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	12/12/2025

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

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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	Based on interview, and record review, the facility failed to protect one of five sampled residents from abuse (Resident 1) when a Certified Nursing Assistant (CNA) hit Resident 1 on the head and the CNA, along with Witness 1 and Witness 2, physically restrained Resident 1 during care.This failure resulted in violation of Resident 1's right to be free from abuse of any type and had the potential to result in physical and psychosocial harm.Findings:During a review of Resident 1's admission record, Resident 1 was admitted in February of 2025 with diagnoses of Traumatic Hemorrhage of Cerebrum (bleeding within the brain tissue), Dementia (disorder affecting memory, thinking, language, and problem-solving) and muscle weakness. Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment (a score of 11 out of 15 suggests the individual has noticeable issues with memory and orientation, requiring more support for daily living tasks). During an interview on 12/12/25 at 11:11 a.m. with Director of Staff Development (DSD), the DSD reported that there were two students that witnessed a CNA hit Resident 1 on the head. The DSD stated, .They [Witness 1 and Witness 2] witnessed the abuse .they [Witness 1 and Witness 2] were petrified .the teacher came to my office with the two students, and they told me the story of what happened. The DSD further stated, the witnesses reported, .she [CNA] used her hand to open slap him [Resident 1] on the face . During an interview on 12/12/25 at 12 p.m. with the Director of Nursing (DON), the DON stated it is never ok to hit or restrain a resident. The DON explained that her expectation is, .every resident should be treated with kindness and respect . The DON reported that after the incident, . [CNA] was suspended and terminated. During an observation and interview on 12/12/25 at 12:40 p.m. with Resident 1, Resident 1 was laying down in bed. Resident 1 declined to be interviewed about the incident. During an interview on 12/12/25 at 1:09 p.m. with the DON, when a policy for restraints and/or policy on restraining residents was requested, the DON stated that she is unsure if they have a restraint policy. Per the DON, it is not the policy of the facility to restrain residents. During an interview on 12/16/25 at 8:36 a.m. with the Clinical Instructor (CI), the CI reported that Witness 1 and Witness 2 reported to her that the [CNA] that they were assigned to shadow, hit Resident 1 on the head during the resident's care. During an interview on 12/16/25 at 8:45 a.m. with Witness 1, Witness 1 stated, We [Witness 1 and Witness 2] were assisting her [CNA] with his [Resident 1] care .we were changing his [Resident 1] brief [incontinent brief] .when we were changing his [Resident 1] shirt .that is when she [CNA] hit him [Resident 1] on the forehead .one time with an open hand .I knew I had to report this .it is not ok to hit someone . During an interview on 12/16/25 at 8:54 a.m. with Witness 2, Witness 2 stated, .we CNA, [Witness 1 and Witness 2] had to give him [Resident 1] a brief [incontinent brief] change. she [CNA] lost control in a way and hit him [Resident 1] with her hand, on his [Resident 1] temple area of his head.we [Witness 1 and Witness 2] felt really uncomfortable .no one should ever place hands on a patient.he [Resident 1] doesn't deserve that . Witness 2 reported [CNA] instructed her and Witness 1 to hold Resident 1's arms and legs during this incident. Witness 2 stated, . [CNA] held his [Resident 1] left arm, and I [Witness 2] was able to hold down his [Resident 1] legs .During an interview on 12/17/25 at 8:44 a.m. with the CNA, the CNA reported that she was asked to have Witness 1 and Witness 2 observe her providing care to Resident 1. CNA reported that during providing care to Resident 1, she observed Witness 1 and Witness 2 holding Resident 1's hand and legs. CNA further reported that she was terminated from her employment at the facility after the investigation stemming from the incident with Resident 1. During a follow up interview on 12/17/25 at 9:41 a.m. with the CI, the CI reported that Witness 1 and Witness 2 have both received training on abuse. During a follow up interview on 12/17/25 at 9:49 a.m. with Witness 1, Witness 1 stated, . [CNA] said that [Resident 1] was violent, so she [CNA] told me that I needed to hold his [Resident 1] arms and [Witness 2] to hold his [Resident 1] legs . Witness 1 reported that she observed Witness 2 holding Resident 1's legs. Witness 1 reported that she received abuse training at her school. During a follow up interview on 12/17/25 at 9:52 a.m. with Witness 2, Witness 2 stated, [Witness 1] had his [Resident 1] right arm and I had his [Resident 1] legs.[CNA] told us to hold him [Resident 1] because he [Resident 1] is aggressive so to hold his [Resident 1] legs and arms down.so that he would not kick at me . Witness 2 reported that she observed Witness 1 holding Resident 1's right arm. Witness 2 reported that she observed [CNA] holding Resident 1's left arm. Witness 2 reported that she received abuse training at her school.During a review of CNAs personnel file, in a review of record titled Training/Correction/Disciplinary Action Form dated 11/18/25, under category labeled, Employee Comments: