

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 01/28/2026
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** Based on interviews, and record review, the facility failed to protect two of five sampled residents' (Resident 3 and Resident 4) right to be free from physical abuse by another resident when: Resident 1 punched Resident 4, and Resident 2 punched Resident 3 in his right eye. These failures had the potential to cause physical/mental harm to Resident 3 and Resident 4. Findings: 1. Resident 1 was admitted to the facility in August of 2024 with diagnoses that included schizophrenia (a mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior). A review of Resident 1's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 12/5/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 10 indicating Resident 1 had moderate mental and cognitive impairments. Resident 4 was admitted to the facility in February of 2025 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time). A review of Resident 4's MDS, dated [DATE], indicated Resident 4 had a BIMS score of 10 indicating Resident 4 had moderate mental and cognitive impairments. A review of Resident 4's Nurses Progress Note (NPN), dated 1/8/26, indicated, At approximately 0650, the nurse observed Resident [Resident 4] and male peer [Resident 1] in an altercation in the Resident's [Resident 4] room. During an interview on 1/28/26 at 10:58 a.m. with Licensed Nurse 3 (LN 3), LN 3 confirmed he witnessed the altercation between Resident 1 and Resident 4. LN 3 indicated that when he walked into Resident 4's room for medication administration, he observed Resident 1 punching Resident 4. LN 3 indicated that during the altercation, Resident 1 stood over Resident 4, who was lying in his bed. LN 3 confirmed Resident 1's punches made physical contact with Resident 4's body but was unable to state exact locations. 2. Resident 2 was admitted to the facility in July of 2024 with diagnoses that included schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms and a mood disorder). A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 7 indicating Resident 2 had severe cognitive impairments. Resident 3 was admitted to the facility in October of 2025 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had a BIMS score of 13 indicating Resident 3 was cognitively intact. A review of Resident 3's NPN, dated 1/4/26, indicated, [Resident 2] turned toward [Resident 3] and made kin contact with [Resident 3] in the left eye (sic). During an interview on 1/28/26 at 9:52 a.m., with LN 1, LN 1 confirmed she witnessed the altercation between Resident 2 and Resident 3. LN 1 stated, [Resident 3] was in a wheelchair. [Resident 2] was standing up. [Resident 2] was on the phone with his mom. I was charting during this. [Resident 2] then swung around. [Resident 2] used his right arm and struck [Resident 3] in the right eye. It was a punch like motion. [Resident 2] was on the phone with his mom and that is what might have triggered him. LN 1 then indicated that residents have the right to be free from</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055956	Facility ID: 055956 If continuation sheet Page 1 of 2

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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>abuse.During an interview on 1/28/26 at 10:01 a.m., with LN 2, LN 2 indicated she was present during the altercation between Resident 2 and Resident 3. LN 2 indicated she witnessed Resident 2 talking on the phone with his mom, when he suddenly hung up and turned towards Resident 3. LN 2 indicated Resident 3 then stated, He hit me.During an interview on 1/28/26 at 11:42 a.m., with the Social Services Director (SSD), the SSD stated that physical abuse could, affect residents' mental, physical, social, and overall wellbeing. The SSD indicated residents in the facility have the right to not be physically abused.During a review of the facility's policy and procedures (P&P) titled, Abuse Prevention Program, revised 12/2016, the P&P indicated, Our 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, and physical or chemical restraint not required to treat the resident's symptoms.These findings represent past noncompliance with this regulatory requirement. Observations, interviews and record review confirmed the residents were separated immediately, the residents were assessed, the residents' providers and responsible parties were notified, the residents' care plans were updated, and sitter staff were assigned to each resident to closely supervise them. There was sufficient evidence that the facility corrected the violation as of 1/8/26, and no other occurrences of noncompliance were identified. At the time of the visit, the facility was in substantial compliance with this regulatory requirement, and therefore, this violation does not require a plan of correction.</p>		