

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Elk Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 3) was free from abuse when Resident 2 threw a water pitcher towards Resident 3. This failure had the potential to result in physical injury and psychosocial distress to Resident 3. Findings: A review of Resident 3's record indicated resident 3 was admitted in September of 2025 with a diagnosis of Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest in activities). A review of Resident 3's Minimum Data Set (MDS- an assessment tool) dated 9/26/25 indicated Resident 3 was cognitively intact. A review of Resident 2's record indicated Resident 2 was admitted in September of 2025 with a diagnosis of Paraplegia (a condition that affects the spinal cord affecting use of half the body or lower legs). A review of Resident 2's MDS dated [DATE] indicated Resident 2 was cognitively intact. A review of Resident 2's progress noted dated 2/21/25 indicated Resident 2 grabbed an empty plastic water cup and threw it at Resident 3. During an interview on 9/24/25 at 1:44 p.m. with Resident 3, Resident 3 stated he told his roommate (Resident 2) to quiet down. Resident 3 stated the mother to Resident 2 approached him and started threatening him saying he was going to die anyway. Resident 3 further stated Resident 2 threw water pitcher toward Resident 3 leading to water splashing onto Resident 3. Resident 3 further stated Resident 2 and the family member stated they were going to have other people come into the facility to hurt Resident 3. During a telephone interview on 9/24/25 at 2:02 p.m. with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated he was the CNA assigned to Resident 3 and Resident 2 on the date of the altercation. CNA 1 further stated (Resident 2) was being loud and arguing with (Resident 3). CNA 1 stated he witnessed Resident 2 throw a plastic water pitcher at Resident 3's bed, I saw water hit [Resident 3] but not the pitcher. CNA 1 further stated Resident 2 tried to grab a handle off his chair and was going towards Resident 3's bed and that he had to grab it from Resident 2. During an interview on 9/24/25 at 3:55 p.m. with Director of Nursing (DON), the DON stated resident to resident abuse is not tolerated at the facility. During a review of facility Policy and Procedure (P&P) dated 2/23/21, the P&P indicated, . Abuse is defined as willful infliction of injury . Verbal Abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients and their families or within hearing distance.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, and record review, the facility failed to provide a written bed hold notice upon transfer to the hospital to Resident 4 or her family. This failure had the potential risk to deny Resident 4 re-admission to the facility. Findings: During a review of Resident 4's clinical record, the record indicated Resident 4 was admitted in August 2025 with a diagnosis of Diverticulitis (inflammation of the intestinal wall) of the large intestine. During a review of resident 4's MDS (Minimum Data Set- a assessment tool) dated 8/21/25 indicated Resident 4 was cognitively intact. During a review of Resident 4's clinical record, the progress notes dated 9/13/25 indicated, .resident admitted to hospital. During a review of Resident 4's clinical record, the progress noted dated 9/14/25 indicated, .received a call from resident daughter. she verbally understanding the situation and agrees with plan of care to send her to ER (emergency room) for evaluation. During an interview and concurrent record review on 9/24/25 at 3:55 p.m. with Director of Nursing (DON), the DON confirmed there was no documented evidence that a written bed hold notice upon transfer to the hospital was provided to the resident or family as required by the regulations. During a review of facility Policy and Procedure (P&P) titled Bed-Hold and Returns. dated October 2022, the P&P indicated, . Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff were unable to reach and notify the representative timely . The requirement that resident be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source.		

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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. Based on interview and record review the facility failed to ensure one of four sampled patients (Patient 1) with a known elopement risk had adequate supervision to ensure safety when Patient 1 could not be located by facility staff. This failure resulted in Patient 1 leaving the facility unaccompanied on 9/13/25 and 9/14/25. Findings: A review of Patient 1's clinical record indicated Patient 1 was admitted in September of 2025 with a diagnosis of Type 2 Diabetes Mellitus (a condition where the body is unable to regulate blood sugar levels). A review of Patient 1's Minimum Data Set (MDS- an assessment tool) dated 9/14/25 indicated Patient 1 was cognitively intact and the functional abilities section indicated Patient 1 was independent for wheelchair mobility up to 150 feet. During a review of Patient 1's care plan titled, The resident is non compliant., dated 9/13/25 indicated, .Frequent safety checks, Monitoring residents' whereabouts and any attempts to leave facility without staff knowledge. A review of Patient 1's progress note dated 9/13/25 indicated, . receptionist saw the resident [Patient 1] at 1340 [1:40 p.m.] outside in his W/C [wheelchair] sitting in the parking lot. the admission personnel came to tell me that the resident [Patient 1] said he was going to the grocery store and was heading down the street. went out to the parking lot to talk with the resident [Patient 1] that he doesn't have a LOA [leave of absence] order but he was already out of site . At 1437 [2:37 p.m.] . called [local law enforcement agency] . resident [Patient 1] told the [officer] he got lost . was brought back to the facility by [local law enforcement agency] . at 1545 [3:45 p.m.] . A review of Patient 1's progress note dated 9/14/25 indicated, . at 15:15 [3:15 p.m.] staff attempted to deliver the Glucerna [supplement for diabetes] . but the resident [Patient 1] was not located in room, bathroom, or activity room. A facility-wide search was initiated. extended search to surrounding streets. At 16:15 [4:15 p.m.] [law enforcement] was contacted. Officer. confirmed . the resident [Patient 1] had placed a 911 call at 16:07 [4:07 p.m.], reporting that he (Patient 1) was behind. facility. staff on the North Wing observed the resident [Patient 1] wheeling away from the facility. At 16:25 [4:25 p.m.] [law enforcement] . made contact with [Patient 1] . During an interview on 9/24/25 at 3:22 p.m. with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, . I was gatekeeping in the back hall and I saw Patient 1 take his shoes off and roll his wheelchair down the street . CNA 1 further stated she ran 1.5 miles away from the facility and Patient 1 was yelling. CNA 1 further stated,. [Patient 1] was yelling and wheeled himself far away. During an interview and concurrent record review on 9/24/25 at 2:52 p.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed facility staff were not able to locate Patient 1 on 9/13/25 and 9/14/25. During a concurrent interview and record review on 9/24/25 at 3:55 p.m. with Director of Nursing (DON), the DON confirmed that Patient 1 was a known elopement risk on admission. The DON further confirmed that Patient 1 left the facility on 9/13/25 without a Leave of absence (LOA) order and staff was unable to locate (Patient 1). The DON further confirmed (Patient 1) did elope the facility two times without informing staff during both elopement incidents. During a review of facility policy and procedure (P&P) titled, Elopements. dated 2/21/25, the P&P indicated, . The resident who exhibit. and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care. During a review of facility P&P titled, .Accidents and Incidents., dated 7/2017 the P&P indicated, .All accidents or incidents involving residents. occurring on our premises. will be reviewed by the Safety Committee for trends related to accident or safety hazards. and to analyze any individual resident vulnerabilities.		