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	03/11/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect resident right to be free from physical abuse for two of five sampled residents (Resident 1 and Resident 2) when Resident 2 struck Resident 1 and Resident 1 scratched Resident 2 during an altercation on 2/21/26.This failure resulted in physical injury to Resident 1 and Resident 2 and had the potential to result in psychosocial harm for both residents.Findings:Resident 1 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction with hemiplegia and hemiparesis (oxygen and nutrients to part of the brain is blocked causing brain tissue death resulting in physical paralysis and physical weakness) and difficulty walking.A review of Resident 1's Minimal Data Set (MDS) (a standardized assessment tool used in nursing homes), dated 12/11/25, indicated Resident 1 had Brief Interview for Mental Status (BIMS) (short test used to check a person's memory and thinking) of 15/15 indicating intact cognition.Resident 2 was admitted to the facility 1/21/23 with diagnoses of cerebral infarction with hemiplegia and hemiparesis, dementia (a disease process of the brain causing inability to think clearly), communication deficit, difficulty walking, and a history of falls.A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS of 10/15 indicating moderate cognitive impairment.During an observation on 3/11/26 at 11:00 AM in the hallway, Resident 2 was observed with a healed, thin scar to the right side of his/her forehead.A review of Resident 2's Change of Condition (COC) Evaluation dated 2/21/26 at 6:12 p.m., indicated, resident involved in physical altercation with roommate 40a. Superficial scratches to right forehead and right neck. Resident 2 stated I don't know why she scratched me, I just asked her to move and no recollection of striking Resident 1.During an interview with Resident 4 on 3/11/26 at 11:34 AM, Resident 4 stated, [Resident 2] hit [Resident 1] [in the doorway to their room]. [Resident 1] clawed back at [Resident 2] and scratched her in the face.During an interview with Resident 1 on 3/11/26 at 12:55 PM, Resident 1 stated, I was in my wheelchair in the doorway, [Resident 2] pushed my chair to get me out of the way. I told [Resident 2] to wait, but my [Resident 2] continued to push me into the hallway. I was resisting. [Resident 2] hit me in the right eye. I responded and reached back and swatted her away and she was scratched.During an interview with Certified Nursing Assistant 2 (CNA 2) on 3/11/26 at 12:04 PM, CNA 2 stated, I. saw Resident 2 hitting Resident 1. Resident 2 was bleeding from forehead and neck from scratches. Resident 1 was in her wheelchair.A review of the Facility Report investigated by the Director of Nursing (DON) and reported by the Administrator (ADM) dated 2/26/26 indicated, Resident 2 tried forcing her way out [of the room] when resident 1 responded by scratching resident 2 on the face.A review of Resident 2's Care plan updated 2/21/26 indicated, Root Cause: Both residents in the same bedroom, OOB in wheelchair, when resident got impatient, unable to wait and wanted to pass the other resident, she pushed [his/her] way to get pass, that prompted the other resident to scratch her in the face.A review of Resident 1's COC Evaluation dated 2/21/26 at 5:35 PM indicated, Resident was involved in physical altercation with [Resident 2] . An initial assessment. revealed no injury to [Resident 1] but after 30-45mins has right eye-subconjunctival redness.During an interview with the ADM on 3/11/26 at 2:04 PM, ADM stated awareness of the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-to-resident abuse that occurred on 2/21/26. ADM stated there was an altercation between Resident 1 and Resident 2. Resident 1 was struck and Resident 2 was scratched in the altercation.During an interview with the DON on 3/11/26 at 2:12 PM in the Infection Control nurse's office, DON stated there were no previous incidents of Resident to Resident abuse between both residents. Resident 1 was hit in the eye, the right one I think, and had redness on the side of the eye. Resident 2 was scratched on the right side of the face. Injuries did not affect their ADLs and have resolved. Resident 2 was re roomed. Both residents showed no psychosocial changes.A review of the facility's policy and procedure (P&P) titled Abuse Prohibition Policy and Procedure, revised 2/21, the P&P indicated, Health Centers prohibit abuse, The center will implement an abuse prohibition program through. prevention of occurrences., Physical abuse includes hitting., etc.These findings represent past noncompliance with this regulatory requirement. Observations, interviews, and records' reviewed confirmed Resident 1 and Resident 2's involvement in resident-to-resident physical abuse. Interviews and record review confirmed facility staff promptly intervened, and the residents were immediately separated, resident 2 was re-roomed in a different hall, and facility management was notified. Record review confirmed physical and psychosocial assessment and monitoring was performed and a thorough facility led investigation and root cause analysis were conducted, the residents' care plans were updated with corresponding interventions initiated, local law enforcement was notified and a law enforcement investigation was conducted, an SOC 341 was faxed to the Ombudsman and the California Department of Public Health, the residents' physicians and responsible parties were notified, and in service abuse training was conducted. Interviews confirmed the facility continues to conduct and investigate performance improvement. There was sufficient evidence that the facility corrected the violation as of 2/27/26 and no other occurrences of noncompliance were identified. At the time of the survey, the facility was in substantial compliance of this regulatory requirement therefore, the violation does not require a plan of correction.