

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555442</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/01/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAPITAL POST ACUTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6821 24TH STREET</b> <b>SACRAMENTO, CA 95822</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of two (2) complaints #CA00958847 and #CA00959812.</p> <p>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.</p> <p>Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure Resident 1 was treated with respect and dignity for a census of 116.</p> <p>This failure had the potential for Resident 1 to not experience her highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated Resident was admitted to the facility in February 2025 with diagnoses which included spinal cord disease (conditions that affect the spinal cord, causing damage or deterioration)</p>	F 000	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance:</p> <p><b>F557: Respect and Dignity</b></p> <p><b>1. Immediate Corrective Action for the Identified Deficient Practice:</b> The resident(s) involved in the identified incident were immediately assessed to ensure their physical and emotional well-being. Staff members involved were counseled and re-educated on residents' rights related to respect and dignity.</p> <p><b>2. Measures to Identify Other Residents Potentially Affected:</b> No other residents were affected by this deficient practice.</p> <p><b>3. Systemic Changes to Prevent Recurrence:</b></p> <ul style="list-style-type: none"> <li>• All staff will receive in-service training on Residents' Rights, with a focus on respect, dignity, communication, and sensitivity.</li> <li>• Ongoing education will be added to the facility's annual training schedule and orientation for all new hires.</li> <li>• Social Services and Department Heads will incorporate random resident interviews into weekly rounds to monitor staff-resident interactions and ensure dignity is preserved.</li> </ul>	F 557
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Eric Lawrence</i>	TITLE  Administrator	(X6) DATE  May 18, 2025
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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.

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F 557	<p>Continued From page 1 and post-traumatic stress disorder (PTSD, an anxiety disorder caused by very stressful, frightening or distressing events).</p> <p>A review of Resident 1 ' s Brief Interview for Mental Status (BIMS, an assessment tool), dated 3/4/25, indicated Resident 1 was cognitively intact.</p> <p>A review of Resident 1 ' s Care Plan (CP, a document that outlines a person's specific care needs, medical history, and the interventions that will be used to address those needs), dated 3/5/25 indicated Resident 1 was dependent on facility staff for meeting her emotional, intellectual, physical and social needs.</p> <p>During an interview on 5/1/25 at 11:49 a.m. with Resident 1, in the resident ' s room, Resident 1 stated she had difficulty hearing, so the interview was conducted using a whiteboard. Resident 1 reported that she had been waiting to be cleaned and changed after having a bowel movement when Certified Nursing Assistant (CNA) 1 entered her room, walked past her bed to Resident 2 ' s side of the room, then turned around and started to walk out of the room. Resident 1 asked, "Are you my CNA for tonight?" CNA 1 ignored</p> <p>Resident 1 ' s question and continued to walk out of the room. CNA 1 then re-entered Resident 1 ' s room, stood at the foot of her bed and started to "yell" and "wave her arms up and around her head." Resident 1 stated, "I asked her [CNA 1] to write it down on the white board, I couldn ' t hear what she was saying ...I was embarrassed and afraid, I can ' t hear well, and she [CNA 1] was</p>	F 557	<p><b>4. Monitoring to Ensure Sustained Compliance</b></p> <ul style="list-style-type: none"> <li>• The Administrator or designee will conduct monthly audits of resident interactions on all shifts for the next 6 months using a standardized Respect &amp; Dignity Observation Tool.</li> <li>• Any issues identified will be brought to the Quality Assurance and Performance Improvement (QAPI) committee for review and action planning.</li> <li>• Results of the audits and interviews will be tracked, trended, and reviewed at quarterly QAPI meetings.</li> </ul> <p><b>5. Completion Date:</b> May 18, 2025</p>		

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F 557	<p>Continued From page 2</p> <p>moving her arms above her head rapidly ...I was scared, I didn ' t know what she would do." Resident 1 stated another staff member came in and took CNA 1 out of the room.</p> <p>During an interview on 5/1/25 at 12:13 p.m. with Resident 2, in the resident ' s room, Resident 2 stated CNA 1 stood at the foot of Resident 1 ' s bed and was "yelling" and "waving her arms over her head" at Resident 1. Resident 2 stated, "She [CNA 1] pushed herself inside our room and another staff member had to come into the room and physically remove her."</p> <p>During an interview on 5/1/25 at 3:49 p.m. with Family Member (FM), the FM stated that FM witnessed CNA 1 yelled at Resident 1, "I told you I ' d come back ... I have other patients to attend to ..." on 4/29/25 during the evening shift. FM stated, "There ' s a white board with a pen on her bedside table, I don ' t know why staff don ' t use it ...[Resident 1] can be hard of hearing, this is a new condition, she doesn ' t read lips effectively and it doesn ' t help when the staff continue to yell through their masks ...when there ' s a white board right there...what happens when we aren ' t here to advocate for [Resident 1]."</p> <p>During an interview on 5/1/25 at 4:36 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 would verbally tell you when she needed to be cleaned or changed and would ask questions about her care. LN 1 stated, "[Resident 1] requested assistance from [CNA 1] but I couldn ' t find [CNA 1] at first ...a few minutes passed, and I saw [CNA 1] go into another resident ' s room ...I told her [Resident 1] was asking for her and [CNA 1] became defensive, complaining about having</p>	F 557			

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F 557	Continued From page 3 to assist [Resident 1] ...At that point, I told the supervisor on the floor ...Yes, CNA 1 was yelling at [Resident 1]."  During an interview on 5/1/25 at 5:16 p.m. with the Director of Nursing (DON), the DON acknowledged she was aware of the incident with CNA 1 on 4/29/25. The DON stated the facility did not follow up on Resident 1's psychosocial or emotional needs.The facility ' s policy and procedure (P&P) related to resident Communication and Respect and Dignity was requested but was not provided.	F 557			