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Form Approved OMB
No. 0938-0391

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	08/27/2024

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	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** 46872 Based on interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for one of eight sampled residents (Resident 5) when facility staff witnessed Resident 4 punch Resident 5. This failure resulted in Resident 5 not being free from abuse and had the potential for Resident 5 to feel afraid and scared. Findings: Resident 5 was originally admitted to the facility in 2016 with multiple diagnoses which included dementia (impaired ability to remember, think, or make decisions), major depressive disorder (health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), bipolar disorder (mental health condition that causes extreme mood swings) and undifferentiated schizophrenia (symptoms may include signs of psychosis, such as delusions and hallucinations, or drastic changes in behavior, speech, or mobility). A review of Minimum Data Set (MDS, an assessment tool), dated 6/19/24, indicated Resident 5 had extreme impairment in cognition. Resident 4 was admitted to the facility June 2021 with multiple diagnoses which included dementia, bipolar disorder and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). A review of an MDS, dated [DATE], indicated Resident 4 had extreme impairment in cognition. During a review of Resident 5's Progress Notes, dated 8/23/24, at 5 p.m., indicated, .two CNA observed this resident [Resident 5] attempting to enter a room in B Hall .the other resident [Resident 4] emerged from his room .and punched him [Resident 5] .this resident [Resident 5] fall to the ground .resident [Resident 5] begin to yell at the nurse as the nurse tried to conducta [sic] full head to toe assessment. (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	During an interview on 8/27/2024, at 12:20 p.m., and a follow up interview at 2:55 p.m., with the Administrator (ADM), the ADM stated two facility staff members observed Resident 4 punch Resident 5 while Resident 5 was trying to enter Resident 4's room from the courtyard. ADM stated Resident 5 got access to the courtyard from the sliding glass doors in the Activity Room. The ADM confirmed Resident 5 lived in the locked memory care unit and staff were supposed to always supervise residents while in the Activity Room. During an interview on 8/27/24, at 2:30 p.m., with Resident 4, Resident 4 confirmed a few days ago a man was trying to enter his room from the sliding glass door. Resident 4 stated, . I knocked him down. During a review of Resident 4's Progress Notes, dated 8/23/24, at 5:01 p.m., indicated, RP [Responsible Party] was notified via phone; voicemail left regarding physical altercation that occurred today. During a review of Resident 5's care plan initiated on 11/17/19, the care plan indicated, Monitor for behaviors of intrusiveness/wandering into other's rooms and redirect . During a review of Resident 5's care plan initiated on 12/24/16, the care plan indicated, Monitor whereabouts regularly; Recognize any unsafe conditions or escalating patterns. During a review of Resident 5's care plan initiated on 6/12/24, the care plan indicated, [Resident 5] requires frequent checks for his needs . During a review of Resident 4's care plan initiated on 8/23/24, the care plan indicated, Risk for decline in psychosocial well being related to: resident to resident altercation. During a review of Resident 4's Order Summary Report, dated 9/5/24, indicated monitor for episodes of depression m/b [manifested by] aggressive, loud, angry outbursts r/t [related to] lack of control of environment . During a review of the facility's Policy and Procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting revised 10/22, the P&P indicated, Each resident has the right to be free from abuse .facility will implement policies and procedures to prevent and prohibit all types of abuse .establishing a safe environment .identifying, correcting and intervening in situations with which abuse .is more likely to occur . monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055922	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Courtyard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46872 Based on interview and record review, the facility failed to provide monitoring and supervision for one of eight sampled residents (Resident 5) when Resident 5, who has a history of disruptive behavior, was hit by Resident 4 while out in the courtyard unsupervised. This failure resulted in Resident 5 getting punched and had the potential for harm to other residents. Findings: Resident 5 was originally admitted to the facility in 2016 with multiple diagnoses which included dementia (impaired ability to remember, think, or make decisions), major depressive disorder (health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), bipolar disorder (mental health condition that causes extreme mood swings) and undifferentiated schizophrenia (symptoms may include signs of psychosis, such as delusions and hallucinations, or drastic changes in behavior, speech, or mobility). A review of Minimum Data Set (MDS, an assessment tool), dated 6/19/24, indicated Resident 5 had extreme impairment in cognition. Resident 4 was admitted to the facility June 2021 with multiple diagnoses which included dementia, bipolar disorder and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). A review of the MDS, dated [DATE], indicated Resident 4 had extreme impairment in cognition. During a review of Resident 5's Progress Notes, dated 8/23/24, at 5 p.m. indicated, .two CNA observed this resident [Resident 5] attempting to enter a room in B Hall .the other resident [Resident 4] emerged from his room .and punched him [Resident 5] .this resident [Resident 5] fall to the ground .resident [Resident 5] begin to yell at the nurse as the nurse tried to conducta [sic] full head to toe assessment. During an interview on 8/27/2024, at 12:20 p.m., and a follow up interview at 2:55 p.m., with the Administrator (ADM), the ADM stated two facility staff members observed Resident 4 punch Resident 5 while Resident 5 was trying to enter Resident 4's room from the courtyard. ADM stated Resident 5 got access to the courtyard from the sliding glass doors in the Activity Room. The ADM confirmed Resident 5 lived in the locked memory care unit and staff were supposed to always supervise residents while in the Activity Room. The ADM stated residents from the locked memory care unit were not allowed in the courtyard and could potentially get hurt while unsupervised. During an interview on 8/27/2024, at 1:55 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 confirmed Resident 5 was not allowed in the courtyard without supervision. CNA 1 stated all sliding glass doors including the sliding glass doors in the Activity Room were supposed to always be locked. CNA 1 stated residents could potentially get hurt if allowed in the courtyard unsupervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/2024, at 2 p.m., with the Activity Assistant (AA), the AA confirmed residents from the locked memory care unit were not allowed in the courtyard without supervision. AA stated she did not know how Resident 5 got access to the courtyard. During an interview on 8/27/2024, at 2:20 p.m., with the Sr Regional Director Clinical (SRDC), the SRDC also confirmed residents from the locked memory care unit were not allowed in the courtyard and did not know how Resident 5 got access. During an interview on 8/27/24, at 2:30 p.m., with Resident 4, Resident 4 confirmed a few days ago a man was trying to enter his room from the sliding glass door. Resident 4 stated, . I knocked him down. During a review of Resident 4's Order Summary Report, dated 9/5/24, indicated monitor for episodes of depression m/b [manifested by] aggressive, loud, angry outbursts r/t [related to] lack of control of environment . During a review of Resident 4's care plan initiated on 8/23/24, the care plan indicated, Risk for decline in psychosocial well being related to: resident to resident altercation. During a review of Resident 5's care plan initiated on 11/17/19, the care plan indicated, Monitor for behaviors of intrusiveness/wandering into other ' s rooms and redirect . During a review of Resident 5's care plan initiated on 12/24/16, the care plan indicated, Monitor whereabouts regularly; Recognize any unsafe conditions or escalating patterns. During a review of Resident 5's care plan initiated on 6/12/24, the care plan indicated, [Resident 5] requires frequent checks for his needs . During a review of the facility's Policy and Procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting revised 10/22, the P&P indicated, Each resident has the right to be free from abuse .facility will implement policies and procedures to prevent and prohibit all types of abuse .establishing a safe environment .identifying, correcting and intervening in situations with which abuse .is more likely to occur . monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse .