STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555442	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Post Acute	6821 24th Street Sacramento, CA 95822

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 3) was free from abuse when facility staff witnessed Resident 4 hit Resident 3 with an object.This failure resulted in Resident 3 to feel unsafe in the facility and had the potential for Resident 3 to be harmed. Findings:During a review of Resident 3's clinical record, Resident 3 was admitted [DATE] with diagnosis that included bilateral below the knee amputation (surgical removal of the leg below the knee), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/26/24, Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 3 had intact cognitive.During a review of Resident 4's clinical record, Resident 4 was admitted [DATE] with diagnosis that included depression, anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), psychoactive substance abuse (A drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior).During a review of Resident 4's MDS, dated [DATE], Resident 4 had a BIMS score of 14 out of 15 which indicated Resident 4 had intact cognitive.During a review of Resident 3's change of condition (COC), dated 11/14/25, the COC indicated Resident 3 had been involved in an altercation (a noisy argument or disagreement) with another resident.During an interview on 11/18/25 at 10:10 a.m. with the Administrator (ADM), the ADM stated staff reported that Resident 3 and 4 were having a hostile (unfriendly and aggressive) argument and while staff were separating them, Resident 4 threw a dessert cup at Resident 3 hitting Resident 3 on the right eye.During an interview on 11/18/25 at 10:49 a.m. with Resident 3, Resident 3 stated Resident 4 threatens him all the time. Resident 3 stated Resident 4 was yelling threats while walking toward him in the hallway on 11/14/25 and when staff tried to intervene (come between to prevent or alter a result or course of event), Resident 4 threw something at him, hitting his right eye. Resident stated, I don't feel safe around here.During an interview on 11/18/25 at 11:12 a.m. with Resident 5, Resident 5 stated he has heard Resident 4 threaten to physically harm and kill Resident 3. Resident 5 confirmed that he saw Resident 4 throw something that hit Resident 3 on the eye on 11/14/25. During an interview on 11/18/25 at 11:16 a.m. with Resident 6, Resident 6 stated he has heard Resident 4 threaten Resident 3 saying, I will beat his ass. Resident 6 stated he witnessed Resident 4 throw something at Resident 3 and it hit Resident 3's eye.During an interview on 11/18/25 with Licensed Nurse (LN) 1 and LN 2 at 2:55 and 4:02 p.m., both stated that Resident 3 and 4 were verbally fighting in the hallway and Resident 4 threw a pudding cup at Resident 3 and hit Resident 3 in the face.During an interview on 11/18/25 with Certified Nurse Assistant (CNA) 1 and CNA 2 at 3:05 p.m. and 3:25 p.m., they both stated Resident 3 and 4 were arguing and Resident 4 threw something at Resident 3, hitting Resident 3.A review of Resident 3's care plan initiated 10/4/24 and 10/8/24, indicated, The resident is/has potential to be physically aggressive r/t Anger, Depression, Poor impulse control related to 10/4/2022 argument incident with another resident; 10/8/24- slapped other resident's face. Interventions included Staff to closely monitor resident to remain distant with the other resident involved in the argument. Monitor episodes of aggressive behavior/s and intervene accordingly. When the resident becomes agitated: Intervene before agitation escalates. A review of Resident 4's care plan initiated on 10/17/25, indicated, The resident has potential to verbally aggressive r/t poor impulse control. Interventions included, Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document.During an interview on 11/18/25 at 4:06 p.m. with the DON, the DON stated she and the ADM were unaware of the ongoing tension between Residents 3 and 4. The DON stated the expectation is that staff report abuse. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention Policy dated 3/14/2025, the P&P indicated, Residents have the right to be free from all forms of abuse. This includes but is not limited to freedom from physical abuse, verbal abuse. Staff will be instructed to report any risks of abuse.