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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a current copy of advance directive (a legal document indicating resident preference on end-of-life treatment decisions) was available in the medical records for three out of 31 sampled residents (Resident 47, Resident 10 and Resident 85). This failure decreased the facility's potential to provide health care to residents when incapacitated (a state where you don't have the capacity or ability to accomplish something).Findings: A review of Resident 47's admission Record, indicated Resident 47 was admitted to the facility in July 2024 with a diagnosis of cognitive communication deficit. A review of Resident 47's Physician Orders for Life-Sustaining Treatment (POLST), dated 7/2/24, indicated Resident 47's advance directive was not available. A review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/26/25, indicated Resident 47's advance directive was available and reviewed. During a concurrent interview and record review on 12/3/25 at 4:12 p.m. with the Director of Nursing (DON), Resident 47's medical record was reviewed. DON confirmed a copy of Resident 47's advance directive was not available and stated if Resident 47's MDS indicated an advance directive was available and reviewed then a copy of the advance directive should have been placed in Resident 47's medical record. A review of an admission record indicated Resident 10 was readmitted to the facility in June 2025 with a diagnosis of cognitive communication deficit. A review of Resident 10's POLST, dated 6/25/25, indicated an advance directive was available and reviewed by a staff member. During a concurrent interview and record review on 12/2/25 at 4 p.m. with the MDS Coordinator (MDSC), Resident 10's medical records and quarterly MDS assessment, dated 9/26/25 were reviewed. MDSC confirmed Resident 10's advance directive was unavailable. During an interview on 12/3/25 at 8:01 a.m. with DON, DON stated Resident 10's advance directive should have been obtained from the resident's responsible party and maintained by staff to ensure the residents' wishes are honored in times of disability. A review of an admission Record indicated Resident 85 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a complex mental illness that includes hallucinations) (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and bipolar disorder (a brain disorder causing extreme mood swings). A review of Resident 85's MDS, dated [DATE], indicated an advance directive was available and reviewed. During a concurrent interview and record review on 12/2/25 at 12 p.m. with the Medical Records Assistant (MRA), Resident 85's health record was reviewed. MRA was unable to locate Resident 85's advance directive in the electronic health record or physical chart. MRA stated Resident 85's advance directive should have been placed in the chart. During an interview on 12/3/25 at 7:53 a.m. with DON, DON stated if Resident 85's MDS indicated the advance directive was available and reviewed, then it should have been readily available in the medical record. A review of the facility's policy titled, Advance Directives, revised in 4/2013, indicated, Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. A review of the facility's policy titled, Advance Directive, revised in 9/2022, indicated, If the resident or the resident's representative has executed . advance directive . upon admission copy of this document are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff . The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive . The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record .

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure two of 31 sampled residents (Resident 18 and Resident 86) were free from unnecessary psychotropic medications (drugs that alter brain chemistry to affect mood, thinking, and behavior), when:A Gradual Dose Reduction (GDR - tapering of dose to determine if symptoms can be managed at a lower dose or if a medication can be discontinued) was not attempted for Resident 18's olanzapine (an antipsychotic medication used to treat symptoms of psychosis).Resident 86's lorazepam (an antianxiety medication) as needed (PRN; pro re nata) order was beyond 14 days from 9/25/25; andResident 86's sertraline (an anti-depression medication) was administered without a manifestation.These failures increased the residents' potential to receive unnecessary medications.Findings: 1- A review of Resident 18's admission Record, indicated he was admitted to the facility in September 2024 with diagnoses including psychotic disorder (a severe mental illness causing distorted reality) with hallucinations and recurrent major depressive disorder with severe psychotic symptoms. A review of Resident 18's Order Summary Report (OSR), dated 6/12/25, indicated, an order for olanzapine 15 milligrams (mg; unit of measurement) to be administered at bedtime for auditory hallucinations (sensory experiences of hearing sounds, often voices, that aren't actually present). The OSR further indicated monitoring Resident 18's hallucinations started in September 2025. A review of Resident 18's Medication Administration Record (MAR), indicated Resident 18 experienced no episodes of auditory hallucinations in September 2025. The MAR further indicated Resident 18 had two episodes of hallucinations in October 2025 and seven episodes in November 2025. A review of the facility's Medication Regimen Review (MRR), dated November 2025, indicated a GDR recommendation by the pharmacist regarding Resident 18's use of olanzapine. The recommendation was unmarked with no actions written in response. During a concurrent interview and record review on 12/3/25 at 2 p.m. with the Director of Nursing (DON), Resident 18's MAR and MRR, dated July-November 2025 were reviewed. DON confirmed Resident 18 started to receive olanzapine in June 2025 and a GDR was not attempted. DON also confirmed Resident 18's pharmacist recommendation for a GDR in November 2025 was not addressed. DON stated the pharmacist recommendation should have been fulfilled and discussed with the physician in order to properly determine if Resident 18 would benefit from taking the medication. A review of the facility's policy titled, Tapering Medications and Gradual Dose Reduction, revised in 2/2025, indicated, After the resident has been started on psychotropic medications, the staff and practitioner will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated . All medications are considered for possible tapering/GDR. 2- A review of Resident 86's admission Record, indicated Resident 86 was admitted to the facility in 2025 with diagnoses including depression and anxiety. A review of Resident 86's Order Summary Report, dated 12/2/25, indicated an order for lorazepam 0.5 mg one tablet by mouth every 12 hours PRN for anxiety manifested by restlessness and inability to (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	relax. The OSR further indicated Resident 86 was started on lorazepam on 9/25/25 with no stop date. A review of Resident 86's Consultant Pharmacist's Medication Regimen Review, dated 11/1/25 to 11/18/25, indicated the pharmacist's comment was to add a 14 day stop date to the PRN lorazepam order or have the provider document the need for extended therapy and add the extend stop date. The record indicated no response from the physician. A review of Resident 86's Note to Attending Physician/Prescriber, dated 11/18/25, indicated the last risk/benefit medications review was completed in August 2024. The note indicated no further response from the physician. During a concurrent interview and record review on 12/4/25 at 10:23 a.m. with the DON, Resident 86's medical record was reviewed. DON confirmed Resident 86's lorazepam 0.5 mg PRN order had no stop date and stated it should have an end date after 14 days of start. A review of the facility's policy titled, Psychotropic Medication Use, revised in 2/25, indicated, PRN orders for psychotropic medications are limited to 14 days. 3- A review of Resident 86's Order Summary Report, dated 12/2/25, indicated an order for sertraline 50 mg by mouth one time a day for depression. The OSR further indicated Resident 86's sertraline was started on 4/28/25 without a manifestation. A review of Resident 86's Consultant Pharmacist's Medication Regimen Review, dated 10/1/25 to 10/16/25, indicated the pharmacist's comment was to add a manifestation to the sertraline order. The record indicated no response from the physician. During a concurrent interview and record review on 12/4/25 at 10:23 a.m. with the DON, Resident 86's medical record was reviewed. DON stated psychotropic medication like sertraline should have a manifestation listed in the order. A review of the facility's policy titled, Psychotropic Medication Use, revised in 2/25, indicated, Psychotropic medication may be considered appropriate when a resident's behavioral symptoms present a danger to the resident or others . The policy further indicated, The clinical rationale for the use of psychotropic medication . is documented in the medical record. Diagnosis alone does not necessarily warrant the use of psychotropic medication.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to follow the monthly pharmacist medication regimen reviews (MRR) for two of 31 sampled residents (Resident 18 and Resident 86), when:A Gradual Dose Reduction (GDR - tapering of dose to determine if symptoms can be managed at a lower dose or if a medication can be discontinued) was not attempted for Resident 18's olanzapine (an antipsychotic medication used to treat symptoms of psychosis); Resident 86's lorazepam (an antianxiety medication) as needed (PRN; pro re nata) order was beyond 14 days from 9/25/25; andResident 86's sertraline (an anti-depression medication) was administered without a manifestation.These failures decreased the facility's potential to follow the pharmacist recommendations and prevent residents from receiving unnecessary medications. Findings: 1- A review of Resident 18's admission Record, indicated he was admitted to the facility in September 2024 with diagnoses including psychotic disorder (a severe mental illness causing distorted reality) with hallucinations and recurrent major depressive disorder with severe psychotic symptoms. A review of Resident 18's Order Summary Report (OSR), dated 6/12/25, indicated, an order for olanzapine 15 milligrams (mg; unit of measurement) to be administered at bedtime for auditory hallucinations (sensory experiences of hearing sounds, often voices, that aren't actually present). The OSR further indicated monitoring Resident 18's hallucinations started in September 2025. A review of Resident 18's Medication Administration Record (MAR), indicated Resident 18 experienced no episodes of auditory hallucinations in September 2025. The MAR further indicated Resident 18 had two episodes of hallucinations in October 2025 and seven episodes in November 2025. A review of the facility's Medication Regimen Review (MRR), dated November 2025, indicated a GDR recommendation by the pharmacist regarding Resident 18's use of olanzapine. The recommendation was unmarked with no actions written in response. During a concurrent interview and record review on 12/3/25 at 2 p.m. with the Director of Nursing (DON), Resident 18's MAR and MRR, dated July-November 2025 were reviewed. DON confirmed Resident 18 started to receive olanzapine in June 2025 and a GDR was not attempted. DON also confirmed Resident 18's pharmacist recommendation for a GDR in November 2025 was not addressed. DON stated the pharmacist recommendation should have been fulfilled and discussed with the physician in order to properly determine if Resident 18 would benefit from taking the medication. A review of the facility's policy titled, Tapering Medications and Gradual Dose Reduction, revised in 2/2025, indicated, After the resident has been started on psychotropic medications, the staff and practitioner will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated . All medications are considered for possible tapering/GDR. 2- A review of Resident 86's admission Record, indicated Resident 86 was admitted to the facility in 2025 with diagnoses including depression and anxiety. A review of Resident 86's Order Summary Report, dated 12/2/25, indicated an order for lorazepam 0.5 mg one tablet by mouth every 12 hours PRN for anxiety manifested by restlessness and inability to (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	relax. The OSR further indicated Resident 86 was started on lorazepam on 9/25/25 with no stop date. A review of Resident 86's Consultant Pharmacist's Medication Regimen Review, dated 11/1/25 to 11/18/25, indicated the pharmacist's comment was to add a 14 day stop date to the PRN lorazepam order or have the provider document the need for extended therapy and add the extend stop date. The record indicated no response from the physician. A review of Resident 86's Note to Attending Physician/Prescriber, dated 11/18/25, indicated the last risk/benefit medications review was completed in August 2024. The note indicated no further response from the physician. During a concurrent interview and record review on 12/4/25 at 10:23 a.m. with the DON, Resident 86's medical record was reviewed. DON confirmed Resident 86's lorazepam 0.5 