STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Double Tree Post Acute Care Center	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 - 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 a resident for one of three sampled residents (Resident 2) when facility staff witnessed Resident 1 hit Resident 2. This failure resulted in Resident 2 not being free from abuse and had the potential for Resident 2 to be injured. Findings: Resident 1 was admitted [DATE] with diagnoses which included anxiety disorder and muscle weakness. A review of Minimum Data Set (MDS, an assessment tool), dated 7/30/24, indicated Resident 1 had intact cognition. Resident 2 was admitted [DATE] with diagnoses which included hemiplegia (muscle weakness or partial paralysis on one side of the body) and reduced mobility. A review of the MDS, dated [DATE], indicated Resident 2 had intact cognition. During an interview on 10/24/24, at 11:23 a.m. with the Director of Nursing (DON), the DON stated on the morning of 10/16/24, she was informed by Janitor (JN) that he witnessed Resident 1 and Resident 2 get into a verbal and physical altercation outside on the smoking patio. DON confirmed JN stated he witnessed Resident 1 hit Resident 2. DON stated the expectations were for residents to involve facility staff when there is a disagreement and to not get into physical altercations. During an interview on 10/24/24, at 11:40 a.m. with Social Services Director (SSD), the SSD confirmed she had observed on video Resident 1 approach Resident 2 outside in the smoking area. SSD stated Resident 1 hit Resident 2 and saw Resident 2 attempt to hit Resident 1 but wasn't sure if contact was made. SSD confirmed she educated Resident 1 and Resident 2 on smoking policy, resolving conflict and not fighting. During an interview on 10/24/24, at 11:54 a.m., with Resident 1, Resident 1 confirmed a few days ago he got upset at Resident 2 for taking his cigarettes and had confronted Resident 2 outside. Resident 1 stated he hit Resident 2 in his face and Resident 2 had hit him on his shoulder. Resident 1 stated, Didn't hit him hard and he didn't hit me hard. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10/24/24, at 12:05 p.m., with Resident 2, Resident 2 confirmed Resident 1 had approached him outside, told him to not take his cigarettes and then hit him. Resident 2 stated he tried hitting Resident 1 in return. During an interview on 10/24/24 at 12:25 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated expectations were for staff to keep residents safe and to keep their smoking supplies. CNA 1 confirmed residents could potentially be hurt and injured if arguments and fights escalated. During a review of Resident 1's Progress Notes (PN), dated 10/16/24, the PN indicated, Resident involved in an altercation in our facility with resident [Resident 2] .Resident is seen on camera assaulting resident [Resident 2]. During a review of Resident 1's PN, dated 10/21/24, the PN indicated, Late entry for 10/16/24 .so I went after him [Resident 2] to the smoking patio and I swung at him but I didn't hit him the first time, but I did the second time, the only thing is that I just don't remember where I hit him. During a review of Resident 2's PN, dated 10/21/24, the PN indicated, Late entry for 10/16/24. This resident [Resident 2] had an physical altercation with other male resident .He [Resident 1] came after me to the smoking patio and hit me in the head . During a review of Resident 2' s SBAR Communication Form, dated 10/16/24, indicated Resident stated aggressor [Resident 1] took his hat, struck him on his face once and hit him with the walker. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention Program, revised 8/2011, the P&P indicated, Our facility is committed to protecting our residents from abuse by anyone including .other residents . During a review of the facility's Policy and Procedure (P&P) titled, Residents Rights, revised 12/2023, the P&P indicated, .certain basic rights to all residents of this facility. These rights include the resident ' s right to: .be treated with respect, kindness, and dignity .be free from abuse .