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	05/14/2026

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. Based on interview and record review, the facility failed to ensure one of 30 sampled residents (Resident 37) was free from abuse, when Resident 117 hit Resident 37. This failure had the potential to negatively impact Resident 37's highest practicable physical, mental, and psychosocial well-being.Findings: A review of an admission record indicated Resident 37 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (a decline in mental ability such as memory, reasoning, and problem solving that interferes with daily life), anxiety disorder (a mental health condition characterized by excessive persistent, and uncontrollable fear or worry), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and loss of interest in activities). A review of an admission record indicated Resident 117 was admitted to the facility with a diagnosis of dementia. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 5/12/26, indicated Resident 117 got into a physical altercation with Resident 37 on 5/12/26 at 8 p.m. During an interview on 5/13/26 at 2:36 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she observed on 5/12/26 at approximately 8 p.m. Resident 117 sitting in her wheelchair and blocking the entrance into Resident 37's room. CNA 1 attempted to redirect Resident 117 to move out of the doorway of Resident 37's room, but she did not. Then, Resident 37 woke up in her bed and told Resident 117 to put a shirt on as she was only covered with a towel at that time. CNA 1 further stated Resident 117 stood up from her wheelchair, walked to the edge of Resident 37's bed and hit Resident 37 twice on her lower right leg with a closed left fist. During an interview on 5/13/26 at 1:11 p.m. with Licensed Nurse (LN) 2, LN 2 stated CNA 1 reported to her that Resident 117 hit Resident 37. LN 2 further stated Resident 117 got out her wheelchair and went towards the end of the bed where Resident 37 was lying down and hit Resident 37 twice on her lower right leg with her left closed fist. During an interview on 5/13/26 at 12:54 p.m. with LN 1, LN 1 stated she received a report of physical altercation between Resident 37 and Resident 117 when Resident 117 hit Resident 37 at night. During an interview on 5/14/26 at 2:08 p.m. with Director of Nursing (DON), DON confirmed Resident 37 was hit twice by Resident 117 while lying in her bed and stated all residents should be free from any type of abuse. A review of the facility's policy and procedure titled, Abuse Prohibition Policy and Procedure, revised 2/21, indicated, Health care centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents . Physical Abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .

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