STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Grove Post Acute	9461 Batey Avenue Elk Grove, CA 95624

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to protect one of five sampled residents (Resident 1) from abuse when Resident 2 pushed Resident 1 during an altercation.This failure resulted in Resident 1 falling into the ground and had the potential for Resident 1 to experience fear or distress. Findings:During a review of Resident 1's admission records, the records indicated Resident 1 was admitted to the facility in October 2025 with diagnoses that included left femur shaft fracture (a break in the thighbone), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body), and malignant neoplasm of occipital lobe (a cancerous tumor in the part of the brain that controls vision). Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 1 had moderate cognitive impairment.During a review of Resident 2's admission records, the records indicated Resident 2 was admitted to the facility in March 2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), generalized muscle weakness, and difficulty in walking. Resident 2's MDS indicated Resident 2 had moderate cognitive impairment.During a review of Resident 1's Change in Condition (CIC) notes, dated 11/5/25, the notes indicated, .1100 [11 a.m.] [Resident 1] was found sitting on the floor in [Resident 1's] room next to [Resident 2's] closet. [Resident 1] reports that roommate [Resident 2] pushed [Resident 1] from his chest.Nurse tried to help [Resident 1] up but resident got up and sat on his wheelchair. Resident was then assisted out of his room to the hallway.During a review of Resident 1's Nurses Progress Note, dated 11/5/25, the note indicated, .1100 [11 a.m.] Nurse observed [Resident 1] on a sitting position on the floor. Resident explains that [Resident 2] pushed him on my chest. [Resident 1] was pushed by [Resident 2] and end up on the floor after [Resident 2] tried to stop [Resident 1] from rummaging around [Resident 2's] closet.During a review of Resident 1's Nurses Progress Note, dated 11/5/25, the note indicated, .1100 [11 a.m.] - Elevated voices heard in SE [Southeast] hallway, upon entering observed [Resident 1] and [Resident 2] using profanity towards each other with elevated voices.Upon investigation, [Resident 1] stated [Resident 2] physically pushed [Resident 1] and made [Resident 1] fall. [Resident 2] verbally stated the [Resident 2] physically pushed [Resident 1] after [Resident 2] witnessed [Resident 1] going through his personal belongings and personal side of the closet.During a review of Resident 1's Interdisciplinary Team (IDT) note, dated 11/5/25, the note indicated, .Resident to resident Physical altercation: 11/5/25 at around 11AM [Resident 1] was about to hit [Resident 2] with his cane but was intervened by staff. [Resident 1] said that [Resident 2] push him on the chest area in the room and he fell backwards.ROOT CAUSE: [Resident 1] was going through closet of [Resident 2]. [Resident 2] told [Resident 1] to stop but not listening, so [Resident 2] pushed him from his chest, and he fell on the floor.During a review of Resident 2's CIC Note, dated 11/5/25, the note indicated, .[Resident 2] said he pushed [Resident 1] and he fell backward on the floor. [Resident 2] said that he told [Resident 1] to stop going through his closet. [Resident 1] continued to do so. I pushed him, [Resident 1] won't listen. per [Resident 2].[Resident 2] said that someone got me out from my room to the hallway but [Resident 1] saw [Resident 2] and tried to hit [Resident 2] with [Resident 1's] cane but was intervene [sic] by staff.During a review of Resident 2's IDT note, dated 11/6/25, the note indicated, .On 11/5/25 at around 11AM, staff saw [Resident 1] about to hit [Resident 2] with [Resident 1's] cane but was intervened by staff. [Resident 2] said he pushed [Resident 1] in the room because [Resident 2] tried to stop [Resident 1] from going to [Resident 2's] closet and [Resident 1] won't listen and now [Resident 1] was trying to hit [Resident 2]. During an interview on 11/13/25 at 11:51 a.m. with Resident 2, Resident 2 stated he told Resident 1 to stay out of Resident 2's closet but Resident 1 did not listen. Resident 2 stated, [Resident 1] lifted [Resident 1's] cane up and I grabbed [Resident 1] and threw [Resident 1] on the floor. Resident 2 further stated Resident 1 was screaming to get out of the way, was swinging the cane up, and tried to hit Resident 2 with the cane. During an interview on 11/13/25 at 1:47 p.m. with the Social Services Assistant (SSA), the SSA stated Resident 1 had behaviors of being rude, volatile, and cussing towards residents and staff. The SSA stated Resident 1 did not need the cane and that Resident 1 said the cane was for Resident 1's protection.During an interview on 11/13/25 at 2:08 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 2 admitted pushing Resident 1 because Resident 1 was not listening, which led to Resident 1's fall. The ADON stated Resident 1 got up so fast and wanted to follow Resident 2 in the hallway while still holding the cane. The ADON stated, I saw [Resident 1] with the cane and about to hit [Resident 2]. The ADON further stated it was witnessed that when both residents were in the hallway, Resident 2 was on his back and

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure professional standards of practice were followed for one of 5 sampled residents (Resident 3) when Resident 3's medication was not administered as ordered and was left at bedside.This failure had the potential to result in contamination of the medication and for Resident 3 not having the desired effects of the medication.Findings:During a review of Resident 3's admission records, the records indicated Resident 3 was admitted to the facility in November 2025 with diagnoses that included complete lesion of thoracic spinal cord (a severe injury where there is a total loss of all feeling and all ability to control movement resulting in paralysis), paraplegia (loss of movement and/or sensation, to some degree, of the legs), depression (persistent feelings of sadness and loss of interest that interfere with daily life) , and retention of urine (the inability to completely empty the bladder). Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 3 had intact cognition.During a review of Resident 3's Order Summary Report, dated 11/7/25, the report indicated a physician order for Bethanechol (medication used to relieve difficulties in urinating) 25 mg (milligrams, a unit of measurement), two tablets by mouth three times a day for retention of urine.During a review of Resident 3's Medication Administration Record (MAR) for November 2025, the MAR indicated Resident 3's Bethanechol was signed and administered on 11/13/25 at 9 a.m.During a review of Resident 3's Medication Self-Administration Evaluation, dated 11/7/25, the evaluation indicated, 22. Approval granted to self-administer? .no.does not meet criteria.During a concurrent observation and interview on 11/13/25 at 10:48 a.m. with Resident 3 in his room, Resident 3 was observed awake and alert, lying in bed, verbally responsive to questions. Two unlabeled medication cups were observed on Resident 3's bedside table, one medication cup contained yellow powder, and the other medication cup contained yellow medication crushed into smaller pieces combined with yellow powder. Resident 3 stated the nurse left the medication around 9 a. m. and Resident 3 stated he did not know what the medication was for.During a concurrent observation and interview on 11/13/25 at 10:55 a.m. with the Director of Nursing (DON), the DON confirmed two unlabeled medication cups containing powdered and crushed yellow medications were at Resident 3's bedside table. The DON stated no resident in the facility met the criteria to self-administer medication and that medications should not be left at bedside.During an interview on 11/13/25 at 10:58 a.m. with Licensed Nurse 1, LN 1 stated Resident 3's morning medications were given at 9 a.m. When the two medication cups containing crushed medications were shown by the DON, LN 1 stated the medication was Resident 3's Bethanechol and showed the bubble pack (a plastic packaging for medications) containing tablets similar to the powder's color. LN 1 confirmed the medication was crushed and there was no physician order to crush the medication. LN 1 further confirmed that the contents of the medication cups indicated Resident 3 did not receive the full dose of Bethanechol.During an interview on 11/13/25 at 2:28 p.m. with the DON, the DON confirmed LN 1 crushed Resident 3's Bethanechol and Resident 3 did not receive the full dose of Bethanechol. The DON stated the expectation was for staff to make sure residents receive the medication and not leave the medication at bedside and administer the whole dose of the medication.During a review of the facility's policy and procedure (P&P) titled, IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated 10/2017, the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.15) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.