

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER McKinley Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 H Street Sacramento, CA 95816	
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 interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for three residents (Resident 1, Resident 2, and Resident 3) of four sampled residents when: 1. Resident 1 struck Resident 2 in the face; and, 2. Resident 2 struck Resident 3 in the face. These failures resulted in resident to resident physical abuse and had the potential for Resident 2 and Resident 3 to suffer physical and emotional injury. Findings: 1. During a review of Resident 2's admission Record (AR), indicated Resident 2 was admitted on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following non-traumatic intracerebral hemorrhage (bleeding in the brain) affecting left non-dominant side, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and generalized anxiety disorder (a mental health condition involving excessive, ongoing fear and worry that do not go away and make it hard to do daily activities.) During a review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 5/24/26, the MDS indicated Resident 2 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 over 15, which indicated Resident 2 had very mild cognition (memory) issues. During a review of Resident 1's AR, the AR indicated, Resident 1 was admitted on [DATE] with diagnoses which included wedge compression fracture of third lumbar vertebrae (front part of the lower back bone has crushed and flattened into a wedge shape under pressure), other intervertebral disc disorder (wear, tear or damage to cushion pads that sit between the bones of the spine) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had a BIMS score of 10 over 15, which indicated Resident 1's cognition was moderately impaired. During a review of Resident 2's Nurse's Note (NN), dated 7/1/26, indicated staff notified the nurse that Resident 1 had an altercation with another resident in room [ROOM NUMBER]A (Resident 2). During an interview on 7/24/26 at 9:36 a.m. with Janitor (JN), JN stated that the altercation between Resident 1 and Resident 2 occurred in the back parking lot. JN stated that he witnessed the residents punching each other and striking each other in the face. During an interview via telephone on 7/24/26 at 10:09 a.m. with Resident 1, Resident 1 confirmed that the incident with Resident 2 occurred in the parking lot. Resident 1 confirmed that he struck Resident 2 in the face a couple of times. During an interview on 7/24/26 at 10:47 a.m. with Resident 2, Resident 2 confirmed that the incident occurred in the back parking lot. Resident 2 stated that Resident 1 struck him in the face. 2. During a review of Resident 3's AR, the AR indicated, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555122	Facility ID: 555122 If continuation sheet Page 1 of 2

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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	Resident 3 was admitted on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), difficulty in walking and bipolar disorder. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 1 had a BIMS score of 15 which indicated Resident 3 was cognitively intact (no memory issues). During a review of Resident 3's (NN), dated 6/7/26, the NN indicated that the resident in room [ROOM NUMBER] A (Resident 2) was outside the resident's room when Resident 3 was coming down the hallway. The NN indicated that the nurse heard, 'get out of my way', and then Resident 2 struck Resident 3 on the right side of the face. During a review of Resident 3's NN, dated 6/7/26, the NN indicated that during the skin assessment, Resident 3 verbalized feeling upset and frustrated after being struck in the face by another resident (2). During an interview on 7/24/26 at 11:22 a.m. with the Director of Nursing (DON), DON stated that the incidents involving Resident 1 and 2, and between Residents 2 and 3, met the definition of physical abuse. DON stated that all residents had the right to be free from abuse. During an interview via telephone on 7/24/26 at 2:49 p.m. with Licensed Nurse (LN) 1, LN 1 stated that during the incident involving Resident 2 and Resident 3, she was in the hallway with her medication cart when she heard someone say, 'get out of my way'. LN 1 stated that she walked toward the residents and saw Resident 2 struck Resident 3 in the face with the right hand. LN 1 confirmed that she saw Resident 2's right hand hit Resident 3's face. During a review of the facility's policy & procedure (P&P) titled, Identifying Type of Abuse, revised 9/22, the P&P indicated, 'abuse of any kind against residents is strictly prohibited. instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. abuse includes verbal abuse, sexual abuse, physical abuse. physical abuse includes but is not limited to hitting, slapping, biting, punching or kicking.'		