STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street Sacramento, CA 95816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to ensure safety for two of six sampled residents (Resident 1 and Resident 2), when: 1. Resident 1 eloped twice to a nearby hospital without facility's knowledge; and 2. Resident 2 eloped from facility and was found outside the front door on the ground near her wheelchair. These failures decreased the facility's potential to maintain residents' safety and prevent injuries. Findings: 1. A review of Resident 1's Facesheet, indicated he was admitted to the facility in September 2024 with diagnoses including metabolic encephalopathy (brain dysfunction caused by systemic illness rather than direct brain trauma), cognitive communication deficit (impairment in communication due to underlying thinking disruptions), psychotic disorder with hallucinations (severe mental health condition causing a loss of contact with reality). A review of Resident 1's Minimum Data Set (MDS; an assessment tool), dated 12/1/25, indicated Brief Interview of Mental Status (BIMS) score was 11 out of 15 with moderate cognitive impairment. A review of Resident 1's Change of Condition, dated 1/20/26, indicated one of the nurses at the facility received a call from the nearby hospital who informed them Resident 1 was in the emergency room (ER). A review of Resident 1's Progress Notes, dated 1/21/26, indicated Resident 1 exited the facility without staff authorization. A review of Resident 1's Nurse's Notes, dated 2/1/26, indicated Resident 1 took himself to the ER during lunch. The note further indicated staff from the nearby hospital notified the facility that Resident 1 was in the ER. During an interview on 2/10/26 at 10:30 a.m. with Director of Nursing (DON), DON confirmed Resident 1 had two separate elopement incidents that occurred on 1/20/26 and 2/1/26. DON stated a wander guard (an electronic alarm device that is placed on residents who are at risk for elopement) was ordered and implemented after the second elopement occurred. DON also stated both elopements occurred without facility's knowledge and the nearby hospital contacted facility staff to inform them of Resident 1's location. 2. A review of Resident 2's Facesheet, indicated she was admitted to the facility in July 2024 with diagnoses including unspecified dementia (cognitive decline and memory loss), cognitive communication deficit, and difficulty in walking. A review of Resident 2's MDS, dated [DATE], indicated BIMS score was three out of 15 with severe cognitive impairment. A review of Resident 2's Progress Notes, dated 1/21/26, indicated on 1/20/26 at 11:30 a.m., Resident 2 had an unwitnessed fall and was found by staff sitting on the ground next to the sloped walkway outside the front door. The record also indicated Resident 2 was noted to have a bluish colored bump to her left cheek and left temporal area, a skin tear to left elbow with moderate bleeding, and a skin abrasion to left knee. The record further indicated Resident 2 was crying and complaining of pain when she was found. During an interview on 2/11/26 at 2:59 p.m. with Licensed Nurse (LN) 1, LN 1 stated she saw Resident 2 sitting on the ground next to her wheelchair outside of the front door at the top of the sloped walkway crying. LN 1 further stated she observed a bleeding from Resident 2's elbow and a bump forming on the left side of her (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	face. A review of Resident 2's undated record titled, Investigation Summary Report Unwitnessed Fall Elopement, indicated the most likely contributing factor to Resident 2's elopement was the reception area (located near front door) being unattended for a brief period. During an observation on 2/10/26 at 1:36 p.m. in front of Resident 2's room, Resident 2 was observed sitting in her wheelchair with faded bluish colored bruising to the left side of her face from the left temporal area and spread across left cheek. During an interview on 2/10/26 at 1:59 p.m. with DON, DON confirmed the three elopements occurred within a short span of time with two of the three occurring on the same day. DON expected facility staff to do everything they can to prevent elopements and injuries to residents from occurring. A review of the facility's policy titled, Wandering and Elopements, dated 3/2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintained the least restrictive environment for residents . If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. A review of the facility's policy titled, Falls and Fall Risk, Managing, dated 12/2007, indicated, . the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident form falling and to try to minimize complications from falling. These findings represent past noncompliance with this regulatory requirement. Observations, interviews, and records' review, confirmed Resident 1 and Resident 2 who had eloped were safely back in facility. The residents' care plans were updated post elopement and fall. Resident 1 was placed on new interventions (wanderguard) post second elopement, and care plans were updated. Resident 2 was assessed post fall/elopement and change of condition and elopement risk assessment was done. Elopement Performance Improvement Project (PIP) was updated, a facility led investigation and root cause analysis was conducted, and an elopement in-service training was conducted on 1/23/26. There was sufficient evidence that the facility corrected the violation as of 2/3/26, and no other occurrences of noncompliance were identified. At the time of the survey, the facility was in substantial compliance with this regulatory requirement and therefore, this violation does not require a plan of correction.