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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision for one of three sampled residents (Resident 1), when the facility failed to identify, implement and monitor new interventions to prevent falls after Resident 1 fell at the facility on 1/4/26 and fell twice more on 1/10/26.These failures could have contributed to a fall on 1/13/26 that resulted in a broken clavicle (a break in the outer end of the collarbone, often caused by a direct fall onto the shoulder causing intense pain), pain, and a four-day hospitalization for Resident 1. Findings:Resident 1 was admitted to the facility on [DATE] with multiple medical diagnoses which included dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 1/6/26, the MDS indicated, .brief interview for mental status [BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident] be conducted .No [Resident 1] is rarely/never understood .cognitive skills for daily decision making severely impaired .never/rarely made decisions. The MDS indicated Resident 1's functional status required two-person assistance with dressing, bathing, toileting hygiene (cleaning after voiding or bowel movement), and transferring on and off the toilet. Resident 1 required one-person assistance with oral and personal hygiene (brushing teeth, combing hair, etc.), transferring to and from a bed to a chair, and with standing from a seated position.During a review of Resident 1's physician progress note (PPN), dated 1/6/26, the PPN indicated, [Resident 1] Baseline functional status: nonverbal, poor participation, history of falls, requires assistance for ADLs, feeding, and mobility. Baseline cognitive status: minimally interactive, unable to engage in meaningful interviews, lacks capacity for informed consent.Resident 2 was admitted to the facility in March 2019. Resident 2 had a BIMS score of 13 out of 15 which indicated Resident 2's cognitive function was intact.During an observation on 1/26/26 at 2:30 p.m. in Resident 1's room, an attempted interview was made. Resident 1 made eye contact, but Resident 1's words were impossible to understand. Resident 1 could not participate in the interview. No fall mats were observed on either side of Resident 1's bed on the floor.During an interview on 1/26/26 at 3:57 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 had fallen in the facility and required transfer to the emergency department on 1/13/26. LN 1 stated she joined Certified Nursing Assistant (CNA) 1 in Resident 1's shared bathroom when she heard Resident 2 screaming for help. LN 1 stated she saw Resident 1 lying on the bathroom floor; Resident 1 was confused and had difficulty communicating. LN 1 stated Resident 2 reported Resident 1 had hit his head. LN 1 stated 911 was called and Resident 1 was transported to the hospital on 1/13/26.During an interview on 1/26/26 at 4:09 p.m. with CNA 1, CNA 1 stated Resident 1 had fallen in the facility on 1/13/26. CNA 1 stated Resident 1 was impulsive, confused, (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a known fall risk. CNA 1 stated when he entered Resident 2's room, he saw Resident 1 lying on the bathroom floor. CNA 1 stated he alerted LN 1 and remained with Resident 1 until paramedics arrived at the facility.During an interview on 1/26/26 at 4:18 p.m. with Resident 2, Resident 2 stated he witnessed Resident 1 fall on 1/13/26. Resident 2 stated he was in his room when he saw Resident 1 standing in the shared bathroom. Resident 2 saw Resident 1 trip and fell forward hitting his head hard against the door then fell backwards and hit the back of his head when he landed on the ground. Resident 2 stated Resident 1 began shaking and shaking on the floor of the bathroom. Resident 2 stated he turned on his call light and yelled for nursing staff as loud as I could.During an interview on 1/26/26 at 4:44 p.m. with LN 2, LN 2 stated he was familiar with Resident 1. LN 2 stated he had witnessed Resident 1 fall in the facility on 1/10/26, prior to 1/13/26 fall, and referred to Resident 1's progress notes (PN), dated 1/10/26.During a concurrent interview and record review on 1/28/26 at 12:06 p.m. with Administrator (Admin) and Director of Nursing (DON), Resident 1's care plan (CP), dated 1/4/26 and 1/10/26, Resident 1's IDT Fall [IDTF], dated 1/6/26, 1/12/26, and 1/12/26, and Resident 1's PN, dated 1/4/26 and 1/10/26 were reviewed.During a review of Resident 1's CP, dated 1/4/26, and revised on 1/10/26 and 1/13/26, indicated, [Resident 1] has had an actual fall with no injury [on] 1/4/2026.[on] 1/10/2026.[on] 1/13/2026.During a review of Resident 1's progress note (PN), dated 1/4/26, the PN indicated, This nurse and another nurse heard [roommate] scream, 'Man down!' Upon arrival [Resident 1] was on the floor next to the bed . [Resident 1] has discoloration to the R [right] forehead, which contradicted Resident 1's CP, dated 1/4/26, which indicated Resident 1 sustained no injuries from the fall on 1/4/26. DON acknowledged the discrepancy and stated the PN could be expanded.DON stated Resident 1's fall on 1/4/26 (a weekend) was reviewed by the interdisciplinary team (IDT). DON stated she had not interviewed any nursing staff or residents to investigate Resident 1's fall on 1/4/26, nor had she instructed any other staff to do so. DON stated Resident 1's CP had been updated on 1/4/26. During a review of Resident 1's CP, dated 1/4/26 indicated, Monitor/document /report PRN [as needed] x 72h [72 hours] to MD [medical doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. DON stated no other steps were taken to identify, monitor or prevent Resident 1 from future falls. During a review of Resident 1's CP, dated 1/4/26, no new interventions were indicated to prevent falls.During a review of Resident 1's IDT Fall [IDTF], dated 1/6/26, the IDTF indicated, New Fall Prevention Intervention Implemented: Sent to hospital for eval [evaluation], Report to EMT [Emergency Medical Technician], which contradicted Resident 1's MR, that did not indicate Resident 1 was sent to the hospital on 1/4/26.During a review of Resident 1's PN, dated 1/10/26, the PN indicated, [Resident 1] had. unwitnessed fall .no visible injuries noted.During a review of Resident 1's IDTF, dated 1/12/26, the IDTF indicated, New Fall Prevention Intervention Implemented: fall mats and lower bed, which contradicted Resident 1's CP which did not indicate fall mats.During a review of Resident 1's IDTF, dated 1/12/26, the IDTF indicated, Nurse witness [Resident 1] roll to R [right] side of bed, falling out of bed, colliding head with roommates bed, onto floor. [Resident 1] LOC [loss of consciousness] for 20 sec [seconds] .active bleeding noted from R [right] forehead .[Resident 1] nonverbal, when asked if in pain [Resident 1] nods head up.down .[Resident 1] transferred to [emergency department] .New Fall Prevention Intervention Implemented: transfer to acute.During a review of Resident 1's Prehospital Care Report [PCR], dated 1/10/26, the PCR indicated, [Resident 1] .presented with a [one] inch laceration above his right eye. During a review of Resident 1's ED [Emergency Department] Provider Notes [EDN], dated 1/10/26, the EDN indicated, FALL .after closed head injury .small right frontal abrasion [an injury located on the forehead, forehead region, or face, caused by the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	friction or shearing of the skin against a rough surface, characterized by the scraping away of the outermost layer of skin]. During a review of Resident 1's ED RN [Registered Nurse] Flowsheet [EDRNF], dated 1/10/26, the EDRNF indicated, Wound Skin Tear 1/10/26 Right: Upper Face .IRRIGATION [a continuous flow of liquid] .DRY DRESSING.During a review of Resident 1's CP, dated 1/10/26, the CP indicated, [Resident 1] is at risk for falls .Interventions .Anticipate and meet [Resident 1's] needs .Educate [Resident 1] about safety reminders and what to do if a fall occurs .Pt [Physical Therapy] evaluate and treat as ordered or PRN [as needed], however Resident 1's CP, dated 12/31/25 already indicated, [Resident 1] is at risk for falls .Interventions .Anticipate and meet [Resident 1's] needs .Educate [Resident 1] on fall prevention .Refer resident to physical therapy .if indicated, which indicated the interventions added by the facility on 1/10/26, were not new interventions to prevent future falls for Resident 1.DON stated Resident 1's falls on 1/10/26 had occurred over the weekend and both falls were reviewed by IDT on the following Monday. DON stated Resident 1's CP had been updated by the activities department over the weekend to include activities, but during a record review of Resident 1's CP, dated 12/31/25, CP indicated,[Resident 1] is at risk for falls .Encourage resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility, which indicated the activities intervention was not new and had been added upon Resident 1's admission. In addition, during a review of Resident 1's CP, an updated activities care plan was not found for the falls on 1/10/26. DON stated Resident 1's interventions were evaluated when Resident 1 was transferred to the