STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide supervision for two of three sampled residents (Resident 1, Resident 2) when Resident 2 pushed Resident 1's wheelchair from behind causing Resident 1 to react impulsively and strike Resident 2 on the hand.This failure had potential to cause harm and psychosocial distress. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in October 2025 with multiple diagnoses including schizoaffective disorder (mental condition that is characterized by symptoms of schizophrenia, including delusions and hallucinations, with mood disorder symptoms such as depression or mania), borderline personality disorder (mental health condition causing unstable emotions characterized by impulsivity and difficulty regulating feelings), and bipolar disorder (mental health condition causing extreme mood swings from manic highs to depressive lows).A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 10/6/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 13 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's Change of Condition Assessment, dated 11/14/25, indicated . [Resident 1] was sitting in her chair in the hallway when another resident was trying to pass her but was not able to due to not having enough space. The other resident states she reached to move [Resident 1's] wheelchair over so she could pass and alleged that [Resident 1] made contact with her left arm. Staff member immediately stepped in between and separated them. Both residents assessed and no injuries noted .A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in April 2025 with multiple diagnoses including encephalopathy (disorder that alters brain structure causing confusion and personality changes), sepsis (body responds improperly to infection causing organ damage), and dementia (disease characterized by memory loss and decline in judgment that interferes with daily life). A review of Resident 2's MDS, Cognitive Patterns, dated 10/29/25, indicated Resident 2 had a BIMS score of 13 out of 15 that indicated Resident 2 was cognitively intact. A review of Resident 2's Change of Condition Assessment, dated 11/14/25, indicated . alleged altercation with another resident in the hallway .A review of Resident 2's Progress Note, dated 11/14/25, indicated . [Resident 2] was mobilizing in her wheelchair in the hallway and was making an attempt to pass another resident but that residents chair was blocking her ability to pass so she stated that she reached out in an attempt to move the other resident's wheelchair so she could pass her when that resident made contact with her left arm. Staff member immediately stepped in between the and separated them. Both residents assessed and no injuries noted .During an interview on 12/30/25 at 12:29 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 was in the front lobby by the nursing station in her wheelchair when Resident 2 pushed her wheelchair forward and Resident 1 reacted by reaching back making contact with Resident 2. Resident 1 said, Hey, don't do that. The DSD stated Resident 1 was startled when her wheelchair was moved. The DSD stated the residents were separated. The DSD stated the residents had no prior incidents with each other or any other residents. During an interview on 12/30/25 at 12:42 p.m. with the Administrator (ADM), the ADM stated Resident 1 and Resident 2 were in wheelchairs in front of the nursing station when Resident 2 was trying to go around Resident 1 and moved her wheelchair. The ADM stated Resident 1 was startled and swung her arm and made contact with Resident 2's arm. The ADM stated he spoke with Resident 1 who stated she did not mean to hurt her but was startled. The ADM stated a staff member witnessed the incident and separated the residents. The ADM stated there were no injuries to either resident. The ADM stated both residents are in the behavioral program and they are monitored for behavioral needs and have not had any previous incidents with each other or other residents. During a telephone interview on 12/30/25 at 12:58 p.m. with the Director of Rehab (DOR), the DOR stated she was a witness to the incident between Resident 1 and Resident 2 on 11/14/25. The DOR stated she saw both residents in their wheelchairs by the nursing station. The DOR stated Resident 2 wanted to get by and pushed Resident 1's wheelchair forward. The DOR stated Resident 1 reached back and swiped Resident 2's left hand. The DOR stated Resident 1 was upset because her wheelchair was moved and said, Don't push me. The DOR stated the residents were separated and then assessed by nursing. During a concurrent observation and interview on 12/30/25 at 2:34 p.m. with Resident 2, observed Resident 2 with frequent mouth and jaw movements and folding blanket over and over. Resident 2 stated she was hit by a man in a wheelchair but did not recall any altercation with a woman. Resident 2 then indicated she did not want to talk any further.During an interview on 12/30/25 at 2:36 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1