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	02/20/2026

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

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure nine residents (Resident 32, Resident 17, Resident 59, Resident 84, Resident 94, Resident 122, Resident 71, Resident 36 and Resident 126) out of 32 sampled residents were free from involuntary seclusion when resident room doors were left closed.This failure had the potential to increase the risk of psychosocial trauma and physical injury when residents were unable to exit their rooms independently or access staff during an emergency. Findings:A review of Resident 32's admission Record (AR) indicated the resident was initially admitted to the facility in January 2024 with diagnoses which included difficulty speaking and dementia (a progressive decline in memory, language and cognitive function severe enough to disrupt daily life).A review of Resident 32's Minimum Data Set (MDS, an assessment tool) dated 11/18/25 indicated Resident 32's had a moderate memory problems.A review of Resident 17's AR indicated the resident was initially admitted to the facility in October 2024 with diagnoses which included difficulty speaking and seizures (sudden, uncontrolled bursts that cause temporary, involuntary changes in movement, behavior and consciousness).A review of Resident 17's MDS, dated [DATE], indicated Resident 17 is rarely to never understood and based on the facility staff's assessment Resident 17's had severe memory problems.A review of Resident 59's AR indicated the resident was admitted to the facility in June 2024 with diagnoses which included dementia and anxiety disorder (an overwhelming feeling of fear, dread, or unease that impacts daily life and mental wellbeing).A review of Resident 59's MDS, dated [DATE], indicated Resident 59 had no memory problems.A review of Resident 84's AR indicated the resident was initially admitted to the facility in August 2016 with diagnoses which included difficulty speaking, anxiety disorder, and psychosis (hallucinations, delusions, or disorganized thinking).A review of Resident 84's MDS, dated [DATE], indicated Resident 84 had moderate memory problems. A review of Resident 94's AR indicated the resident was admitted to the facility in March 2021 with diagnoses which included psychosis, need for assistance with personal care, and vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain).A review of Resident 94's MDS, dated [DATE], indicated Resident 94 had severe memory problems. A review of Resident 122's AR indicated the resident was admitted to the facility in July 2019 with diagnoses which included psychosis and mixed receptive-expressive language disorder (a neurodevelopmental condition characterized by significant difficulties in both understanding (receptive) and producing (expressive) spoken language).A review of Resident 122's MDS, dated [DATE], indicated Resident 122 is rarely to never understood and was unable to complete the BIMS interview and based on the facility staff's assessment Resident 122 had severe memory problems.A review of Resident 71's AR indicated the resident was admitted to the facility in February 2025 with diagnoses which included cognitive communication deficit (an impairment in communication, verbal or nonverbal) and the need for assistance with personal care.A review of Resident 71's MDS, dated [DATE], indicated Resident 71had severe memory problems.A review of Resident 36's AR indicated the resident was admitted to the facility in November 2025 with diagnoses which included dementia and the need for assistance with personal care.A review of Resident 36's (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS, dated [DATE], indicated Resident 36 had moderate memory problems.A review of Resident 126's AR indicated the resident was initially admitted to the facility in January 2020 with diagnoses which included psychosis, anxiety disorder, cognitive communication deficit and major depressive disorder with psychotic features (a severe, high-risk subtype of depression where profound sadness is accompanied by hallucinations or delusions).A review of Resident 126's MDS, dated [DATE], indicated Resident 126 had no memory problems. During the initial facility tour observation on 2/17/26 at 8:15 a.m., multiple residents in the 200 - 203 hallway which housed Resident 32, Resident 17, Resident 59, Resident 84, Resident 94, Resident 122, Resident 71, Resident 36 and Resident 126 were heard calling out for various reasons. Resident 126 repeatedly stated, Help me, help me, I need my medicine, I need my medicine, I need my medicine now. Resident 71 repetitively asked, Can I have some toast?During a concurrent observation and interview on 2/17/26 at 8:43 a.m., in the 200 - 203 hallway, with Certified Nursing Assistant (CNA) 8, stated, Yes, the section back here [Resident 32, Resident 17, Resident 59, Resident 84, Resident 94, Resident 122, Resident 71, Resident 36 and Resident 126] is tough, there are a lot of residents who yell and scream.During a follow-up concurrent observation and interview on 2/17/26 at 8:58 a.m. with CNA 8, outside of Resident 71, Resident 36, and Resident 126's shared room, CNA 8 stated, I checked in on [Resident 126] at 6:30 a.m. and as soon as I opened the door the room smelled of urine. CNA 8 stated when she arrived for her morning shift the residents' room doors were closed. CNA 8 stated, The room doors are only closed if the resident is able to ask for it [to be closed], resident room doors are not supposed to have the doors closed due to resident safety. CNA 8 acknowledged the staff at night have a history of closing the resident room doors since there are multiple residents yelling out in this section.During an observation on 2/18/26 at 5:30 a.m., Resident 71's, Resident 36's, and Resident 126's room doors were closed.During an observation on 2/18/26 at 6:03 a.m., Resident 32's, Resident 17's, Resident 59's, Resident 84's, Resident 94's, Resident 122's, Resident 71's, Resident 36's and Resident 126's room doors were closed.During a concurrent observation and interview on 2/19/26 at 9:34 a.m., in the 200 - 203 hallway with CNA 9, CNA 9 acknowledged the various residents calling out for assistance, medication and breakfast. CNA 9 stated, I don't have enough time to care for all of these residents, I do my best, but it's hard. CNA 9 agreed residents should have their room doors open, unless they are able to request the door to be closed and everyone in the room agreed, or if a CNA is