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	05/14/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility failed to protect the privacy of one of six sampled residents (Resident 1) when Resident 1's private health information was entered into Resident 2's chart. This failure gave Resident 2 access to Resident 1's personal health history.Findings:Resident 1 was admitted to the facility in early 2026 with diagnoses that included brain dysfunction caused by a chemical imbalance, anxiety, depression, back pain, and a urinary tract infection.Resident 2 was admitted to the facility in early 2026 with diagnoses that included degenerative joint disease in the knee and difficulty walking.During a review of Resident 2's electronic health record (EHR), the EHR included an entry dated 2/6/26 by a nurse practitioner (NP). The NP entered a progress note for Resident 1 into Resident 2's EHR, which included Resident 1's name, date of birth , medical history, medical diagnoses, physical examination information, and treatment plan.During a concurrent interview and record review on 5/14/26 at 11:34 a.m. with the Director of Nursing (DON), the DON was asked to review the entry dated 2/6/26. The DON confirmed Resident 1's information was inaccurately documented in Resident 2's EHR and stated it was a violation of Resident 1's privacy. The DON stated they expected resident information to be documented under the correct resident.During a concurrent interview and record review on 5/14/26 at 11:57 a.m. with the Medical Record Director (MRD), the MRD confirmed that on 2/6/26 the NP incorrectly documented Resident 1's information in Resident 2's chart. The MRD stated it was important to have correct information in a medical record.During an interview on 5/14/26 at 12:45 p.m. with Resident 2 in her room, Resident 2 stated she had requested copies of her own health record and, upon reviewing them, found a progress note for Resident 1. Resident 2 stated the progress note included personal information about Resident 1.During a review of the facility's policy and procedure (P&P) titled Confidentiality of Information and Personal Privacy, dated 2/01, the P&P indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. The facility will safeguard the personal privacy and confidentiality of all residents' personal and medical records. The facility will strive to protect resident's privacy regarding his or her. medical treatment. Access to resident personal and medical records will be limited to authorized staff and business associates.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the Department for one of six sampled residents (Resident 3) when Resident 3 told staff that Resident 4 threw a comb at him, striking him in the head. This failure had the potential for an allegation of abuse not being investigated.Findings:Resident 3 was admitted to the facility in early 2025 with diagnoses that included major depressive disorder, difficulty walking, and muscle weakness.During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/29/26, the MDS showed a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 15/15, which indicated no cognitive impairment.Resident 4 was admitted to the facility in late 2025 with diagnoses that included difficulty walking and deafness.During a review of Resident 4's MDS dated [DATE], the MDS showed a BIMS score of 13/15, which indicated no cognitive impairment.During a review of Resident 3's Progress Notes (PN) dated 4/9/26 at 10:24 a.m. the PN indicated, At around 7 am, this writer was doing her rounds/check and observed that [Resident 3] was involved in altercation with roommate [Resident 4]. This writer was asked to flip TV so he [Resident 3] can watch the news, this his roommate [Resident 4] woke up and mumbles and said NO. [Resident 4] then grabhis (sic) comb, and threw it towards him, striking [Resident 3] head. Triter assessed immediately.Per [Resident 3] he had asked to this writer to call 911, and this writer responded that it is a minor issue that we can all figure and resolved (sic).At approx. (sic) 7:15am, Police came and investigate, DON [Director of Nursing] present.During a review of Resident 4's PN dated 4/9/26 at 3:30 p.m. the PN indicated, At approx. 7 am during nursing rounds, this writer witnessed [Resident 4] was upset that is roommate [Resident 3] TV was on, and he [Resident 4] threw a comb towards his roommate [Resident 3] writer tried to communicate and his roommate [Resident 3] was frightened and threatened and stated that he is vulnerable and could get himself hurt again from is roommate's [Resident 4] behavior.During a telephone interview on 5/13/26 at 2:51 p.m. with Resident 3, Resident 3 stated that on 4/9/26, in front of a nurse, Resident 4 threw a hard plastic brush that hit him on the forehead.During an interview on 5/14/26 at 10:41 a.m. with Licensed Nurse (LN 1), LN 1 stated she was the nurse working on 4/9/26. LN 1 stated Resident 3 was screaming that Resident 4 threw a comb at him. I was not sure it happened, but [Resident 3] was claiming it happened. LN 1 confirmed a resident who stated they were abused made an allegation that should be reported to the Department.During an interview on 5/14/26 at 11:34 a.m. with the Director of Nursing (DON), the DON stated he was notified of the incident and confirmed the progress notes indicated an incident occurred between Resident 3 and Resident 4, and that Resident 3 called the police after the incident occurred.During an interview on 5/14/26 at 1:20 p.m. with Resident 4 in his room, a tablet was used to communicate with Resident 4. Resident 4 confirmed he threw a comb at his previous roommate and that his previous roommate [Resident 3] called the police. Resident 4 stated Resident 3 was angry about the television.During an interview on 5/14/26 at 2:04 p.m. with the Administrator (ADM), the ADM stated any allegations of abuse should be reported to the Department within two hours. The ADM stated it was not reported as they had treated this incident as a grievance.During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 9/22, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The local/state ombudsman; The resident's representative; Adult protective services (where state law provides jurisdiction in long-term care); Law enforcement officials; The resident's attending physician; and the facility medical director. ?Immediately' is defined as within two hours of an allegation involving abuse.