| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055417 | A. Building<br>B. Wing | 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Saylor Lane Healthcare Center | 3500 Folsom Boulevard<br>Sacramento, CA 95816 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect one of four sampled residents (Resident 4) from physical abuse when Resident 1 hit Resident 4 with a walker on his left knee in the rehabilitation room.<br><br>This failure had the potential to cause serious injury, fear and distress to Resident 4 and other facility residents that were present in the rehabilitation room during the incident.<br><br>Findings:<br><br>A review of Resident 1 ' s admission record indicated Resident 1 was admitted to the facility in early 2025 with multiple diagnoses including Huntington ' s Disease (a progressive brain disorder that worsens over time causing gradual decline in movement, thinking, and mood). A review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/24/25, reflected a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 out of 15 indicating Resident 1 had intact cognition.<br><br>A review of Resident 4 ' s admission record indicated Resident 4 was admitted to the facility in early 2025 with multiple diagnoses which included chronic kidney disease. A review of Resident 4 ' s MDS, dated [DATE], reflected a BIMS score of 13 out of 15 which indicated Resident 4 was cognitively intact.<br><br>During a review of Resident 1 ' s physician orders dated 4/10/25, indicated, Olanzapine Oral tablet 2.5 MG [MG-Milligram – a unit of measurement] (Olanzapine) Give 1 tablet by mouth two times a day for Huntington ' s Disease physical abuse (throwing stuff to others). ICO [informed consent obtained] by MD from patient, verified by LN [Licensed Nurse] 4/10/2025 .<br><br>During a review of the Medication Administration Record (MAR) for Resident 1, dated 4/10/25, Resident 1 had an order directing staff to, Target behavior for [NAME]-psychotic monitor episodes of Huntington ' s Disease M/B [sic manifested by] physical abuse (throwing stuff to others) & Doc [document] # Times each occurs per shift. Record non-pharmacological intervention if behavior is noted .DC [discontinue] date 04/11/2024 .<br><br>A review of progress notes dated 4/10/2025 indicated Resident 1 claimed the Asian man [Resident 4] grunted towards him, making him feel inferior to [Resident 4] . [Resident1] states that the grunt and feelings of inferiority and dislike triggered him to throw his walker towards [Resident 4] .<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| Saylor Lane Healthcare Center | 3500 Folsom Boulevard<br>Sacramento, CA 95816 |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During a telephone interview on 4/15/25 at 11:34 a.m. with Director of Rehab (DOR), the DOR stated Resident 1 came back from a walk with staff and returned to the rehab room. While in the rehab room and out of nowhere, Resident 1 threw their walker at Resident 4. DOR stated the situation was unprovoked. DOR confirmed what he observed was a resident-to-resident abuse.<br><br>During an interview on 4/15/25 at 1:15 p.m. with Physical Therapy Assistant (PTA) in the rehabilitation room, the PTA stated she witnessed the incident together with the DOR. PTA stated she saw [Resident 4] get hit by the walker, saw it hit [Resident 4 ' s] left knee, we checked it. PTA further stated after the walker was thrown by Resident 1, Resident 1 got up again and attempted to attack Resident 4 and tried to hit him again and was screaming at him. PTA stated the DOR and PTA held him back, he wasn ' t responding to questions and was focused on that situation. PTA further stated they managed to get him [Resident 1] in the wheelchair and to leave the rehab room. PTA confirmed other residents were present in the rehabilitation room during the incident.<br><br>During an interview on 4/15/25 at 11:43 a.m. with LN 1 assigned to Resident 1 and Resident 4 in the hallway, the LN 1 stated Resident 1 reported Resident 4 grunted at him in rehab room which is why he tried to throw a walker towards Resident 4 and tried to harm Resident 4. LN 1 further stated Resident 1 ' s family member had told LN 1 he had a history of throwing things at others due to diagnoses of Huntington ' s disease.<br><br>During a follow up interview on 4/15/25 at 12:56 p.m. with LN 1 assigned to Resident 1 and Resident 4, LN 1 stated this was a resident-to-resident altercation that was unprovoked and the LN 1 added she had interviewed both residents. LN 1 further stated it should have been reported to the Department.<br><br>During an interview on 4/15/25 at 11:57 a.m. with Director of Nursing (DON) in the DON's office, the DON stated [Resident 1] stated [Resident 4] grunted at him and it provoked him. DON further stated it was not deemed resident to resident abuse by the facility because it was a behavioral outburst so the IDT [interdisciplinary- a group of professionals that collaborates patient care] team treated it as an outburst.<br><br>During a concurrent follow up interview and record review on 4/15/25 at 1:56 p.m. with DON, the Nurse ' s progress note dated 4/10/25 was reviewed. The DON stated this was a behavioral incident where Resident 1 tried to harm Resident 4.<br><br>A review of the facility ' s policy and procedure titled, Abuse Prevention Program, dated December 2016 indicated, .residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse to the Department for 2 of 4 sampled residents (Resident 1 and Resident 4), when Resident 1 was witnessed throwing a walker at Resident 4 hitting his left knee in the facility's rehabilitation room.<br><br>This failure decreased the facility ' s potential to protect vulnerable residents and provide a safe environment.<br><br>Findings:<br><br>A review of Resident 1 ' s admission record indicated Resident 1 was admitted to the facility in early 2025 with multiple diagnoses including Huntington ' s Disease (a progressive brain disorder that worsens over time causing gradual decline in movement, thinking, and mood).<br><br>A review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/24/25, reflected a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 out of 15 indicating Resident 1 had intact cognition.<br><br>A review of Resident 4 ' s admission record indicated Resident 4 was admitted to the facility in early 2025 with multiple diagnoses which included chronic kidney disease.<br><br>A review of Resident 4 ' s MDS, dated [DATE], reflected a BIMS score of 13 out of 15 which indicated Resident 4 was cognitively intact.<br><br>A review of progress notes dated 4/10/2025 indicated Resident 1 claimed the Asian man [Resident 4] grunted towards him, making him feel inferior to [Resident 4] . [Resident1] states that the grunt and feelings of inferiority and dislike triggered him to throw his walker towards [Resident 4] .<br><br>During a telephone interview on 4/15/25 at 11:34 a.m. with Director of Rehab (DOR), the DOR stated Resident 1 came back from a walk with staff and returned to the rehab room. While in the rehab room and out of nowhere, Resident 1 threw their walker at Resident 4. DOR stated the situation was unprovoked. DOR confirmed what he observed was a resident to resident abuse. DOR stated that he informed the facility ' s Administrator and DON (Director of Nursing) of the incident, and they had informed the DOR that it had been reported and they would handle the documentation further. DOR confirmed he is a mandated reporter.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During an interview on 4/15/25 at 1:15 p.m. with Physical Therapy Assistant (PTA) in the rehabilitation room, the PTA stated she witnessed the incident together with the DOR. PTA stated she saw [Resident 4] get hit by the walker, saw it hit [Resident 4 ' s] left knee, we checked it. PTA further stated after the walker was thrown by Resident 1, Resident 1 got up again and attempted to attack Resident 4 and tried to hit him again and was screaming at him. PTA stated the DOR and PTA held him back, he wasn ' t responding to questions and was focused on that situation. PTA further stated they managed to get him [Resident 1] in the wheelchair and to leave the rehab room. PTA further stated she understood there was a state telephone line that could have been called for reporting witnessed altercations and confirmed she was a mandated reporter.<br><br>During an interview on 4/15/25 at 11:43 a.m. with Licensed Nurse 1 (LN 1) assigned to Resident 1 and Resident 4 in the hallway, the LN 1 stated Resident 1 reported Resident 4 grunted at him in rehab room which is why he tried to throw a walker towards Resident 4 and tried to harm Resident 4. LN 1 further stated Resident 1 ' s family member had told LN he had a history of throwing things at others due to diagnoses of Huntington ' s disease.<br><br>During a follow up interview on 4/15/25 at 12:56 p.m. with LN 1 assigned to Resident 1 and Resident 4, LN 1 stated this was a resident-to-resident altercation that was unprovoked and the LN added she had interviewed both residents. LN further stated it should have been reported to the Department.<br><br>During an interview on 4/15/25 at 11:57 a.m. with Director of Nursing (DON) in the DON's office, the DON stated [Resident 1] stated [Resident 4] grunted at him and it provoked him. DON further stated it was not deemed resident to resident abuse by the facility because it was a behavioral outburst so the IDT [interdisciplinary- a group of professionals that collaborates patient care] team treated it as an outburst.<br><br>During a concurrent follow up interview and record review on 4/15/25 at 1:56 p.m. with DON, the Nurse ' s progress note dated 4/10/25 was reviewed. The DON stated this was a behavioral incident where Resident 1 tried to harm Resident 4.<br><br>A review of the facility ' s policy and procedure titled, Abuse Investigation and Reporting, dated July 2017 indicated, . Reporting . all alleged violations involving abuse, neglect, exploitation or mistreatment . will be reported by the facility Administrator and or his/her designee to . State licensing/certification agency . local ombudsman . Law enforcement official . will be reported immediately but not later than: . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury . |