

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055956	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Bridgewood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Lemon Hill Ave Sacramento, CA 95824	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41054</p> <p>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 face and head.</p> <p>This failure had the potential to result in serious physical injury for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated he was admitted in 5/23 with diagnoses including hemiplegia and hemiparesis (paralysis and weakness) following a cerebral infarction (stroke) affecting the left non-dominant side.</p> <p>A Minimum Data Set (MDS, an assessment tool), dated 2/16/24, indicated Resident 1 had moderate cognitive impairment.</p> <p>A review of Resident 1's clinical record included the following documents:</p> <p>A nursing progress note, dated 4/5/24 and written by the Director of Nursing (DON), indicated a certified nursing assistant (CNA) had heard scuffling coming from Resident 1 and Resident 2's room around 6 a.m. that morning and upon entering the room saw Resident 2 hitting Resident 1 in the face and head. The note indicated Resident 1 was assessed by a licensed nurse (LN) and found to have no injuries but was transferred to a General Acute Care Hospital (GACH) for evaluation as a precaution per a physician's order.</p> <p>A review of Resident 2's admission record indicated he was admitted in 3/24 with diagnoses including unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>A MDS, dated [DATE], indicated Resident 2 had severe cognitive impairment.</p> <p>A review of Resident 2's clinical record included the following documents:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 4/5/24 and written by the DON, indicated a CNA had heard scuffling coming from Resident 1 and Resident 2's room around 6 a.m. that morning and upon entering the room saw Resident 2 hitting Resident 1 in the face and head. The note indicated Resident 2 was assessed by a LN and found to have no injuries but was transferred to a GACH for evaluation as a precaution per a physician's order.</p> <p>In an interview, on 4/10/24 at 12:52 p.m., Resident 1 stated that he had been asleep in his bed when he awoke and saw Resident 2 standing over him. Resident 1 stated Resident 2 had then punched him several times in the face and head. Resident 1 stated he hollered for help and was frightened by Resident 2.</p> <p>In an interview, on 4/10/24 at 1:08 p.m., the DON confirmed on 4/5/24 Resident 2 had been witnessed hitting Resident 1 in his face and head and Resident 2 was a safety issue. The DON stated both residents returned from the GACH without any findings.</p> <p>In an interview, on 4/10/24 at 1:34 p.m., the Social Services Director (SSD) stated she considered resident to resident abuse to include any unwelcome contact such as punches and slaps. The SSD agreed it was the facility's responsibility to ensure residents were free of abuse and Resident 1 had been physically abused by Resident 2.</p> <p>In an interview, on 4/10/24 at 1:54 p.m., the Administrator (ADM) agreed it was the facility's responsibility to protect residents from abuse and that if Resident 1 had woken up to being struck in the face and head by Resident 2 and was frightened he had been abused.</p> <p>A review of the facility's policy titled, Reporting Allegations of Abuse/Neglect, dated 1/1/24, stipulated that abuse was, The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The policy also indicated physical abuse included hitting and slapping.</p>		