STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055497	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Placerville Healthcare Center	1040 Marshall Way Placerville, CA 95667

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 the interview and record review, the facility failed to protect one of three sampled residents (Resident 2) to be free from physical abuse when Resident 1 swung his arms several times at Resident 2, contacting Resident 2's upper body.This failure resulted in Resident 2 with pain from being hit.During a review of Resident 1's admission record (AR), dated 9/23/25 (print date), the AR indicated that Resident 1 was admitted to the facility in mid-2025 with diagnoses which included dementia (memory loss that gets worse over time), anxiety (fear, worry), depression (a serious mood disorder causing prolonged feelings of sadness or loss of interest that interfere with daily life), restlessness and agitation.During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/21/25, the MDS indicated Resident 1 had severely impaired cognition.During a review of Resident 1's care plan (CP) titled, COMBATIVE/PHYSICAL CARE PLAN initiated on 8/16/25, the CP indicated that Resident 1 had a history of being physically combative and abusive and was striking out and grabbing. The care plan further indicated, [Resident 1] Will not harm self and/or others secondary to socially inappropriate and/or disruptive combative behavior.During a review of Resident 1's nursing note (NN), dated 8/17/25, the NN indicated, [Resident 1] Disoriented, delusional, unaware of social distance, aggressive later in evening shift. Unable to be redirected. Going into other rooms and being resistive when told to leave. Touching med carts and things at the ns' [Nurse's] station. DON [Director of Nursing] and ADON [Assistant Director of Nursing] informed of concerns via telephone call.During a review of Resident 1's NN, dated 9/18/25 at 8:53 p.m., the NN indicated, [Resident 1] noted with attempt elopement at 2000 [8:00 p.m.]. Redirected into facility. Resident noted wandering off to side one as usual. This writer continued with medication administration when I heard a loud commotion. [Resident 1] seen attempting to assault another [Resident 2] while 3 staff members were separating both parties. [Resident 1] was unable to calm down and continue to resist staff then became combative with staff. PA [Physician Assistant] notified with orders to send out to acute. 911 arrived then transferred resident to acute care [hospital].During a review of Resident 1's NN, dated 09/18/25 at 22:31, the NN indicated, Behaviors: Restless, angry, combative and agitated. Resident is out of facility in acute care at this time. [Resident 1] attempted to elope with constant redirecting. requires wander guard [a monitoring device] due to elopement risk and poor safety awareness. [Resident 1] became angry then attempted to assault another resident. Both parties separated. This resident couldn't calm down and had to be restrained until PPD [police] arrived.During a review of Resident 2's AR, dated 9/23/25 (print date), the AR indicated that Resident 2 was admitted to the facility at the end of 2024 with diagnoses which included cerebral edema (a brain swelling caused by excess fluid buildup in brain tissue), dementia, and depression.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognition.During a review of Resident 2's CP titled, DEMENTIA CARE PLAN, initiated on 12/5/24, the CP indicated that Resident 2 has memory impairment with short and long term problem. risk for behavioral problems.During a review of Resident 2's NN dated 9/18/25 at 9:46 p.m. indicated, Resident noted involved in attempted physical altercation with another resident. Both (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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(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	parties separated immediately and kept apart.During a review of Resident 3's AR, dated 9/23/25 (print date), the AR indicated that Resident 3 was admitted to the facility in late 2022 with diagnoses which included low back pain and depression.During a review of Resident 3's MDS, dated [DATE], the MDS indicated that Resident 3 had intact cognitive abilities.During a review of the facility's security camera footage video titled Hall 2 (Man Cave) time stamped yesterday [9/18/25] 8:43-8:45 p.m., the video recording showed Resident 2 sitting on the wheelchair in the hallway. Resident 2 extended her right arm, blocking Resident 1's passage as he walked down the hallway and grabbed Resident 1 on his right hand, and Resident 1 reacted and pulled back his right hand and reached for Resident 2's neck not completely making contact with the neck as his hand moved down to Resident 2's upper chest area. Resident 1 swung his arms around, contacting Resident 2's arms a few times before the staff were able to pull both residents apart.During a concurrent observation and interview on 9/23/25 at 2:50 p.m. with Certified Nurse Assistant (CNA 1) in the facility's hallway, CNA 1 pointed out facility locations and described an incident that happened between Resident 1 and Resident 2 on 9/18/25. CNA 1 stated that initially, she was in room [ROOM NUMBER] as Resident 1 wandered into the room (room [ROOM NUMBER]), and she had to ask him to get out of the room because it was not his room. CNA 1 further stated that Resident 1 became agitated and responded with foul language and went out walking down the adjacent hallway towards the area close to room [ROOM NUMBER] and room [ROOM NUMBER], where Resident 1 was sitting on the w/c in the hallway. CNA 1 further stated that she saw how Resident 1 hit Resident 2 in the chest area.During an interview on 9/23/25 at 3:19 p.m. with Resident 2, Resident 2 stated that there was a guy in the hallway who twisted her hand and hit her on the chest, and it did hurt.During an interview on 9/23/25 at 4:39 p.m. with Resident 3, Resident 3 stated that few days ago she was in the hallway next to Resident 2 as she saw how Resident 1 approached Resident 2. Resident 3 further stated that during the incident, Resident 2 moved her arm out, blocking the passage to Resident 1, and Resident 1 pushed back on her and then hit her on the arm and chest. Resident 3 stated it was an audible hard hit by Resident 1.During a video call interview on 9/24/25 at 11:30 a.m. with the Director of Nursing (DON), the DON confirmed that she expected facility residents to be free from abuse, including physical abuse and undesirable touching.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/20/21, the P&P 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. The resident abuse, neglect and exploitation prevention program consists of a facility -wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents.