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	07/09/2025

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** Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse for one (Resident 1) out of a census of 108 when Resident 1 was pushed by a visitor during an altercation.This failure resulted in Resident 1 not free from abuse by a visitor.Findings:During a review of Resident 1's admission Record (AR), indicated Resident 1 was admitted [DATE] with diagnosis including Alcohol Induced Psychotic Disorder- Unspecified.During a review of Resident's 1 Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 7/9/25 indicated Resident 1 had intact cognition.During a review of Resident 1's Care Plan (CP), indicated there was no documented evidence of a person-centered care plan, related to the potential risk of aggression. During a review of SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers for changes in residents' conditions) dated 7/1/25, it indicated that Resident 1 exhibited verbal and physical aggression towards a visitor and staff members.During an interview with Licensed Nurse 2 on 7/9/25 at 11:48 a.m., LN 2 reported that she witnessed the visitor pushed Resident 1 during the altercation.During an interview on 7/9/25 at 12:50 p.m. with the Director of Nursing (DON), the DON confirmed that residents at their facility have the right to be free from any form of abuse, by any individual.During a review of the facility's policy and procedure (P&P) titled, Resident Rights and Abuse Prevention Policy and Procedure Manual, revised August 2011, indicated, .resident has the right to be free from abuse.residents must not be subjected to abuse by anyone including, but not limited to.family members, friends, or other individuals.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported timely within 2 hours for one of four sampled residents (Resident 1), when an allegation of abuse was reported to the department the following day.This failure reduced the potential to ensure resident safety.Findings:A review of a facility document titled, SBAR (Situation, Background, Assessment, Recommendation - a communication tool used by healthcare workers for changes in residents' conditions) note dated 7/1/25 indicated, .Writer [Licensed Nurse (LN) 3] was also approached by this Resident [1] and also got in writers face . Resident [1] got agitated, and pushed the visitor. visitor reacted and pushed back [Resident 1] as he was getting in his face as well with yelling and cursing. Primary Care Clinician notified 7/1/25 at 6:30 p.m.A review of Interdisciplinary Team (IDT) Follow up dated 7/2/25 at 9:48 a.m. indicated, . On 7/1/25, pm shift, res [1] was verbally aggressive to staff in the hallway. Staff asked him to calm down. Res [1] got close to charge nurses' face about the CNAs. res [1] got agitated and pushed the visitor. Visitor reacted and pushed back [Resident 1]. Staff intervened and calmed the situation.A review of an initial report from the facility indicated the report was faxed on 7/2/25 at 2:57 p.m. and received by the Department on 7/2/25 at 4:16 p.m. indicated, an allegation of suspected dependent adult/elder altercation had been made related to a visitor against Resident 1. During an interview on 7/9/25 at 11:37 a.m. with LN 1, LN 1 stated, any abuse allegations must be reported to the department within 2 hours.During an interview on 7/9/25 at 11:48 a.m. with LN 2, LN 2 stated, she saw the Visitor pushed the resident.During an interview on 7/9/25 at 12:50 p.m. with Director of Nurses (DON), DON stated, the abuse allegation was submitted 7/2/25 because she did not know it was a reportable incident.During interview via telephone on 7/11/25 at 8:30 a.m., the Director of Nurses (DON) stated that it is the facility's policy to report any allegation of abuse to the department within 2 hours. The DON confirmed that the abuse allegation made on 7/1/25 was not reported to the department within the required 2-hour timeframe.During a review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and Other Entities/Individuals, revised August 2011, indicated, All suspected violations. of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Should a suspected violation. of mistreatment. or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies. of such incident.The State licensing/certification agency responsible for surveying/licensing the facility.A review of Center of Medicare and Medicaid State Operations Manual (SOM-a document that provides guidance for surveyors on long term care facilities) indicated, .S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.