

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Double Tree Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 24th Street Sacramento, CA 95822	
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 - Some	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 four of seven sampled residents (Resident 1, Resident 2, Resident 3 and Resident 4) were free from abuse when: 1. Resident 1 and Resident 2 had an altercation resulting in Resident 2 sustaining a skin tear; and 2. Resident 3 and Resident 4 had an altercation resulting in Resident 3 sustaining a skin tear. These failures had the potential to result in serious physical injury to the residents. Findings: 1. A review of Resident 1's admission record indicated he was admitted in 3/24 with diagnoses including hemiplegia and hemiparesis (paralysis and weakness) following a cerebral infarction (stroke) affecting the right dominant side. A review of a Minimum Data Set (MDS, an assessment tool), dated 2/26/24, indicated Resident 1 had no cognitive impairment. A review of a Situation, Background, Assessment, Recommendation (SBAR) Communication form, dated 4/5/24 and written by Licensed Nurse 1 (LN 1), indicated Resident 1 had been in an altercation with Resident 2. Resident 1 stated Resident 2 had hit him in the face and on assessment LN 1 found Resident 1 had no injuries. A review of Resident 2's admission record indicated he was admitted in 1/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and dementia (a group of thinking and social symptoms that interferes with daily functioning). An MDS, dated [DATE], indicated Resident 2 had no cognitive impairment. An SBAR, dated 4/5/24 and written by LN 1, indicated Resident 2 had been in an altercation with Resident 1. Resident 2 stated Resident 1 had hit him in the jaw so he hit him back in the face and on assessment LN 1 found Resident 2 had a small skin tear on his right arm. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview, on 4/17/24 at 11:04 a.m., Resident 2 stated Resident 1, Had a mouth on him, and was, Always in trouble with you. Resident 2 stated Resident 1 had slapped him in the face so he had punched him back in the jaw and denied injury. In an interview, on 4/17/24 at 11:13 a.m., Resident 5, Resident 1 and Resident 2's roommate, stated he was lying in bed at the time of the altercation between Resident 1 and Resident 2 and phoned the nurses' station to let them know the residents were fighting. Resident 5 stated he saw Resident 2 pull aside the bed curtain and hit Resident 1 with his cane but did not see if Resident 1 had hit him back. In an interview, on 4/17/24 at 11:27 a.m., Resident 1 stated Resident 2 had started the fight and that Resident 2 had hit him in the face and he in turn hit Resident 2 back in the face. In an interview, on 4/17/24 at 11:51 a.m., the Social Services Director (SSD) stated she was aware of the incident between Resident 1 and Resident 2. The SSD stated abuse could be physical or verbal and included hitting and confirmed the altercation between the residents was a form of abuse for both residents. In an interview, on 4/17/24 at 12:28 p.m., LN 1 stated she had been at the nurses' station on 4/5/24 and received a call from Resident 5 notifying her Resident 1 and Resident 2 were fighting. LN 1 stated that when she entered the residents' room both residents were sitting on their beds facing each other and stated that the other one had started the fight. LN 1 stated upon assessment, she noticed a small skin tear on Resident 2's right forearm measuring approximately half an inch (a unit of measurement). 2. A review of Resident 3's admission record indicated she was admitted in 4/23 with diagnoses including cognitive communication deficit (a disorder in which a person has difficulty communicating because of injury to the brain). A review of an MDS, dated [DATE], indicated Resident 3 had no cognitive impairment. A review of an SBAR, dated 4/11/23 and written by LN 1, indicated Resident 3 had been in an altercation with Resident 4. Resident 3 stated Resident 4 had spit at her and that she had grabbed Resident 4's arms and hit her and in return Resident 4 had hit her back. The SBAR also indicated Resident 3 had sustained a small skin tear on her right arm. A review of Resident 4's admission record indicated she was admitted in 1/20 with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel and behave correctly) and dementia. A review of a MDS, dated [DATE], indicated Resident 4 had severe cognitive impairment (severe difficulty remembering, making decisions, concentrating or learning). A review of a SBAR, dated 4/11/24 and written by LN 1, indicated Resident 4 had been involved in an altercation with Resident 4. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview, on 4/17/24 at 11:51 a.m., the SSD stated she was aware of the altercation between Resident 3 and Resident 4. The SSD stated Resident 4 had advanced dementia and was unable to recall the incident when she spoke with her. The SSD stated she was not sure who started it but agreed both residents had suffered abuse. In an interview, on 4/17/25 at 12:28 p.m., LN 1 stated she was sitting at the nurses' station and heard a commotion in the hallway. LN 1 stated she stood up and saw both residents with their hands in the air slapping at each other. LN 1 stated Resident 3 reported Resident 4 had spit at her and she hit her in return and Resident 4 had then hit her back. LN 1 stated upon assessment, Resident 3 had a small skin tear on her right forearm measuring approximately half an inch. In an interview, on 4/17/24 at 12:47 p.m., Resident 3 stated she was in her wheelchair in the hallway and passed by Resident 4. Resident 3 stated Resident 4 spit at her so she threw an empty soda can at her and hit her and Resident 4 then hit her back. In an interview, on 4/17/24 at 1:11 p.m., the Administrator (ADM) stated it was difficult to determine who the aggressor was in each of the two resident altercations but agreed all four residents were victims of physical abuse. A review of the facility's policy titled, Abuse Prevention Program, revised 8/11, stipulated, Our residents have the right to be free from abuse .Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents .		