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	02/19/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on the interview and record review, the facility failed to provide the requested medical records within two working days following a written request for one of four sampled residents (Resident 1), when electronic copies of medical records were requested on 1/22/26, and the request was fulfilled on 1/27/26, and a second request was made on 2/5/26 and fulfilled on 2/10/26.This failure resulted in the delayed provision of medical records to Resident 1, which decreased the likelihood of Resident 1 making informed medical decisions regarding her care.Findings:During a review of Resident 1's admission record (AR), dated 2/19/26 (print date), the AR indicated Resident 1 was admitted to the facility in early 2026 with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knees and anxiety (fear, worry) disorder. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/9/26, the MDS indicated that Resident 1 had moderate cognitive impairment. During an interview on 2/18/26 at 2:41p.m. with Resident 1, Resident 1 stated that she emailed facility staff multiple requests for medical records and they were not fulfilled timely. Resident 1 stated that she had to hold staff's feet to the fire to get anything done. During a concurrent interview and record review on 2/19/26 at 11:35 a.m. with the Director of Rehabilitation (DOR), Resident 1's email dated 1/22/26 at 5:31 p.m. [After business hours, but before the morning of the next business day, Friday of 1/23/26] to the DOR was reviewed, and the email indicated that Resident 1 was following up on previously requested medical records. The DOR stated that Resident 1 was requested therapy records that day, and the DOR informed the medical records director about the request on the same day. During a concurrent interview and record review on 2/19/26 at 1:29 p.m. with the Medical Records Assistant (MRA), Resident 1's progress note (PN) dated 1/23/26 at 1:10 p.m. written by the MRA was reviewed. The PN indicated, I Received a Medical Records Request from Rehab Department at around noon of 1/23/26 dated 1/22/26 and i send it right away to our Legal Department. I Received a response from them at around 4:37 on Friday, I am out of Office. The MRA confirmed that the first request for records from Resident 1 was received by the medical records on 1/23/26, and it was successfully fulfilled on 1/27/26. The MRA provided a copy of the email to Resident 1 dated 1/27/26 at 4:46 p.m., sent by the Director of Nursing [DON] with the attachments of the records. [Request time 1/22/26 after hours to fulfillment time of 1/27/26 at 4:46 p.m., with no state-approved holidays during that time period, constituted more than 2 business days]. The MRA further stated that the second request for records, Resident 1 emailed directly to her on 2/5/26 and Resident 1 was refusing to fill out the facility-approved request form, and that request was fulfilled on 2/10/26 after Resident 1 signed the facility-approved form on 2/9/26. The MRA provided a copy of the initial email request dated 2/5/26 at 11:51 a.m., and a copy of the progress note written by MRA dated 2/19/26 at 11:07 a.m., which indicated, [Resident 1] sent an email on 2/5/26 @2:33 pm. Requesting for Medical Records. and she has her own format to request. The following day 2/6/26 I went to her room to give her the authorization (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Mid-Town Oaks Post-Acute	2600 L Street Sacramento, CA 95816

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form for the Release of the Health Information which is a Protocol in the Facility. She accepted the form, but she said that she will do it if she has time. She's threatening us/me she said that we violated under the Federal law that did not provide the records that she wanted right away. Last 2/9/26 Monday I received an email from her again attached is the Medical Records form that I given (sic) to her last Friday 2/6/26. She signed and back dated 2/5/26. My Supervisor talked to her and explained the protocol that we need to follow and fill out the records that she wants to request because it was not properly filled out when i (sic) received it thru email but she didn't comply. Regardless, we Immediately e-mailed our legal team for the approval. They responded right away that we can release the records. The time was 4:28 pm. We released her records the following day thru email 2/10/2026. [Request time 2/5/26 at 11:51 a.m. to fulfillment date 2/10/26, with no state-approved holidays during that time period, constituted more than 2 business days]. During a review of the facility's policy and procedure (P&P) titled, Access to Personal and Medical Records, revised 5/2017, the P&P indicated, Each resident has the right to access and/or obtain copies of his or her personal and medical records upon request. A resident may submit his/her request either orally or in writing for access to personal or medical information pertaining to him/her. The resident may obtain a copy of his or her personal or medical record within two business days of an oral or written request and completion of the Authorization form for the release of health information.

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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. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan to monitor and timely address clinical symptoms and complications for one of four sampled residents (Resident 1), when Resident 1 reported decreased left-hand strength, and when Resident 1 had a broken tooth and developed a tongue ulcer. These failures had the potential for Resident 1 to receive delayed and inadequate care.Findings: During a review of Resident 1's admission record (AR), dated 2/19/26 (print date), the AR indicated Resident 1 was admitted to the facility in early 2026 with diagnoses which included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knees and anxiety (fear, worry) disorder. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/9/26, the MDS indicated that Resident 1 had moderate cognitive impairment. During a concurrent observation and interview on 2/18/26 at 2:41p.m. with Resident 1 in her room. Resident 1 showed her left hand with the thumb overextended backwards and stated that she had nerve issues with her left hand and was seeking referral to a specialist. Resident 1 also demonstrated an ulcer on the right side of her tongue [approximately 1 centimeter (cm) wide and 2 cm long] and stated that it developed after her tooth on that side was broken and had sharp edges, and nobody was looking at it or monitoring the progression of the ulcer. During a concurrent interview and record review on 2/19/26 at 2:13 p.m. with the Director of Nursing (DON), Resident 1's progress notes (PN) were reviewed, and a PN dated 1/27/26 indicated, [Resident 1] had ongoing concern with cracked/molar tooth that was bothering resident and stated it to cause sores on tongue. A review of a physician's note dated 1/7/26 indicated, [Resident 1] has c/o [complaints of] left hand thumb weakness . Resident 1's current orders and care plans were reviewed, and no monitoring orders or care plans were found addressing the issues with the left hand or tongue ulcer. The DON confirmed that the facility was aware of Resident 1's issues with left hand and tongue ulcer, and he expected these issues to be monitored and care planned. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.