providing personal care. CNA 9 stated, Rooms shouldn't be closed just because residents are yelling out.During an interview on 2/19/26 at 1:58 p.m., in the 200 - 203 hallway with Licensed Nurse (LN) 5, LN 5 confirmed resident's room doors should be open for safety, due to the concerns for falls and injuries. LN 5 stated, Some residents can request their doors to be closed, but only if they all [residents] can agree.During an interview on 2/20/26 at 1:20 p.m., with the Director of Nursing (DON), the DON acknowledged the nurse assigned to the 200 - 203 hallway has a tough section and confirmed resident room doors (were closed) should be kept open for safety reasons. The DON agreed if residents are unable to independently exit their room or if staff close the doors to minimize the volume of yelling from residents, this was considered involuntary seclusion. The DON stated, Staff should never be closing resident doors without their permission and only if everyone [residents] in the room agrees.During an interview on 2/20/26 at 3:36 p.m., with CNA 9, LN 5 and Resident 126, CNA 9 and LN 5 agreed the residents' rooms in the 200 - 203 hallway were not to be fully closed due to safety. Resident 126 agreed and stated, No, I do not want my door closed.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/5/25, the P&P indicated, It is the policy of the facility to fully uphold the rights of all residents. Resident Rights: a. Dignity, Respect and Freedom. Be free from abuse, neglect. involuntary seclusion. j. Quality of Life. choose visitors, roommates (consistent with safety and rights of others and as facility availability allows).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure four residents (Resident 139, Resident 96, Resident 116 and Resident 126) of 32 sampled residents were free of medication administration error rates of five percent or more, when 10 errors out of 28 opportunities for errors occurred during the medication administration to the residents.These failures resulted in medication administration error rates of five percent or more, which was 35.71 %. Findings:1. During a medication administration observation on 2/18/26 at 8:08 a.m., with Licensed Nurse (LN) 5, LN 5 was observed preparing four medications for Resident 139.During a concurrent interview and record review on 2/18/26 at 8:42 a.m., with LN 5, Resident 139's medical record was reviewed. The medical record indicated a physician's order dated 2/15/26 for sucralfate (a medication used to treat and prevent active duodenal [upper small intestine] ulcers) 1 gm (gram, a unit of measurement/strength of medication) .give 1 gm by mouth four times a day, give on an empty stomach, which was scheduled for 7 a.m. LN 5 acknowledged the medication was scheduled to be administered at 7 a.m. and confirmed the medication was administered more than an hour late. LN 5 stated one of the five medication rights is to ensure medications are administered at the right time.2. During a medication administration observation on 2/19/26 at 7:57 a.m., with LN 7, LN 7 was preparing seven medications for Resident 96, which included aspirin (a medication used to reduce the risk of blood clots, heart attacks, and strokes by thinning the blood) 81 mg (milligram, a unit of measure) chewable tablet and 7.5 ml (milliliter, a unit of measure) of ferrous sulfate (an iron supplement used to treat or prevent iron-deficiency anemia by increasing iron levels in the blood) 220 mg/5 ml oral solution, to be administered through Resident 96's percutaneous endoscopic gastrostomy tube (PEG-tube, a soft, flexible feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medication directly, bypassing the mouth and throat).During a concurrent interview and record review on 2/19/26 at 8:17 a.m. with LN 7, Resident 96's medical record was reviewed. The medical record indicated the following physician orders: aspirin 81 mg oral tablet chewable tablet give one tablet via PEG-tube one time a day, dated 2/26/25; ferrous sulfate oral solution 300 (60 Fe) mg/5 ml, give 7 ml via PEG-Tube one time a day, dated 2/27/25; and pantoprazole sodium (used to treat erosive esophagitis and gastroesophageal reflux disease (GERD) by decreasing stomach acid) 40 mg oral packet, give 1 packet via G-Tube [PEG-tube] one time a day. LN 7 acknowledged the aspirin was scheduled to be administered at 9 a.m. and administered early and the administered dose of ferrous sulfate oral solution was incorrect per the physician's order. LN 7 stated, The pantoprazole sodium packet is unavailable, this will be a medication error since we don't have it. LN 7 indicated the physician should be notified when a medication is unavailable or if the medication available is the incorrect dosage solution. LN 7 stated, The physician's order and the medication on hand should match.3. During a medication administration observation on 2/19/26 at 8:50 a.m., with LN 6, LN 6 was observed preparing ten medications for Resident 116 which included aspirin 81 mg chewable tablet.During a concurrent interview and record review on 2/19/26 at 9:07 a.m., with LN 6, Resident 116's medical record was reviewed. LN 6 acknowledged the physician order for aspirin 81 mg chewable tablet, dated 12/15/25. LN 6 stated, I should have instructed [Resident 116] to chew that one [aspirin]. LN 6 acknowledged one of the medication rights was to ensure the medication was taken by the right route and acknowledged the chewable aspirin allowed for faster absorption.4. During a medication administration observation on 2/19/26 at 9:48 a.m. with LN 5, LN 5 was observed preparing eight medications for Resident 126 which included aspirin 81 mg chewable tablet, multivitamin with minerals (a medication that contains a combination of vitamins and minerals), quetiapine (an atypical antipsychotic used to treat mental heath disorders) 50 mg tablet, and fluticasone/salmeterol (dry powder inhaler used twice daily for long-term maintenance treatment of lung disorders) 100-50 mcg (microgram, a unit of measure).During a concurrent interview and record review on 2/19/26 at 10:06 a.m., with LN 5, Resident 126's medical record was reviewed. LN 5 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed Resident 126's aspirin, multivitamin with minerals, quetiapine and fluticasone/salmeterol inhaler were administered late. LN 5 acknowledged the importance of administering medications within the scheduled time frame to ensure the efficacy of the medication.During a concurrent interview and record review on 2/20/26 at 1:20 p.m., the Medication Admin Audit Report for medication Cart 2 was reviewed with the Director of Nursing (DON). The DON acknowledged resident medications should be available for administration as scheduled. The DON confirmed medications need to be administered within the scheduled time frame and according to the physician's order to ensure the right dose is administered to ensure the efficacy of the medication. The DON stated, The nurses need to follow the medication rights; which include the right medication, the right time, and the right dose.During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated October 2017, the P&P indicated, Medications are administered as prescribed. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.During a review of the facility's P&P titled, Medication and Treatment Orders, revised July 2016, the P&P indicated, Orders for medications must include: Name and strength of drug. dosage and frequency of administration. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store, prepare, and distribute food in accordance with professional standards for food service safety for 116 out of 116 residents when: 1.Several metal sheet pans, serving utensils and scoop in clean and ready-to-use storage areas:Were stacked wet while stored awayThere was food debris in scoop and metal strainer [NAME] substance inside of the utensil holder.2.There were bags of food items in the walk-in freezer with issues:1 bag of unopened cream puffs, and two unopened bags of chopped green chilies have freezer burnsWalk in freezer had dark brown substances, white particles and an unknown plastic blue container at the back corner of the freezer floor.These failures had potential to cause food-borne illnesses in a highly susceptible population of 116 out of 116 residents who received food from the kitchen.Findings:1.During a concurrent observation and interview on 2/17/26 at 8:44 a.m., at the kitchen's initial tour with the Certified Dietary Manager (CDM), several metal sheet pans stored at the clean and ready to use areas were observed stacked wet, had food debris, and brown substance. The metal pans included:4 small steam table pans and 1 muffin full sheet pan (wet),1 metal scoop (food debris inside),1 metal strainer with (food debris inside),1 metal utensil holder with brown substance inside.The CDM confirmed the metal sheet pans were wet, the scoop and strainer had food debris, and the metal utensil holder had brown substance inside of it. CDM stated, the metal steam table dishes, pans, pots, and utensils need to be cleaned and air dried before being stacked and stored away.During an interview on 2/19/26 at 9 a.m. with Registered Dietician (RD), the RD stated, dishes, pots and pans, utensils must be fully air dried before stacking to prevent mold, fungus, bacteria to grow that can cause food borne illnesses.During a review of the facility's policy and procedure (P&P) titled, Dishware, Utensils, and Pans drying Policy, undated indicated, .Dishware such as utensils, pots, and pans should be air dried after cleaning and sanitizing. dried items should be stored only in clean designated storage areas.2.During a concurrent observation and interview on 2/17/26 at 9:10 a.m., at the initial kitchen tour, in the walk-in freezer had dark brown substance, scattered white particles on the corner behind the freezer racks, and an unknown plastic blue container on the floor were observed. There was one package of unopened cream puffs, two bags of unopened chopped green chilies that had freezer burns. The CDM confirmed the frozen food had freezer burns and ice crystals inside the bags, and the walk-in- freezer floor had scattered white particles, brown substance, and blue plastic container on the floor.During an interview on 2/19/26 at 9 a.m., with RD, the RD stated, her expectations were, the walk-in freezer must be kept clean. RD further stated any frozen food that has freezer burns must be discarded.During a review of the facility's P&P titled, Refrigerators and Freezers, undated, indicated, .the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, .During a review of the facility's P&P titled, Food Receiving and Storage, undated indicated, .Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 116 when:1. Resident 54's nebulizer mask (a medical accessory that fits over a patient's nose and mouth to deliver medication directly into the lungs) had been sitting outside of the antimicrobial bag exposed for an unknown time; and,2. Staff did not follow enhance barrier precaution and did not perform hand hygiene when providing care for residents in Rooms 403, 404, 405 and 407. Findings:1.During a review of Resident 54's clinical record, indicated Resident 54 was admitted [DATE] with diagnosis that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and acute and chronic respiratory failure (occurs when not enough oxygen transfers from the lungs to the blood, or when the lungs can't properly remove carbon dioxide from the blood).A review of Resident 54's active physician order, dated 1/14/26, indicated, Use Enhanced barrier precautions [EBP - infection control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents] required due to (d/t) MDRO [Multidrug-resistant bacteria]- CRE urine cx (culture) 1/6/26 and risk factor (Abdominal Wound: Open surgical incision). Providers and staff must wear gloves and gown for the following High-Contact Resident Care Activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting.During a concurrent observation and interview on 2/17/26 at 9:20 a.m., 9:24 a.m., and 9:27 a.m., respectively with the Respiratory Therapist (RT), in Resident 54's room, Resident 54's nebulizer mask was observed placed on the nebulizer machine tray, uncovered. RT stated nebulizer masks should be placed in an antimicrobial bag after each use. RT placed the nebulizer mask lying on nebulizer machine tray for unknown time in the antimicrobial bag. RT stated and confirmed that the nebulizer mask should have been changed and placed into an antimicrobial bag after each use to prevent infection.During an interview on 2/19/26 at 10:14 a.m., with the Infection Preventionist (IP), stated the expectation for nebulizer masks was that they should be in an antimicrobial bag when they were not being used to prevent germs or infections from developing. During an interview on 2/19/26 at 11:15 a.m., with the Director of Nursing (DON), sated the expectation for the staff was to follow the infection control policy and procedures. DON stated and confirmed that nebulizer masks were supposed to be in a microbial bag with not being used.During a review of the facility's policies and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, undated, the P&P indicated, . The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment. 7. store the circuit in plastic bag or antimicrobial bag.2. During a concurrent observation and interview on 2/18/26 at 5:53 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 did not sanitize hands before entering room [ROOM NUMBER]. CNA 3 had direct contact with Resident 54. CNA 3 stated, Yes, I am supposed to sanitize my hands before entering a resident's room to prevent infection from spreading.During a concurrent observation and interview on 2/18/26 at 6:45 a.m. with CNA 3, CNA 3 removed gown and gloves in room [ROOM NUMBER] and did not sanitize hands after leaving the room. CNA 3 confirmed hand hygiene was not done and stated, sanitizing is for infection control.During a concurrent observation and interview on 2/19/26 at 9:45 a.m., with Licensed Nurse (LN) 3, LN 3 was changing Resident 54's linens without wearing a gown. LN 3 confirmed Resident 54 was on EBP, and stated linen changes for residents on EBP require wearing a gown and gloves. LN 3 stated, I should have worn a gown when changing linens. LVN stated (if not wearing a gown and gloves) we can transport infections to another resident.During a review of Resident 90's clinical record, the clinical record indicated Resident 90 was admitted [DATE] with diagnosis that included DM (diabetes mellitus-a disorder characterized by difficulty in blood sugar control and poor wound healing,) CKD (progressive damage and loss of kidney function) and cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain).A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 90's active order, dated 12/17/24, indicated, .[on]EBP.During a concurrent observation and interview on 2/18/26 at 5:56 a.m., with LN 2, LN 2 had direct contact with Resident 90 and did not sanitize hands when leaving the room. LN 2 confirmed hand hygiene was not done and stated not sanitizing hands can spread infection.A review of Resident 1's clinical record indicated Resident 1 was admitted [DATE] with diagnosis that included CVA, pressure ulcer (a small open sore or wound generally found in the stomach or on the skin), dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).A review of Resident 1's active order, dated 7/18/25, indicated, .[on]EBP.During a concurrent observation and interview on 2/18/26 at 6:17 a.m., with CNA 4, CNA 4 did not sanitize hands after direct contact with Resident 1. CNA 4 confirmed Resident 1 was on EBP and stated that not sanitizing hands can spread germs.A review of Resident 40's clinical record indicated Resident 40 was admitted [DATE] with diagnosis that included heart failure (progressive condition where the heart muscle is too weak or stiff to pump blood efficiently to meet the body's needs), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).During a concurrent observation and interview on 2/18/26 at 6:39 a.m. with CNA 5, CNA 5 removed gown and gloves in the room after direct contact with Resident 40 and did not sanitize hands after. CNA 5 stated she was supposed to sanitize hands after removing gown and gloves to prevent spread of infection.During an interview on 2/19/26 at 10:14 a.m., with the IP, stated staff were expected to perform hand hygiene (HH) per policy & procedure and to wear a gown and gloves for residents on EBP. IP stated staff were expected to remove the gown and gloves in the room and perform HH before and after performing tasks, and before and after entering rooms. IP stated the purpose of gowning and gloving in accordance with EBP precaution protocol is to prevent the spread of disease and infection.During an interview on 2/19/26 with the DON, stated the expectation for infection control was that staff should follow the policy and procedure to prevent spread of infections from resident to resident and staff. The DON confirmed HH should happen before and after you enter any resident room.During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised October 2023, and Enhanced Barrier Precautions, revised December 2024, the P&P indicated, .Indications for Hand Hygiene. immediately before touching a resident, after touching a resident, after touching a resident's environment, immediately after glove removal.During a review of the facility's P&P titled, Enhanced Barrier Precautions, revised December 2024, the P&P indicated, EBPs are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.4. standard precautions apply to the care of all residents regardless of suspected or confirmed infection. 7. EBPs employ targeted gown and glove use. 8. Examples of high-contact resident care. changing linens.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse from one out of five sampled residents (Resident 89) when Resident 61 slapped Resident 89's right hand.This failure resulted in Resident 89 not being free from abuse by Resident 61, and Resident 89's right to be free from abuse not protected.Findings:During a review of Resident 89's admission Record (AR), indicated, Resident 89 was initially admitted [DATE] with diagnosis including Orthopedics (a medical and surgical specialty focused on the prevention, diagnosis, and treatment of muscles, joints, and bones disorders) Aftercare following Surgical amputation (amputation-a surgical removal of all or part of a limb or extremity to treat severe infection, disease such as diabetes [Diabetes Mellitus -a disorder characterized by difficulty in blood sugar control and poor wound healing]).During a review of Resident 89's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/24/25, indicated, Resident 89 had intact memory.During a review of Resident 89's Progress notes dated 2/8/26 at 8:18 p.m., indicated, .CNA [certified nursing assistant] 7, who was present at the time along with CNA 6. Per CNA 6's report, Resident 89 extended his hand outward in front of him as Resident 61 was walking down the hallway toward Resident 89. Resident 61 allegedly made contact with and hit Resident 89's right hand.During a review of Resident 61's AR, indicated, Resident 61 was admitted [DATE] with diagnosis including Cerebral Infarction (a type of stroke where a part of the brain dies due to lack of oxygen caused by a blocked vessel) and Vascular Dementia (a decline in thinking skills caused by restricted blood flow to the brain often following a stroke) with other Behavioral Disturbance.During a review of Resident 61's MDS dated [DATE] indicated, Resident 61 has severe memory problems.During a review of Resident 35's AR, indicated, Resident 35 was initially admitted [DATE] with diagnosis including Central Cord Syndrome (a type of incomplete spinal cord injury, usually in the neck, characterized by disproportionate weakness in the arms compared to the legs.) at C4 level of Cervical Spinal Cord.During a review of Resident 35's MDS dated [DATE] indicated Resident 35 has intact memory.During a review of a signed note by CNA 6 dated 2/8/26, indicated.Resident 61 was coming in the direction of Resident 89. Resident 89 stretched his hands and told Resident 61 to go back. Resident 61 got angry and started cursing and hit Resident 89.During an interview on 2/19/26 at 3:20 p.m. at Resident 89's room, Resident 89 stated he was at Resident 35's doorway talking with Resident 35 when Resident 61 walked straight at him and slapped his right hand. Resident 89 further stated, Resident 61 was angry and was saying he would kick his butt and hurt him.During an interview on 2/19/26 at 3:35 p.m. at Resident 35's room, Resident 35 stated he witnessed Resident 61's right hand raised up and slapped Resident 89's right hand. Resident 35 further stated, Resident 61 was angry and was yelling at Resident 89 saying, .I'm gonna hurt you.I'll kick your butt.During an interview on 2/19/26 at 4:20 p.m. with the Administrator (ADM), the ADM confirmed that residents in their facility have the right to be free from any form of abuse by any individual.During a review of the facility's policy and procedure (P&P) titled, Resident Right's, dated 12/5/25, indicated, .resident rights. be free from abuse, neglect, misappropriation, exploitation, corporal punishment, involuntary seclusion, and retaliation.'

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, the facility failed to ensure an alleged violation involving elopement was reported to the State agency within the required time frames. The facility failed to report the elopement of one out of 32 sampled resident (Resident 138) whose whereabouts were unknown on 11/19/25.This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure residents' safety.Findings:During a closed record review on 2/20/26, the admission Record (AR) indicated Resident 138 was admitted on [DATE] with diagnoses of Acute Pyelonephritis (a serious bacterial infection of the kidney, usually caused by a bladder infection that has spread upwards). Resident 138's clinical record indicated, a history of Diabetes Type 1 (DM 1- a chronic autoimmune condition where the body's immune system mistakenly attacks and destroys insulin-producing cells in the pancreas), Bacteremia (the presence of bacteria in the blood stream), Bipolar Disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels), and Post-Traumatic Stress Disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying events, causing long-lasting symptoms like nightmares, flashbacks, severe anxiety, and avoidance of reminders).Closed review of on 2/20/26 for Resident 138's clinical record also indicated, Resident 138 was on intravenous (giving medicines or fluids through a needle or tube inserted into a vein) antibiotic daily to treat bacterial infection. An outside interfacility medical record review dated 11/19/25 indicated Resident 138 has history of marijuana use and intravenous methamphetamine (controlled drug that needs prescription, highly addictive) abuse.Record review of Resident 138's Progress Notes dated 11/19/25 at 10:58 p.m., indicated .Roughly around 7 p.m., CNA notified charge nurse that the resident was not in her room. per CNA patient was seen 30 minutes before elopement.There was no documented evidence the incident was reported to the State Agency within required timeframes.During a review of facility's incident reporting documentation revealed no submission of a report related to the 11/19/25 elopement.During an interview on 2/20/26 at 11:30 a.m., with Administrator (ADM), and Director of Nursing (DON), confirmed that facility did not report the resident's elopement to the State Agency.During a review of the facility's policy and procedure titled, Resident Rights, dated 12/25 indicated, .any allegation of violating, including privacy breaches, property loss, abuse/neglect.must be reported immediately, investigated per policy and regulatory timelines, and reported to California Department of Public Health (CDPH), law enforcement, and or the ombudsman as required.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two out of 32 sampled residents (Resident 38 and Resident 41) received assistance with their Activities of Daily Living (ADLs-normal daily functions required to meet basic needs) when Resident 41 and Resident 38 had long facial hair and long fingernails with blackish substance underneath.This failure had the potential to negatively affect their self-esteem, comfort, and personal hygiene.Findings:During a review of Resident 41's admission Record (AR), the AR indicated Resident 41 was re-admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease (damage to the heart caused by long term unmanaged high blood pressure), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and depression (persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities).During a review of Resident 41's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/3/25, the MDS indicated, Resident 41 did not have any memory or cognitive impairment. The MDS also indicated, Resident 41 required substantial/maximal assistance with shower/bathing and partial/moderate assistance with personal hygiene.During a review of Resident 38's AR, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses that included severe protein-calorie malnutrition (severe deficit in energy and protein intake leading to significant weight loss), rhabdomyolysis (rare muscle injury where the muscles break down), dementia (a progressive state of decline in mental abilities) and anxiety disorder (persistent, excessive, and uncontrollable worry or fear that interferes with daily life.)During a review of Resident 38's MDS, dated [DATE], the MDS indicated, Resident 38 had moderate impairment in memory and cognition. The MDS also indicated, Resident 38 was dependent on staff assistance for shower/bathing and personal hygiene.During a concurrent observation and interview on 2/17/26 at 9:44 a.m., with Resident 41, in Resident 41's room, Resident 41 had long, thick facial hair. Resident 41 stated staff did not offer to shave or trim his beard and that he needed his beard trimmed