriplegia (paralysis of upper and lower limbs) and a history of COVID-19. During a review of Resident 1's care plan (CP), dated [DATE], the CP indicated, [Resident 1] .receiving muscle relaxant .serious side effects .respiratory depression .and enhanced barrier precautions .MDRO [multidrug resistant organism] .PO [by mouth] ABT [antibiotic] .MD [physician] will not change this due to risk of infection. During a concurrent observation and interview on [DATE] at 8:56 a.m. in Resident 1's room, with CNA 6, CNA 6 stated, The oxygen tubing and the face mask should be dated and labeled weekly. There's someone assigned to change .otherwise, the patient can develop an infection . During a concurrent observation and interview on [DATE] at 8:59 a.m. in Resident 1's room with LN 1, LN 1 stated, The oxygen tubing and the face mask are changed weekly .Not sure why this is not dated or labeled . The tubes and masks are changed weekly to prevent any respiratory infection . 4. Resident 3 was admitted to the facility in the Spring of 2024 with diagnoses that included sepsis (generalized infection), pneumonitis (lung inflammation), and resistance to multiple antimicrobial drugs. During a review of Resident 3's Physician Orders (PO), dated [DATE], the PO indicated, Oxygen - @ 2 Liters/Min [minute, time measure] Via Nasal Cannula (PRN) .Change O2 .every Fri .Monitor O2 Sats . During a review of Resident 3's PO, dated [DATE], the PO indicated, Admit to .Hospice .Oxygen Change O2 tubing .every Fri. During a review of Resident 3's CP dated [DATE], the CP indicated, [Resident 3] .receiving hospice care . abnormal breathing .and enhanced barrier precautions .MDRO .respiratory system .infection . During a review of Resident 3's PO dated [DATE], the PO indicated, Ipratropium-Albuterol Solution .for SOB [shortness of breath] via nebulizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 10:11 a.m. in Resident 3's room with the Director of Nursing (DON), the DON verified that the tubing and face mask should be changed weekly, and the antimicrobial bag should be changed monthly .The antimicrobial bag is dated [DATE] .Our residents are susceptible to infections . During an interview on [DATE] at 2:26 p.m. with the DON, the DON stated, The bags, tubes and nebulizers are changed weekly, and this is standard. If they are not being used, they will be placed on the antimicrobial [agent that kills bacterial growth) bag which is the black bag, and we also change the bag for the nebulizer because it gets dirty for a while. About the used tubing, they have to discard them after they are changed and don't leave it in the room, and the tubes and nebulizer should be labeled with the date when they were changed for infection control. During a review of facility's policy and procedure (P&P) titled, Oxygen Administration, revised ,d+[DATE], the P&P indicated, Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter .The Oxygen tubing is changed at least weekly, labeled with the date it was changed, and stored in anti-microbial bag which is changed at least every 30 days. During a review of the facility's P&P titled, Infection Prevention and Control, revised ,d+[DATE], the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent and manage transmission of communicable diseases and infections.

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	10/03/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 48175 Based on observation, interview, and record review, the facility failed to ensure the antibiotic stewardship guidelines were followed for one of 25 sampled residents (Resident 12), when Resident 12 received an antibiotic with no end date. This failure resulted in inappropriate or unnecessary use of antibiotic treatment for the resident. Findings: Resident 12 was admitted to the facility in the Spring of 2012 with a diagnosis that included diabetes (abnormal blood sugar levels), kidney disease, and urinary tract infection (UTI). During a review of Resident 12's Physician Orders (PO), dated 12/11/22, the PO indicated, [Brand Name] Capsule 250 MG (Cephalexin) Give 250 mg [milligram, unit of weight] by mouth one time a day for UTI . CEPHALEXIN 250 MG CAPSULE - TAKE 1 CAPSULE BY MOUTH ONCE DAILY (NO STOP DATE . INDEFINITE). There was no documented evidence an order of monitoring for signs and symptoms of UTI. During a review of Resident 12's Minimum Data Set (MDS, an assessment tool), dated 8/14/24, the MDS indicated Resident 12 had no memory impairment. During an interview on 10/1/24 at 10:04 a.m. with the Facility Pharmacist (FP), the FP stated, .Taking the lowest dose and don't have a diagnosis .Taking the medication can cause Clostridium difficile [C-Diff, a bacterium that causes diarrhea and colon inflammation]. I am not sure what the diagnosis they are using it for, and we keep on asking for the stop date for the antibiotic, and they say it is indefinite .You cannot take an antibiotic indefinitely . During an interview on 10/1/24 at 10:13 a.m. with the Director of Nursing (DON), the DON stated, [Resident 12] has a history of chronic UTI .There is no specific order to monitor for UTIs .We follow the doctor's order . There was no documentation of failure if [Resident 12] stopped taking the antibiotic .No orders from the doctor indicate monitoring for signs and symptoms of UTI .There's no documentation of monitoring UTIs . During a record review on 10/1/24 at 10:25 a.m. of the Medication Regimen Review (MRR) with the DON, the DON verified the MRR indicated the antibiotic order was not reviewed and no recommendations were made in 2024. During an interview on 10/1/24 at 11:03 a.m. with the Consultant of the Director of Staffing Development/Infection Preventionist (CDSD/IP) and Infection Preventionist (IP), the IP stated, I don't see specific orders to monitor for signs and symptoms for UTI, the [Resident] has been on it for a long time .The CDSD/IP stated, I would have to discuss that with the provider .There is no way to tell with no cultures .We can see if the doctor will change it . During a concurrent observation and interview on 10/2/24, at 12 p.m. in Resident 12's room, Resident sat in a wheelchair, awake, alert and verbally responsive, and stated, I had terrible UTIs. (continued on next page)

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	10/03/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, revised 2/19, the P&P indicated, If an antibiotic .Prescribers will provide .Start and stop date, or Number of days of therapy .