STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Ravine Healthcare Center	750 Auburn Ravine 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to protect one out of seven sampled residents' (Resident 1) right to be free from physical abuse by a resident (Resident 2) when Resident 2 placed her hand over Resident 1's mouth and grabbed and squeezed Resident 1's wrist.This failure resulted in Resident 1 getting hurt and had the potential for Resident 1 and all residents in the facility to experience physical and/or psychosocial harm.Findings:A review of Resident 1's clinical record indicated Resident 1 was admitted August of 2025 and had diagnoses that included dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities) with agitation, and cerebral atherosclerosis (hardening and narrowing of arteries in the brain due to plaque buildup, restricting blood flow and oxygen to brain regions).A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/5/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 0 out of 15 which indicated Resident 1 had a severely impaired cognition (mental process of acquiring knowledge and understanding).A review of Resident 2's clinical record indicated Resident 2 was admitted September of 2025 and had diagnoses that included malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), adult failure to thrive (a decline in older adults characterized by frailty, weight loss, reduced appetite, and cognitive and functional challenges), and muscle weakness.A review of Resident 2's MDS Cognitive Patterns, dated 10/6/25, indicated Resident 2 had a BIMS score of 15 out of 15 which indicated Resident 2 had an intact cognition.A review of Resident 2's progress notes, dated 11/11/25, indicated, CNA [Certified Nurse Assistant] reported to nurse about [Resident 2]'s behavior towards her roommate. She claims she keeps going over roommates side of the room. Taking her pillows, trying to reposition her. CNA and nurse went into the room and resident is back to [the] roommates side of the room [and] taking [the] roommates pillow saying she needs to be reposition and is snoring too loud. Nurse lets her know that she cannot be in her roommate side and cannot be touching her roommate .Resident appears to be aggressive after being told .A review of Resident 2's progress notes, dated 11/22/24, indicated, notified by CNA that [Resident 2] is refusing to wear brief. resident [Resident 2] is sitting on roommates beds without brief on. roommates ask [Resident 2] to stop and resident becomes hostile with roommates. [Resident 2] is taking clothes from roommates. CNA and nurse attemptedmultiple [sic] times to assist resident to own bed and retrieve roommates belongings, unsuccessful and resident became combative with CNA and nurse when asked to stay on her own bed.A review of Resident 2's progress notes, dated 11/23/24, indicated, Approximately around 0510 [5:10 a.m.] CNA notified nurse that while CNA was changing roommate [Resident 1] she kept yelling which made [Resident 2] walk towards roommate's bed. [Resident 2] told roommate [Resident 1] to let CNA change her [Resident 1] and suddenly grabbed her [Resident 1] wrist and covered her [Resident 1] mouth with her [Resident 2] hand .A review of Resident 2's Care Plan, dated 11/23/24, indicated, .Per staff resident [Resident 2] was witnessed trying to calm resident [Resident 1] because she [Resident 1] was yelling [then she] put her [Resident 2] hand to her [Resident 1] mouth and her [Resident 1] wrist.During an interview on 12/18/25 at 12:38 p.m. with CNA 1, CNA 1 stated Resident 2 has been moved to different rooms a lot of times already because she has been an issue with her roommates. CNA 1 then stated Resident 2 was recently moved to Resident 1's room when the incident happened. CNA 1 also stated that Resident 2 was known to make her roommates uncomfortable, that's why she has been moved a lot. CNA 1 further stated there was one time when Resident 2 was caught putting a pillow over her roommate's head that's why she was moved to a different room and then the new roommate was also disturbed too and did not like Resident 2 in their room, so she was moved to a different room again.During an interview on 12/18/25 at 1:08 p.m. with Resident 2's new roommate, (Resident 5), Resident 5 pointed at Resident 2 when she was asked if any resident is bothering or treating her badly. Resident 5 stated Resident 2 wanted her to always be quiet and would always get mad at her when she makes noise. Resident 5 also stated she does not feel comfortable and free in her own room anymore and she felt like she cannot do the things she wanted to do. Resident 5 further stated she likes to watch television, but she cannot watch normally like before anymore.During an interview on 12/18/25 at 1:12 p.m. with CNA 2, CNA 2 stated Resident 2 would get agitated and would yell when the TV gets loud or her surrounding gets noisy, and she would also get mad easily when a resident does things she does not like. CNA 2 also stated Resident 2 has a history of being aggressive towards staff where she grabs, pulls in, and jolts the staff's hand when she's mad or refusing care. CNA 2 further stated, if

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for one out of seven sampled residents (Resident 6) when,1.Two facility staff did not wear required personal protective equipment (PPE) when performing wound care on Resident 6 who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use), and,2. for a facility census of 55, facility staff (Facility Hairdresser [FHD]) did not receive ongoing infection prevention and control training from the facility.These failures resulted in an increased risk for wound contamination, and potential exposure of Resident 6 to germs and infection and the possible spread of germs among the residents in the facility.Findings:1.A review of Resident 6's clinical record indicated Resident 4 was admitted December of 2025 and had diagnoses that included cellulitis (bacterial skin infection affecting the skin's deeper layers and underlying tissue) of right toe, and need for assistance with personal care.A review of Resident 6's active physician's order, dated 12/17/25, indicated, Resident does have the capacity to understand choices &make [sic] health care decisions.A review of Resident 6's active physician's order, dated 12/18/25, indicated, ENHANCED BARRIER PRECAUTIONS R/T [related to] CHRONIC WOUNDS every shift.A review of Resident 6's care plan, dated 12/18/25, indicated, Resident requires Enhanced Barrier Precautions r/t presence of wounds .Implement enhanced barrier precautions (gown, gloves) when providing high risk care activities .A review of the list of residents on EBP, provided by the Infection Preventionist (IP) on 12/18/25 at 12:15 p.m., indicated Resident 6 was on EBP due to having chronic wounds.During an observation on 12/18/25 at 12:31 p.m. in Resident 6's room, two facility staff were observed handling, doing wound care, and changing Resident 6's wound dressing while only wearing gloves and not wearing a gown. There was also EBP signage posted outside of Resident 6's room which indicated, ENHANCE BARRIER PRECAUTION (EBP) .ANYONE PARTICIPATING IN ANY OF THESES SIX MOMENTS MUST ALSO: [NAME] [wear] gown and gloves .Wound care .During a subsequent interview on 12/18/25 at 12:34 p.m. with Treatment Nurse (TN) 1, TN 1 confirmed that she and the wound doctor were only wearing gloves when they did the wound assessment, care, and dressing change on Resident 6's wound. TN 1 stated they should have worn gown too because of the risk of contaminating Resident 6's wound and spreading infection.During an interview on 12/18/25 at 3:15 p.m. with the IP, the IP stated that staff should be wearing both gloves and gowns when doing wound care to prevent the risk of infecting the wound.During an interview on 12/18/25 at 4:35 p.m. with the Director of Nursing (DON), the DON stated that EBP should be practiced and observed properly by staff when doing wound care on chronic wounds to prevent the spread of germs and infection to the resident's wounds.A review of the facility's policies and procedures (P&P) titled, Enhanced Barrier Precautions, revised 12/2024, indicated, 2. Enhanced barrier precautions apply when: .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained .7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .j. wound care (any skin opening requiring a dressing) .2.During an interview on 12/18/25 at 11:50 a.m. with the Social Services Director (SSD), the SSD stated the facility has a hairdresser who does the haircuts of the residents as needed.During an interview on 12/18/25 at 12:01 p.m. with the Facility Hairdresser (FHD), in the Beauty Shop, the FHD stated she provides services to residents from the Skilled Nursing Facility (SNF) per a schedule. The FHD also stated she would usually go take the residents from their room and sometimes would wheel them back to their room when the haircut or beauty shop services are done. The FHD further stated she already did four residents from the SNF since this morning.During an observation on 12/18/25 at 12:17 p.m., in the SNF lobby, a resident was observed being wheeled by a facility staff to the beauty shop for her hair appointment.During an interview on 12/18/25 at 2:05 p.m. with the FHD, in the Beauty Shop, the FHD stated she was a contracted employee of the facility. The FHD further stated she has no ongoing training for infection prevention and control and also, she does not join in-service trainings from the facility.During an interview on 12/18/25 at 3:15 p.m. with the IP, the IP stated she has