STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555261	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acc Care Center	7801 Rush River Drive Sacramento, CA 95831

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interviews, and a review of facility records, the facility failed to implement a care plan intervention for one of three sampled residents (Resident 1) with history of falls when fall mats were not in place at Resident 1's bedside.This failure had the potential to increase Resident 1's injury related to falls. Findings:Resident 1 was admitted to the facility in January of 2026 with diagnoses which included orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities) and fracture of the pelvic.A review of Resident 1's Progress Notes (PN) dated 4/1/26 indicated, Patient does not have capacity to make medical decisions.A review of Resident 1's Care Plan (CP) dated 3/1/26 showed that Resident 1 experienced an unwitnessed fall on that day, prompting implementation of fall precautions. The care plan dated 3/17/26 noted that Resident 1 sustained a fall resulting in a minor head injury. Additionally, a care plan dated 3/24/26 documented a witnessed fall in which Resident 1 hit her head on the floor and was transferred to the emergency department for evaluation, with ongoing fall precautions maintained.A review of the facility document titled Incidents By Incident Types, dated 4/2/26, revealed that Resident 1 experienced unwitnessed falls on 3/1/26 and 3/17/26. The record further indicated an additional witnessed fall involving Resident 1 on 3/24/26.A review of the Resident 1's PN dated 3/1/26 indicated, @ [at] approx [approximately] 5:05 a.m., RN [Registered Nurse] and CNA [Certified Nursing Assistant] immediately went to check noise from room [ROOM NUMBER]. Upon entering room, resident was observed on floor directly next to bed.Res fell on the L [Left] side of bed.fall mat was place on R [Right] side of the bed.A review of the Resident 1's PN dated 3/17/26 indicated, The Change in Conditions.Resident was found on the floor in her room by the door, lying on her right side by wound nurse. Noted with laceration 2cm [centimeter, a unit of measurement] to the right side of the head.A review of the Resident 1's Hospital Document titled Discharge Summary,' dated 4/1/26, indicated, Date of admission: [DATE] 8:49 p.m.Diagnoses: Possible syncopal episode [Temporarily lose consciousness].Orthostatic hypotension [a form of low blood pressure that happens when standing after sitting or lying down].Acute distal left clavicular fracture [a break in the collarbone].Report: XR [x-ray] Shoulder 2+ views.IMPRESSION: Acute distal left clavicular fracture. 03/25/26During a concurrent observation and interview on 4/2/26 at 12:14 p.m., with Resident 1's family member inside the residents room. The family member confirmed that there were no fall mats in place at Resident 1's bedside and stated that the fall mats should have been placed for Resident 1's safety.During a concurrent observation, interview, and record review on 4/2/26 at 12:37 p.m., with License Nurse (LN 1), it was confirmed that fall mats were not in place for Resident 1. LN 1 confirmed Resident 1's history of falls within the facility and emphasized the significance of having fall mats in place to ensure resident safety. LN 1 also stated that Resident 1 was placed on fall precautions, with fall mats being one of the safety measures used.During an interview with the Quality and Compliance Coordinator (QC), who was also an LN, on 4/2/26 at 4:04 p.m., the QC indicated that following a fall incident, a Change in Condition (CIC) should be documented for the (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, and care plans should be updated to include fall precautions. The QC further explained that fall precautions involve ensuring call lights were within reach, the bed was in its lowest position, and a fall mat was properly placed. The QC also added that the fall mat should have been positioned at Resident 1's bedside and stated that while it did not prevent falls, it served to reduce the severity of potential injuries.A review of the facility Policy and Procedure titled, Care Plans, Comprehensive Person-Centered revised 03/2022 indicated, A comprehensive, person-centered care plan .meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .receive the services and/or items included in the plan or care .

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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 interview and record review, the facility failed to ensure adequate supervision for one of three sampled residents (Resident 1), when Resident 1 was left alone in the shower room two times by a Certified Nursing Assistant (CNA 1). This failure resulted in Resident 1 not being supervised while in the shower room increasing the risk potential for accidents for the resident. A review of Resident 1's clinical record indicated, Resident 1 was admitted in March of 2026 with a diagnosis of encounter for orthopedic aftercare.A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 3/17/26 indicated Resident 1 was cognitively intact.During an observation and interview on 4/2/26 at 12:09 p.m. with Resident 1 in Resident 1's room, Resident 1 was observed sitting in her wheelchair with her right leg raised. Resident 1 stated a CNA (CNA 1) left her alone in the shower room twice to get her a brush.During a telephone interview on 4/2/26 at 1:23 p.m. with CNA 2, she stated that she witnessed CNA 1 leave Resident 1 in the shower room alone at least once during her shift.During a review of CNA 1's statement dated 3/22/26, the statement indicated, .I went to supply closet grabbed a brush . she stated that I have a blue brush in my dresser in my room can you grab it . I grabbed the brush . I returned back to shower room .During a telephone interview on 4/2/26 at 1:42 p.m. with CNA 1, CNA 1 stated she left Resident 1 in the shower room alone to grab a brush from the central supply room. CNA 1 further stated she left Resident 1 alone in the shower room a second time to get Resident 1 a brush from Resident 1's room.During an interview on 4/2/26 at 2:54 p.m. with Licensed Nurse (LN 1), LN 1 stated no resident should be left alone in the shower room. LN 1 further stated a resident 1 could have an accident or a fall and get hurt without supervision in the shower room.During an interview on 4/2/26 at 3 p.m. with Nurse Manager (NM), the NM stated the expectation was that no resident was to be left alone in the shower room unattended by staff. NM stated it is a safety risk.During a review of facility policy and procedure (P&P) titled, .Bath/Shower. dated 2001, the P&P indicated, .Stay with the resident throughout the bath. Never leave the resident unattended in the . shower.During a review of facility P&P titled, .Safety and Supervision of Residents. , dated July 2017, the P&P indicated, .Resident supervision is a core component of the systems approach to safety.