hospital and assessed upon return. DON did not state any other steps were taken to identify, monitor or prevent Resident 1 from future falls. DON further stated Resident 1 had not sustained any injuries from the falls on 1/10/26 based on nursing assessments and hospital records, which contradicted Resident 1's EDN, dated 1/10/26, and Resident 1's IDTF, dated 1/12/26.Admin and DON stated they were aware of Resident 1's fall on 1/13/26. DON stated Resident 1 had been hospitalized on [DATE] and returned to the facility on 1/17/26 and was diagnosed with a right clavicle fracture, which contradicted Resident 1's CP, dated 1/4/26 and revised on 1/13/26, which indicated Resident 1 sustained no injuries from the fall on 1/13/26. DON stated there were no witnesses to the fall and she did not investigate further nor speak with any staff or residents about the fall.During a review of Resident 1's PCR, dated 1/13/26, the PCR indicated, Responded C-3 [Code three-an emergency, high-priority response by police, fire, or EMS units, requiring the immediate use of both emergency lights and sirens] to [facility] for [Resident 1] who fell hit his head on thinners [medications that prevent or reduce the risk of blood clots forming in blood vessels, the heart, or veins by interrupting the body's clotting process)]. Staff stated: [Resident 1] roommate reported a loud bang in bathroom .[Resident 1] laying on floor .does take [thinners] and did get his dose today, small bump to back of his head, old bump above rt [right] eye, from fall several days ago .staff reports bump to back of head .ED [Emergency Department] notification of trauma alert [a formal, pre-hospital notification to a hospital that they are transporting a critically injured patient who meets specific physiological or anatomical criteria].During a review of Resident 1's Orthopedic [specialty physician focused on the bones, joints, ligaments, tendons, muscles, and nerves] ER [Emergency Room] Consult [OEC], dated, 1/14/26, the OEC indicated, Reason for consult: R distal clavicle fx [right distal clavicle fracture] .[Resident 1] minimally verbal .mumbling answers .says yes to pain in his right clavicle .tender to palpation [the medical technique of using hands and fingers to feel the body's surface and underlying structures to assess] over the fracture site.During a review of Resident 1's Trauma admission History and Physical Note [TAHP], dated 1/13/26, the TAHP indicated, Imaging .[chest x-ray - a form of high-energy electromagnetic radiation used to produce images of the body's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	internal structures to diagnose conditions such as fractures] result date: 1/13/26 IMPRESSION: 1. Acute appearing [acute appearing fracture refers to a bone break that looks recent on imaging (X-ray) .these injuries, caused by sudden trauma or falls, result in immediate, severe pain, swelling, and bruising, and are distinct from chronic overuse injuries] distal right clavicular fracture [a break in the outer end of the collarbone, often caused by a direct fall onto the shoulder causing intense pain] with overlying soft tissue swelling.During a review of Resident 1's Trauma Discharge Summary [TDS], dated 1/17/26, the TDS indicated, Date of admission [hospital] 1/13/26 .date of discharge 1/17/26 .reason for admission .fall at SNF [skilled nursing facility] and sustained RIGHT clavicle fx [fracture] .NWB RUE [non-weight bearing right upper extremity] .medically stable for discharge to SNF.During a review of the facility's policy and procedure titled, Falls - Clinical Protocol, dated March 2018, indicated, The staff .will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling .Frail elderly individuals are often at greater risk for serious adverse consequences of falls .If the individual continues to fall, the staff .will reevaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions.During a review of the facility's policy and procedure titled, Assessing Falls and Their Causes, dated March 2018, indicated, Continue to collect and evaluate information until the cause of falling is identified .If the cause is unknown but no additional evaluation is done .nursing staff should note why .When a resident falls, the following information should be recorded in the resident's medical record: Appropriate interventions taken to prevent future falls.During a review of the facility's policy and procedure titled, Comprehensive Assessments, dated October 2023, indicated, Comprehensive .assessments are conducted to assist in developing person-centered care plans.