STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055922	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Health Care Center	1850 East 8th Street Davis, CA 95616

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41054 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) was free from abuse when Resident 2 struck him in the chest and face multiple times. This failure had the potential to result in serious physical harm. Findings: According to Resident 1's admission record, he was admitted in 3/24 with diagnoses including Type 2 diabetes (A long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of Resident 1's clinical record included the following documents: A Minimum Data Set (MDS, an assessment tool), dated 4/3/24, indicated Resident 1 had no memory impairment. A Subject, Background, Assessment and Recommendation (SBAR) Report, dated 5/25/24, indicated Resident 1 had bumped into Resident 2's wheelchair while trying to go down the hallway in his wheelchair and in response, Resident 2 struck Resident 1 in the face and chest three times. The report also indicated Resident 1 was not injured. According to Resident 2's admission record, she was admitted in 2/23 with diagnoses including hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) affecting the left non-dominant side. A review of Resident 2's clinical record included the following documents: A MDS, dated [DATE], indicated Resident 2 had moderate memory impairment. A SBAR Report, dated 5/25/24, indicated Resident 2 was angered when Resident 1 had bumped into her wheelchair while in the hallway and in response struck Resident 1 in the face and chest three times. The report also indicated Resident 2 was not injured. (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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(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 Note: The nursing home is disputing this citation.	In an interview, on 6/10/24 at 2:37 p.m., Resident 1 stated he had been going down the hallway in his wheelchair and accidentally bumped into Resident 2's wheelchair as she was in the middle of the hallway. Resident 1 stated he apologized to Resident 2 and asked her to move but she turned around, yelled profanities at him and struck him in the face several times. Resident 1 further stated it brought his self-esteem down because he had been, Beat up by an old lady, in front of other residents. In an interview, on 6/10/24 at 2:47 p.m., the Social Services Director (SSD) stated she was aware of the incident between Resident 1 and Resident 2. The SSD stated she had spoken with Resident 2 after the incident and she was unable to recall it. The SSD agreed the incident resulted in abuse for Resident 1 if his self-esteem had been impacted by it. In an interview, on 6/10/24 at 3:33 p.m., Licensed Nurse 1 (LN 1) stated she had been working on 5/25/24 at the time of the incident and was standing at the nurses' station. LN 1 stated she did not witness the incident but heard yelling and the sound of punches landing and had run to separate the residents. In an interview, on 6/10/24 at 4:10 p.m., Resident 3 stated he was in the hallway at the time of the incident between Resident 1 and Resident 2. Resident 3 stated he had seen Resident 1 bump into Resident 2's wheelchair and heard Resident 1 ask Resident 2 to move. Resident 3 stated he the saw Resident 2's arms swinging at Resident 1 several times, Like a windmill. Resident 3 stated he was unable to see if the punches actually landed though. In an interview, on 6/10/24 at 4:17 p.m., the Assistant Director of Nursing (ADON) agreed that if Resident 1's self-esteem had been impacted by the incident with Resident 2 he had suffered abuse. A review of the facility's policy titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/22, indicated, Each resident has the right to be free from abuse .Resident-to-Resident abuse means the willful infliction of injury .With resulting physical injury, pain or mental anguish by one resident towards another.