and his fingernails cut. Resident 41 showed his fingernails, which were observed to be long with black substance underneath.During an interview on 2/17/26 at 9:47 a.m., with Director of Staff Development (DSD), in Resident 41's room, the DSD stated that on shower days the certified nursing assistant (CNA) checked residents' nails and facial hair. The DSD stated the CNA could trim facial hair and perform nail care, which included cutting and cleaning the nails. The DSD further stated that if a resident was diabetic, the nurse would perform the nail care. At 9:51 a.m., the DSD observed and confirmed that Resident 41 had long facial hair and long fingernails and required trimming. Resident 41 stated he got food stuck in his facial hair and that was why he needed it trimmed. The DSD stated it was important to trim facial hair and nails for infection control and hygiene purposes and that residents could injure themselves if their fingernails were long.During a concurrent observation and interview on 2/17/26 at 10:16 a.m., with Resident 38, Resident 38 was observed with long facial hair and long fingernails with black substance underneath. Resident 38 stated he would appreciate having his facial hair and nails cut and did not recall being offered assistance with trimming.During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 4/25, the P&P indicated, .appropriate care and services are provided for residents who are unable to carry out ADLs independently with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming and oral 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review the facility failed to provide for two residents (Resident 138 and Resident 139) out of 32 sampled residents:Adequate supervision when Resident 138 eloped the facility without staff being aware of Resident 138's whereabouts; and,No smoking assessment completed for Resident 139.These failures placed residents at risk for serious injury, harm, or death related to elopement and fire hazards.Findings: 1.During a closed record review on 2/20/26, the admission Record (AR) indicated Resident 138 was admitted on [DATE] with diagnoses of Acute Pyelonephritis (a serious bacterial infection of the kidney, usually caused by a bladder infection that has spread upwards). Resident 138's medical record indicated, a history of Diabetes Type 1 (DM 1- a chronic autoimmune condition where the body's immune system mistakenly attacks and destroys insulin-producing cells in the pancreas), Bacteremia (the presence of bacteria in the blood stream), Bipolar Disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels), and Post-Traumatic Stress Disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying events, causing long-lasting symptoms like nightmares, flashbacks, severe anxiety, and avoidance of reminders). Resident 138's medical record also indicated, Resident 138 was on intravenous (giving medicines or fluids through a needle or tube inserted into a vein) antibiotic daily to treat bacterial infection. An outside interfacility medical record review dated 11/19/25 indicated Resident 138 has history of marijuana use and intravenous methamphetamine (controlled drug that needs prescription, highly addictive) abuse. A review of Resident 138's order summary report indicated she was receiving intravenous (IV) antibiotic, Ertapenem Sodium Injection Solution 1 Gram (IV antibiotic) use 50 ml intravenous one time a day.until 11/24/25. During a review of Resident 138's Progress Note (PN), dated 11/19/25, the PN indicated, .roughly around 7 p.m., Certified Nurse Assistant (CNA) notified the charge nurse that the resident was not in her room.CNA reported last seeing Resident 138 approximately 30 minutes prior to the elopement. The facility medical record did not contain the following: An individualized nursing assessment for Resident 138 addressing risk for unauthorized departure. Documentation that Resident 138's behavioral and medical history were evaluated in relation to supervision needs. Documentation of physician notification at the time of departure. Documentation verifying Resident 138 safety during the period of absence. Documentation of Interdisciplinary Team Notes related to Resident 138's elopement. Documentation of Resident 138's stated intent to leave against medical advice (AMA) nor a refusal to sign an AMA form. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 138 remained absent overnight without documented verification of her location or her safety. During an interview on 2/20/26 at 11:30 a.m., the Administrator and Director of Nursing (DON) confirmed that the facility was unaware of Resident 138's whereabouts when she eloped on the night of 11/19/2025. No documented evidence that Resident 138 came back the following day. No documented evidence that Resident 138 was found at all. During a review of the facility's policy and procedure titled, Elopement Prevention and Response Policy, undated, indicated, .facility identifies residents at risk for elopement and follows a structured response when a resident leaves the facility without authorization, or required supervision. Actions are based on assessed risk, resident capacity, and regulatory requirements . 2. Review of Resident 139's admission Record, indicated that Resident 139 was admitted [DATE] with diagnoses including arthritis due to other bacteremia (joint inflammation caused by infection), emphysema (chronic lung disease in which air sacs become damaged), asthma (chronic lung disease that causes airway lining to become inflamed) and tobacco use. Review of Resident 139's records on 2/17/26, indicated no smoking assessment was completed and no care plan in place related to smoking. During an observation on 2/17/26 at 1:30 p.m., Resident 139 was in the designated smoking area with other residents and was in possession of cigarettes in her purse. During an interview on 2/19/26 at 8:45 a.m., with Licensed Nurse (LN) 1, LN 1 stated that upon admission, each resident undergoes a smoking assessment, and a staff member provides education on the associated risks and safety precautions. During an interview on 2/19/26 at 9:10 a.m., with Activities Director (AD), AD stated she is responsible for the smoking assessments and was not sure if Resident 139 was a smoker. AD confirmed that a smoking assessment was not done for Resident 139. During an interview on 2/19/26 at 1:40 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that he provided care for Resident 139 for two shifts and stated that Resident 139 smoked outside about two times per shift. During an interview on 2/19/26 at 2:19 p.m., with the Director of Nursing (DON), DON stated her expectation would be that every resident who smokes have a smoking assessment done on admission. The DON further stated if the smoking assessment was not done it could place the residents at risk for safety concerns. Review of the facility policy and procedure (P&P), titled, Resident Smoking Policy, undated, the P&P indicated, The interdisciplinary team.will help to support the resident's right to make an informed decision regarding smoking by: a) including the resident. in discussions regarding the risks associated with smoking, d) developing a safe smoking plan .and 15 b)assessment of relevant functioning and cognitive factors affecting ability to smoke safely.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe storage of medication for one (Resident 139) out of 32 sampled residents.This failure resulted in the facility's inability to monitor Resident 139's medication administration, placing Resident 139 at risk for improper dosing and non-therapeutic medication levels.Findings:Review of Resident 139's admission Records, indicated that Resident 139 was admitted on [DATE] with diagnoses including anxiety disorder (a condition characterized by persistent worry and interferes with daily life), panic disorder (a condition that is characterized by unexpected panic attacks) and depression (a condition that causes persistent sadness that affects how a person feels, thinks and functions in daily life).Review of Resident 139's clinical record indicated no Interdisciplinary Team (IDT-a group of healthcare professionals who collaborate assess and plan a resident's care) notes, no order and no care plan indicating Resident 139 was able to self-administer medications safely.During a concurrent observation and interview on 2/17/26 at 2:36 a.m., in Resident 139's room with Licensed Nurse (LN) 2, Resident 139 was found to have a container of Trazadone (a medication used to treat depression) 100 mg (milligram, unit of measure) tablets with directions give 1-2 tablets at bedtime for depression. LN 2 confirmed this finding and stated that storing medications with a resident's personal belongings was not consistent with the facility policy.During an interview on 2/19/26 at 8:38 a.m., with LN 1, LN 1 stated if a resident were to have medications in their possession, it would require a physician's order, care plan and awareness by the IDT. LN 1 further stated that the resident's cognitive status would be assessed to determine if this was appropriate.During an interview on 2/19/26 at 2:16 p.m., with the Director of Nursing (DON), the DON stated that the facility does not allow residents to keep medication in their possession unless there was a physician's order and the IDT did assessement and approved. The DON stated the potential negative outcomes could be a resident not receiving the correct dose, overdose and inability of nursing staff to monitor medication administration.Review of the facility policy and procedure (P&P), titled, Medication Ordering and Receiving from Pharmacy, dated August 2014, indicated, Medications brought into the facility by a resident or family member are used only upon written order by the resident's attending physician, after contents are verified.and if the packaging meets facility's guidelines.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident's food preference was honored for one of 32 sampled residents (Resident 5) when Resident 5's request for a diet upgrade was not followed.This failure had the potential to negatively impact the residents' food intake and well-being.Findings:During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was re-admitted on [DATE] with diagnoses that included injury of cervical spinal cord (uppermost part of the spinal cord), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and adjustment disorder with depressed mood (persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities).During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/5/25, the MDS indicated, Resident 5 did not have any memory or cognitive impairment. The MDS also indicated Resident 5 did not have any swallowing disorder.During an interview on 2/17/26 at 9:15 a.m., with Resident 5, Resident 5 stated he had been cleared a couple of weeks prior for an upgrade to the next texture level above puree. Resident 5 stated he received one meal tray with the upgraded texture but had continued to receive pureed meals. Resident 5 stated he wanted his diet upgraded.During a review of Resident 5's Progress Note (PN), dated 11/2/25, indicated, Resident 5 had a swallow evaluation completed by the speech language pathologist (ST-speech therapist; treats speech and swallowing disorders) and was cleared for a regular diet with thin liquids but requested to remain on pureed diet at that time. The PN indicated Resident 5 could request a diet upgrade without a speech therapy order.During an interview on 2/19/26 at 10:51 a.m., with Registered Dietician (RD), the RD stated Resident 5 had been on a pureed diet until she changed the diet texture on 2/17/26. RD stated that resident preferences should be honored.During a concurrent interview and record review on 2/19/26 at 11:00 a.m., with Certified Dietary Manager (CDM), Resident 5's Diet Order Change History (DOCH), dated 2/19/26 was reviewed. The DOCH indicated Resident 5's diet was changed from pureed to regular texture in the dietary department's nutritional system on 2/18/26. The CDM confirmed diet order was changed on 2/18/26 and stated the one upgraded meal tray Resident 5 received was a trial tray.During an interview on 2/19/26 at 4:12 p.m., with Director of Nursing (DON), the DON stated there was documentation in the progress note indicating a diet change for Resident 5; however, the diet order was not carried out. The DON confirmed the diet change should have been carried out when the resident requested the upgrade.During a concurrent interview and record review on 2/20/26 at 10:16 a.m., with Speech Therapist (ST), Resident 5's PN, dated 1/28/26 was reviewed. The PN indicated speech therapy received an order to evaluate Resident 5 for a diet upgrade to soft texture, an evaluation was completed on 11/1/25 with a recommendation for a regular diet, documented that Resident 5 affirmed request to trial of soft and bite-sized diet with thin liquids, noted the electronic health record (EHR) order would be updated and dietary notified, PN also indicated the provider was free to adjust (upgrade or downgrade) the diet based on Resident 5's preference. The ST stated the diet upgrade should have been ordered once Resident 5 requested it, as he had been cleared to upgrade or downgrade based on his preference.During a review of the facility's policy and procedure (P&P) titled, Resident Food Preference, revised 07/17, the P&P indicated, .modifications to diet will only be ordered with the resident's or representative's consent.During a review of the facility's P&P titled, Resident Rights, dated 12/5/25, the P&P indicated, .it is the responsibility of all staff to honor resident rights.Resident rights. j. Resident Choice: make decisions about personal routines, participation in activities and aspects of daily living.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure necessary treatment and care services was provided for one (Resident 118) of 32 sampled residents in accordance with professional standards of practice when rehabilitation referral for restorative nursing (RNA) was not started right away for Resident 118.This failure had the potential to place Resident 118 at risk for decline in functional ability, including decreased mobility and muscle strength.Findings:During a review of Resident 118's admission Record (AR), the AR indicated Reisdent 118 was re-admitted on [DATE] with diagnoses that included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), paraplegia (loss of movement and/or sensation, to some degree, of the legs) and muscle wasting/atrophy (weakening, shrinking, and loss of muscle).During a review of Resident 118's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/22/25, the MDS indicated, Resident 118 did not have any memory or cognitive impairment. The MDS also indicated Resident 118 did not receive any restorative programs the last 7 days.During an interview on 2/17/26 at 10:01 a.m. with Resident 118, Resident 118 stated he had a concern with his therapy services and felt therapy was initiated late, just last month. Resident 118 further stated he has MS and expressed concern regarding potential decline in strength and mobility in his upper extremities.During an interview on 2/19/26 at 11:23 a.m. with Director of Rehabilitation (DOR), DOR stated Resident 118 was discharged from physical therapy (PT) on 12/18/25 and discharged from occupational therapy (OT) on 12/17/25.During a review of Resident 118's RNA Program Referral, dated 12/17/25, the RNA referral indicated a referral for a therapeutic exercise/range of motion (ROM) program, including upper and lower extremity passive range of motion (PROM) exercises three times a week per week as tolerated. The RNA referral also indicated the exercises were reviewed with the rna and licensed nurse overseeing the program, with an effective date of 12/19/25.During an interview on 2/19/26 at 3:14 p.m. with Director of Staff Development (DSD), DSD stated Resident 118 was started on RNA in January 2026.During an interview on 2/19/26 at 3:37 p.m. with DOR, DOR stated once RNA training was completed and the referral was entered, it was provided to the staff member overseeing the restorative program. The DOR stated the RNA typically began the program right away, which might not be the same day as the referral, but that an almost two-week delay was too long.During an interview on 2/19/26 at 3:39 p.m. with DSD, DSD stated expectation was for the RNA program to begin right away. The DSD stated a delay in starting the program could result in a delay of care, which could lead to a decline in the resident's functional ability.During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, revised 07/17, the P&P indicated, .residents may be started on a restorative nursing program upon admission, during the course of the stay or when discharged from rehabilitative services.

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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 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 resident's (Resident 105) out of 32 sampled residents, call light was accessible to call for staff assistance, when call light was out of reach. This failure had the potential to result in Resident 105's inability to notify staff if there was an emergency. Findings:A review of Resident 105's admission Record indicated he was admitted to the facility in March 2025 with diagnoses which included subarachnoid hemorrhage (where bleeding occurs between the brain and surrounding tissues) and dysarthria (difficulty speaking).A review of Resident 105's Care Plan (CP, a comprehensive, individualized plan of care) indicated the following concerns and interventions:1. The resident is at risk for alteration in musculoskeletal status: . Be sure call light is within reach and respond promptly to all requests for assistance, dated 4/8/25. 2. At risk for skin breakdown: Keep call light within reach and encourage resident to call for assistance, dated 3/29/25. 3. Resident is at risk for falls and/or injuries: Keep the call light within reach and encourage resident to use it for assistance, as needed, dated 3/29/25. During a concurrent observation and interview on 2/17/26 at 1:32 p.m., with Resident 105 and Family Member (FM), in Resident 105's room, Resident 105's touch pad call light (a circular, flattened pad designed for residents with limited hand movement) was observed hung over a tube feed pump (medical device that delivers liquid formula) attached to a pole out of Resident 105's reach on his right side. Resident 105 was unable to visually locate the call light when prompted. FM stated, They [staff] need to put the call light in [Resident 105's] lap where he can see and reach it.During a concurrent observation and interview on 2/17/26 at 1:53 p.m., with Certified Nursing Assistant (CNA) 2, Resident 105's call light was observed out of Resident 105's visual field and reach. CNA 2 acknowledged Resident 105's call light was out of reach and should be placed within reach in case the resident needed to alert staff during an emergency or if the resident needed assistance.During an interview on 2/20/26 at 1:20 p.m., with the Director of Nursing (DON), the DON stated the call light should always be within reach so residents can call for help or notify staff when they need assistance.A review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, undated, the P&P indicated, All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Staff will ensure the call light is within reach of the resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations with the resident's room.