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	01/08/2026

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 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. Based on observation, interview, and record review, the facility failed to follow physician orders for two of 24 sampled residents (Resident 41 and Resident 31), when:1. Resident 41's administered oxygen amount did not match the physician's order, and 2. Resident 31 received tramadol (an opioid analgesic for pain) on 12/6/25, 12/7/25, 12/27/25, and 12/28/25 without having scheduled physical therapy (PT) sessions as per physician order.These failures decreased the facility's potential to follow the residents' physician orders as prescribed.Findings: 1. A review of an admission record indicated Resident 41 was admitted to the facility in the winter of 2025 with diagnoses including chronic obstructive pulmonary disease (COPD, a lung condition which makes it harder to breathe out because the airways become narrowed, inflamed, or damaged, trapping air and making you feel short of breath) and respiratory failure. During an observation on 1/5/26 at 10:49 a.m., Resident 41's oxygen concentrator was observed to be at 3.5 liters (L; a unit of volume measurement) per minute. A review of Resident 41's physician order, dated 8/25/25, indicated an order for oxygen at two liters per minute via nasal cannula (a thin tube connecting the oxygen source to the resident's nose for administration) for COPD. A review of Resident 41's care plan, dated 11/18/25, indicated Resident 41 required the use of oxygen continuously at two liters via nasal cannula related to COPD. During a concurrent observation, interview, and record review on 1/5/26 at 11:01 a.m. with Licensed Nurse (LN) 1, Resident 41's physician order was reviewed. LN 1 confirmed Resident 41's oxygen concentrator was set at 3.5 liters per minute and stated as per physician order, oxygen was supposed to be at two liters per minute. LN 1 further stated she did not check Resident 41's oxygen during morning round and should have checked it. During a concurrent interview and record review on 1/7/26 at 12:38 p.m. with the Director of Nursing (DON), Resident 41's physician order was reviewed. DON confirmed Resident 41's oxygen order was two liters per minute for COPD. DON stated staff should have set the oxygen condenser based on Resident 41's physician order. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 10/24, indicated, Adjust the oxygen delivery device so . the proper flow of oxygen is being administered . 2. A review of an admission record indicated Resident 31 was admitted to the facility in October 2025 with diagnoses including fracture of the thigh bone and difficulty in walking. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 31's Order Summary Report (OSR), dated 11/21/25, indicated, 50 milligrams (mg; a unit of measure) of tramadol hydrochloride oral tablet to be given by mouth one time a day for pain management prior to therapy. OSR further indicated Resident 31 was scheduled to receive PT five times a week for four weeks. A review of the facility's document titled, Service Log Matrix . PT, dated 1/6/26, indicated Resident 31 did not receive PT sessions on the following dates: 12/6/25, 12/7/25, 12/13/25, 12/14/25, 12/20/25, 12/21/25, 12/26/25, 12/27/25, and 12/28/25. During a concurrent interview and record review on 1/6/26 at 2:24 p.m. with the Director of Rehabilitation (DR), DR confirmed Resident 31 did not have scheduled PT sessions on the dates indicated in the Service Log Matrix, dated 1/6/26. A review of Resident 31's Electronic Medication Administration Record (EMAR), indicated tramadol 50 mg was administered on the following dates without any scheduled PT: 12/6/25, 12/7/25, 12/27/25, and 12/28/25. On 12/7/25, 12/27/25, and 12/28/25 Resident 31's pain level was zero (indicating no pain). The EMAR further indicated Resident 31 was offered tramadol 50 mg and refused it on 12/13/25, 12/14/25, 12/20/25, 12/21/25, and 12/26/25. Resident 31's pain score was zero and had no scheduled PT. During a concurrent interview and record review on 1/6/26 at 2:08 p.m. with LN 1, Resident 31's EMAR was reviewed. LN 1 confirmed the findings documented in Resident 31's EMAR and stated nurses were required to follow the physician's orders. LN 1 further stated failing to follow physician's order could result in harm to residents. During a concurrent interview and record review on 1/6/26 at 2:42 p.m. with DON, Resident 31's EMAR and Service Log Matrix, were reviewed. DON confirmed Resident 31 had an order for tramadol to be administered prior to her PT sessions. DON also confirmed the findings documented in Resident 31's EMAR and the Service Log Matrix. DON stated nurses must ensure they were administering the correct medication to the right resident, at the appropriate dose, and frequency. DON also stated nurses need to make sure they follow exactly what the physician's order indicate. A review of the facility's P&P titled, Administering Medications, revised 10/24, indicated, . Medications are administered in accordance with prescriber orders, including any required time frame . The individual administering the medications checks the label to verify . right dosage, right time.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for a census of 93 residents, when:1. Resident bowls and food containers were found stacked upright in the drying area;2. Unsealed bags of food were found in the refrigerator and freezer; and3. Unlabeled food items were found in the refrigerator.These failures decreased the facility's potential to prevent foodborne illness among vulnerable residents eating facility prepared food.Findings:1. During a concurrent observation and interview on 1/5/26 at 8:20 a.m. with the Registered Dietitian (RD) and the Dietary Manager (DM), several resident bowls and containers were observed stacked upright in the air-drying area. RD confirmed the observation.A review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-901.11, indicated, After cleaning and sanitizing, equipment, and utensils: (A) Shall be air-dried . The guidance further 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.A review of the FDA Food Code 2022, Section 4-903, indicated, Cleaned Equipment and Utensils . shall be stored . where they are not exposed to splash, dust, or other contamination; The guidance further indicated, (1) In a self-draining position that allows air drying; and (2) covered or inverted.2. During a concurrent observation and interview on 1/5/26 at 8:29 a.m. with the DM, a bag of chopped onions was found stored in the refrigerator unsealed. DM stated the bag of chopped onions should have been properly sealed.During a concurrent observation and interview on 1/5/26 at 8:50 a.m. with the RD and DM, frozen pot stickers were stored unsealed with freezer burn (in which frozen food dehydrates due to air exposure, creating tough, discolored spots which can affect taste) in the freezer. RD stated the bag should have been well sealed.A review of the facility's policy titled, Labeling and Dating of Foods, dated 2023, indicated, all food items in the storeroom, refrigerator, and freezer . should be closed A review of the United State (US) FDA 2022 Food Guide, section 3-305.11 on Food Storage, indicated in bullet (A) . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. The guide further indicated, Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate and drafts of unfiltered air can be sources of microbial contamination for stored food.3. During a concurrent observation and interview on 1/5/26 at 8:31 a.m. with the DM, a bag of Danish pastries was found unlabeled in the refrigerator. DM stated the Danish pastries should have been labeled.During an interview on 1/8/26 at 9:15 a.m. with the Director of Nursing (DON), DON stated food should be properly closed and labeled because failure to do so had the potential to cause gastrointestinal (stomach and intestinal) issues for residents.A review of the facility's policy titled, Labeling and Dating of Foods, dated 2023, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.

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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. Based on observation, interview, and record review, the facility failed to maintain a safe environment for one of 24 sampled residents (Resident 112), when a transition strip (a narrow piece of material [often metal, wood, or vinyl] used to cover and protect the seam where two different types of flooring meet) between Resident 112's bedroom and bathroom was not securely affixed.This failure decreased the facility's potential to prevent Resident 112 from a fall, injury or harm due to tripping hazard.Findings:A review of an admission record indicated Resident 112 was admitted to the facility in late 2025 with a diagnosis of difficulty in walking.A review of Resident 112's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 12/30/25, indicated Resident 112 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognitive function. MDS also indicated Resident 112 used a walker and wheelchair for ambulation.During a concurrent observation and interview on 1/5/26 at 8:54 a.m. with Resident 112, a transition strip between the bedroom and bathroom was loose and could be easily lifted off the floor. Resident 112 had a two-wheeled walker with two rear legs capped with rubber tips. Resident 112 stated the transition strip between the bedroom and bathroom was not properly secured and she might fall when using the walker. Resident 112 also stated the transition strip catches on the rubber tips when moving in and out of the bathroom and she had to remember to lift the back of walker when passing over the transition, which was not safe too. Resident 112 further stated she reported this issue to staff in December of 2025, but no corrective action was taken.A review of Resident 112's care plan, dated 12/28/25, indicated Resident 112 was at risk for falls due to history of falls, unsteady gait, and visual impairment. Care plan further indicated Resident 112 will not experience fall related to risk factors.A review of the facility's Maintenance Repair Log, dated December 2025, indicated no records of a loose transition strip inside Resident 112's room.During an interview on 1/6/26 at 3:24 p.m. with Licensed Nurse (LN) 2, LN 2 stated the transition strip located inside Resident 112's room was not properly secured and may cause accidents.During an interview on 1/6/26 at 3:45 p.m. with the Maintenance Supervisor (MS), MS confirmed the transition strip was not properly secured and stated, It would be a trip hazard if it was not fixed.During an interview on 1/6/26 at 3:49 p.m. with the Director of Nursing (DON), DON stated the loose transition strip inside Resident 112's room could be a trip hazard and maintenance should have been notified so they get it fixed. DON expected staff to report anything that needs repair promptly to ensure resident safety.A review of the facility's policy and procedure titled, Physical Environment and Accommodation Policy, revised in 2024, indicated, The facility shall be clean, safe, sanitary and in good repair always . Maintenance shall include provision of maintenance services and procedures for the safety and well-being of resident, employees and visitors.