mg PRN order had no stop date and stated it should have an end date after 14 days of start. A review of the facility's policy titled, Psychotropic Medication Use, revised in 2/25, indicated, PRN orders for psychotropic medications are limited to 14 days. 3- A review of Resident 86's Order Summary Report, dated 12/2/25, indicated an order for sertraline 50 mg by mouth one time a day for depression. The OSR further indicated Resident 86's sertraline was started on 4/28/25 without a manifestation. A review of Resident 86's Consultant Pharmacist's Medication Regimen Review, dated 10/1/25 to 10/16/25, indicated the pharmacist's comment was to add a manifestation to the sertraline order. The record indicated no response from the physician. During a concurrent interview and record review on 12/4/25 at 10:23 a.m. with the DON, Resident 86's medical record was reviewed. DON stated psychotropic medication like sertraline should have a manifestation listed in the order. A review of the facility's policy titled, Psychotropic Medication Use, revised in 2/25, indicated, Psychotropic medication may be considered appropriate when a resident's behavioral symptoms present a danger to the resident or others . The policy further indicated, The clinical rationale for the use of psychotropic medication . is documented in the medical record. Diagnosis alone does not necessarily warrant the use of psychotropic medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were safely stored and secured for a census of 96 residents, when:A medication refrigerator temperature log for December 2025 was found incomplete in the medication room at station-3;An expired and discontinued medication was found inside a medication refrigerator in the medication room at station-3;Eight loose tablets and three loose bubble packs were found in and behind medication cart 2's drawers at station-2; andFour over the counter (OTC) medications were stored insecurely inside Resident 89's room.These failures decreased the facility's potential to safely store and secure medications for its residents. Findings: 1- During a concurrent observation and interview on 12/3/25 at 11:22 a.m. with Licensed Nurse (LN) 3 in the medication room at station-3, an incomplete temperature log was observed posted at the door of a medication refrigerator. LN 3 confirmed the refrigerator temperature was not recorded for three days from 12/1/25 to 12/3/25 for the morning shift. 2- During a concurrent observation, interview, and record review on 12/3/25 at 11:32 a.m. with LN 3 in the medication room at station-3, a partially used box of formoterol fumarate (a medicine used to treat breathing difficulties) 20 micrograms (mcg-a unit of measurement)/two milliliters (ml-a unit of measurement) nebulizer vials (single use plastic container filled with drug used for inhalation) was found stored beyond its expiration date 10/22/25 inside a medication refrigerator. LN 3 confirmed the medication expired on 10/22/25. LN 3 reviewed the facility's electronic health records and stated the medication was prescribed for a resident who was discharged from the facility on 8/1/25. 3- During a concurrent observation and interview on 12/4/25 at 8:33 a.m. with LN 4 at station-2, medication cart 2 was inspected. LN 4 confirmed eight loose tablets were found in a drawer and three loose bubble packs were stored behind the bottom drawer. LN 4 stated the loose tablets were unidentifiable and needed to be discarded in a pill buster immediately. LN 4 also stated two out of three loose bubble packs were discontinued and belonged to residents who were discharged from the facility. During an interview on 12/4/25 at 9 a.m. with Director of Nursing (DON), DON stated staff should have checked the temperature of medication refrigerator twice in 24 hours and recorded in the log as instructed to maintain the medications' safety and potency. DON confirmed expired, discontinued and loose medications were stored in a medication refrigerator and medication cart 2. DON expected staff to check and remove expired and discontinued medications from the storage to reduce the chances of medication diversion and misuse. 4- A review of Resident 89's admission Record, indicated Resident 89 was admitted to the facility in 2024. During a concurrent observation and interview on 12/1/25 at 9:06 a.m. with Resident 89 and LN 1 inside Resident 89's room, LN 1 confirmed four OTC medications were stored insecurely on top of Resident 89's cabinet. The medications were famotidine (medication used to decrease stomach acid production), a stool softer, fiber gummies, and stimulant laxative tablets. LN 1 stated the medications needed to be locked up. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/1/25 at 9:43 a.m. with DON, DON stated Resident 89's medications should be stored safely to prevent misuse. A review of facility's policy titled, Storage of Medications, dated 2001, indicated, The facility stores all drugs . in a safe, secure, and orderly manner .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to provide a clean environment for a census of 96 residents, when one out of four garbage dumpsters located outside the facility was not closed securely due to a gap between the lids.This failure decreased the facility's potential to maintain a safe environment and prevent pest infestation.Findings:During a concurrent observation and interview on 12/2/25 at 10 a.m. with the Dietary Services Supervisor (DSS), four dumpsters used by the facility were inspected. One dumpster's lids did not fully cover the dumpster and had a two-inch gap in the middle. DSS stated the dumpster lid should be replaced.During an interview on 12/3/25 at 2 p.m. with the Director of Nursing (DON), DON stated the dumpsters where all the trash was disposed should always be kept closed by ensuring the lids fit properly. DON further stated it was necessary to maintain such a safe practice to prevent pests from entering and potentially spreading disease.A review of the facility's undated policy titled, Food-Related Garbage and Rubbish Disposal, indicated, Food-related garbage and rubbish shall be disposed of in accordance with current state laws . Outside dumpsters provided by garbage pick-up services will be kept closed . Garbage and rubbish containing food wastes will be stored in a manner that is inaccessible to vermin.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to administer a medication according to professional standards of quality for one of 31 sampled residents (Resident 86), when Resident 86's metoprolol succinate (a medication used to treat high blood pressure and heart failure) was not administered as ordered by the physician.This failure decreased the facility's potential to follow physician's orders and safely administer medications to residents as prescribed.Findings:A review of Resident 86's admission Record, indicated Resident 86 was admitted to the facility in July 2023 with a diagnosis of hypertensive heart disease with heart failure (a long-time high blood pressure weakens the heart and reduces its ability to pump blood effectively).During a concurrent observation and interview on 12/2/25 at 8:55 a.m. with Licensed Nurse (LN) 2, LN 2 was observed preparing and administering Resident 86's morning medications. LN 2 stated metoprolol succinate tablet was withheld because Resident 86's blood pressure (BP) and heart rate (HR) were lower than the physician's ordered values. LN 2 further stated Resident 86's BP was 108/58 and HR was 59.A review of Resident 86's Order Summary Report (OSR), dated 12/4/25, indicated a 75 milligrams (mg - a unit of measurement) tablet of metoprolol succinate was to be administered by mouth once daily for high BP and to be held for a BP less than 90/50 and a HR less than 50.During a concurrent interview and record review on 12/2/25 at 1:33 p.m. with LN 2, Resident 86's Medication Administration Record (MAR) and OSR were reviewed. The MAR indicated the 8 a.m. scheduled dose of metoprolol succinate was withheld by LN 2 on 12/2/25. LN 2 documented Resident 86's vital signs (BP and HR) were out of parameters. LN 2 confirmed she did not administer Resident 86's scheduled dose of metoprolol and stated she misread the physician's order.During a concurrent interview and record review on 12/2/25 at 1:45 p.m. with the Director of Nursing (DON), Resident 86's OSR and MAR were reviewed. DON confirmed LN 2 did not administer Resident 86's metoprolol succinate on 12/2/25 and stated Resident 86's BP and HR were within the ordered values. DON expected LN 2 to read the orders correctly to avoid drug errors. DON further stated a missed dose of metoprolol succinate might increase Resident 86's potential to develop high blood pressure or heart attack.A review of the facility's policy titled, Administering Medications, revised in 2019, indicated, . Medications are administered in accordance with the prescriber orders .

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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 ensure two out of 31 sampled residents (Resident 9 and Resident 61's) environment was safe and free of accident hazards, when: 1. Licensed Nurse (LN) 5 did not check Resident 61's wanderguard (a device that activates sensors on doors to alarm, alerting staff to intervene when wandering residents attempt to elope) functionality; and2. Resident 9 was smoking without supervision.These failures decreased the facility's potential to maintain residents' safety.Findings: 1- A review of Resident 61's admission Record, indicated she was admitted to the facility in October 2022 with diagnoses including dementia (a progressive state of decline in mental abilities) with agitation and history of falling. During an observation on 12/2/25 at 2:49 p.m., Resident 61 was observed pacing up and down the hallway going to the nurses' station. Resident 61 was redirected by staff to keep her from wandering to other residents' rooms. During a concurrent observation and interview on 12/2/25 at 3:49 p.m. with LN 5 inside Resident 61's room, LN 5 confirmed Resident 61 was wearing a wanderguard on her right ankle. LN 5 stated she checked Resident 61's wanderguard placement during her shift, but not its functionality. LN 5 further stated the wanderguard's functionality was checked monthly by the nurses. A review of resident 61's Medication Administration Record (MAR), dated 12/4/25, indicated an order to check Resident 61's wanderguard placement and functionality every shift for safety. LN 5 signed the MAR on the evening shifts of 12/1/25 and 12/2/25. During a concurrent interview and record review on 12/2/25 at 4:15 p.m. with LN 5, Resident 61's MAR, dated 12/25 was reviewed. LN 5 confirmed Resident 61's wanderguard placement and functionality should have been checked every shift as ordered. LN 5 stated she was unsure of the proper method to check the wanderguard's functionality and considered the wanderguard functional if Resident 61 passed by the door and the door alarm sound was activated. A review of a facility's document titled, Transmitter Testing, revised in 1/20, indicated, Testing the patient transmitters is an integral part of your facility's patient security program and should be done on a regular basis . You must test all wander management transmitters prior to use . Failure to test the transmitters can result in system failure or elopement. The document further indicated, Never take a patient to a door to test their transmitter. During an interview on 12/3/25 at 2 p.m. with the Director of Nursing (DON), DON stated LN 5 was not properly trained to check the residents' wanderguards functionality. DON further stated staff should know the method of checking the wanderguards in order to properly monitor the safety of residents with exit seeking behaviors. A review of the facility's undated policy titled, Elopement and Wandering, indicated, This facility ensures that residents who exhibit wandering behavior or are at risk for elopement receive supervision to prevent accidents and receive care in accordance with their person-centered plan of care . The facility shall establish and utilize systematic approach . Implementing interventions . monitoring for effectiveness and modifying interventions when necessary. (continued on next page)

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	055493	A. Building B. Wing	12/04/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2- A review of Resident 9's admission Record, indicated Resident 9 was admitted to the facility in August 2025 with diagnoses including encephalopathy (disease that affects the brain) and respiratory failure. A review of Resident 9's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/24/25, indicated Resident 9 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of nine out of 15 with moderate cognitive impairment. During an interview on 12/1/25 at 3:36 p.m. with Resident 9, Resident 9 stated she was a smoker and kept a lighter and cigarettes in her room. Resident 9 further stated she had no smoking schedule and would smoke whenever she wanted. During a concurrent observation and interview on 12/2/25 at 1:47 p.m. with Resident 9 in her room, an oxygen concentrator (a medical device that provides supplemental oxygen) was found at the bedside. Resident 9 stated she occasionally used oxygen. A review of Resident 9's Order Summary Report, dated 12/4/25, indicated Resident 9 had an order for oxygen at 2.5 liters (L, a unit of measurement) per minute via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed. During an observation on 12/2/25 at 2:05 p.m., Resident 9 was observed in the smoking patio area. Resident 9 lit a cigarette and started to smoke without staff supervision. During a concurrent observation and interview on 12/2/25 at 2:10 p.m. with the Staffing Coordinator (SC), Resident 9 was observed smoking at the smoking patio area. SC confirmed Resident 9 was smoking without staff supervision. A review of Resident 9's Nursing – Smoking Observation/Assessment, dated 11/24/25, indicated Resident 9 required smoking supervision. During a concurrent interview and record review on 12/3/25 at 3:59 p.m. with DON, Resident 9's Nursing – Smoking Observation/Assessment, dated 11/24/25 was reviewed. DON confirmed Resident 9's smoking assessment indicated Resident 9 required smoking supervision. DON stated Resident 9 should not have smoked without supervision, as there was a risk of self-injury, damage to clothing, or potential fire hazard when smoking unsupervised. A review of the facility's policy titled, Smoking Policy – Resident, revised in October 2023, indicated, Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care was consistent with professional standards of practice for one of 31 sampled residents (Resident 42), when Resident 42's nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not changed weekly.This failure decreased the facility's potential to prevent the risk of lung infection for Resident 42. Findings:A review of Resident 42's admission Record, indicated Resident 42 was admitted to the facility in October 2024 with diagnoses including chronic obstructive pulmonary disease (a chronic lung disease causing difficulty breathing) and respiratory failure.During an observation on 12/1/25 at 10:40 a.m. in Resident 42's room, Resident 42 was wearing NC. The NC was labeled with a date of 11/18.A review of Resident 42's Order Summary Report, dated 12/4/25, indicated Resident 42 had an active order for continuous oxygen at one liter (a unit of measurement) per minute via NC and to change NC every Sunday and as needed.During a concurrent observation and interview on 12/1/25 at 11:57 a.m. with Licensed Nurse (LN) 1 in Resident 42's room, Resident 42's NC was observed. LN 1 confirmed the NC was labeled with a date of 11/18. LN 1 stated the NC was supposed to be changed weekly. During an interview on 12/3/25 at 4:09 p.m. with Director of Nursing (DON), DON stated it was important to change the NC weekly and as needed to prevent the risk of lung infection for Resident 42. A review of the facility's policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised November 2011, indicated, Change the oxygen cannula [NC] and tubing every seven (7) days, or as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 safely store food for a census of 96 residents, when an expired food item was available for use in the facility's kitchen.This failure decreased the facility's potential to prevent foodborne illness among residents.Findings:During a concurrent observation and interview on 12/1/25 at 8:12 a.m. with the Dietary Services Supervisor (DSS) in the kitchen, DSS confirmed a loaf of bread with expiration date of 11/30/25 was stored on the bread rack.During an interview on 12/3/25 at 2 p.m. with the Director of Nursing (DON), DON stated kitchen staff should not store expired food items that can be served to residents which might make them sick.A review of the facility's undated policy titled, Food-Related Garbage and Rubbish Disposal, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure one of 31 sampled residents (Resident 87's) call light was within reach, when Resident 87 was in bed and could not reach the call light.This failure decreased the facility's potential to provide Resident 87 with assistance when needed.Findings:A review of Resident 87's admission Record, indicated Resident 87 was admitted to the facility in 2025 with diagnoses including anxiety and inability to sleep.A review of Resident 87's Minimum Data Set (MDS, a federally mandated assessment tool), dated 10/27/25, indicated Resident 87 had moderate memory impairment.During a concurrent observation and interview on 12/1/25 at 9:27 a.m. with Resident 87 inside his room, Resident 87 stated he could not reach the call light and could not find it. The call light was hanging off the left side of bed. During a concurrent observation and interview on 12/1/25 at 9:34 a.m. with the Director of Nursing (DON) inside Resident 87's room, DON confirmed the call light was hanging off the bed and stated it should have been within arm-reach of Resident 87.A review of the facility's policy titled, Answering the Call Light, dated 10/2010, indicated, When the resident is in bed or in a chair be sure the placement of the call light is within reach of the resident.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure staffing information was posted daily for a census of 96 residents, when staffing information was not updated for two days during the weekend.This failure decreased the facility's potential to have staffing information available for residents and visitors.Findings:During an observation on 12/1/25 at 7:07 a.m. near the facility's main entrance door, the posted staffing information was found with a date of 11/28/25.During an interview on 12/3/25 at 9:35 a.m. with Staffing Coordinator (SC), SC stated the supervisor during the weekend should have updated the staffing information. SC further stated staffing information should be posted daily. During an interview on 12/3/25 at 1:14 p.m. with Director of Staff Development/Infection Preventionist (DSD/IP), DSD/IP stated staffing information should be posted daily to show the residents and visitors the facility's compliance with staffing to provide care to residents. A review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised 8/22, indicated, Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.