STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Blvd. Fair Oaks, CA 95628

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. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe and protective environment to be free from physical abuse was provided for one of three sampled residents (Resident 1), when Resident 1 was hit in the back of the head by Resident 2. This failure resulted in Resident 1's feeling scared of Resident 2 and had the potential to expose Resident 1 and other residents from further possible physical abuse from Resident 2. During a review of Resident 1's admission Record (AR) dated 5/2018, the AR indicated Resident 1 had diagnoses which included major depression. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/29/25, the MDS indicated Resident 1's memory was intact.During a review of Resident 2's AR dated 5/2018, the AR indicated Resident 2 had diagnoses which included dementia (a progressive state of decline in mental abilities). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. During a review of Resident 2's Nursing Care Plan (NCP), dated 8/23/25, the NCP indicated, Physical altercation with fellow residents related to dementia, poor impulse control, and anger as evidenced by resident hits other resident at random times. Resident to be supervised by staff when in the dining room. During a review of Resident 2's Psychiatric Consultation Notes (PCN) dated 8/12/25, the PCN indicated, Aggressive behavior towards other patients.During a review of Resident 1's Change of Condition Evaluation (COCE) dated 8/23/25, the COCE indicated at 6:35 in the morning, Resident 1 was in the dining room and carried a chair toward a friend to sit together in the same table when Resident 2 came and started hitting Resident 1 on her back. During a review of Resident 2's Interdisciplinary Team (IDT, group of professionals with distinct expertise who work collaboratively and interdependently to achieve a common goal) notes, dated 8/25/25, the IDT notes indicated Resident 2 was in the dining area with two other residents when Resident 2 kicked and hit Resident 1. The IDT notes indicated the cause of the altercation was when Resident 1 took a chair from Resident 2's table that caused Resident 2 to get agitated and hit Resident 1 on the back of her head.During a concurrent interview and record review on 9/9/25 at 11:11 a.m. with the Licensed Nurse (LN), Resident 2's record was reviewed. The LN stated the incident was not the first time that Resident 2 got involved in resident altercation. The LN stated Resident 2 easily got mad and irritated and he needed frequent supervision throughout the shift. During an interview 9/9/25 at 11:37 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the incident was not the first time Resident 2 was involved with altercation, and stated, He had the tendency to hit and to aggravate. CNA 1 stated she did not supervise Resident 2 while he was at the dining area. During a concurrent observation and interview on 9/9/25 at 12:52 p.m. in Resident 1's room, Resident 1 was alert and verbally responsive, and stated she was in the dining area with another female resident, picked up a chair and brought the chair to her friends table to have coffee. Resident 1 stated, [Resident 2] turned around, hit me in the arm and I dropped the chair, and [Resident 2] hit me in the back of my head. I did not drop on the floor when [Resident 2] hit me, but I dropped the chair, and so I yelled for help. Resident 1 added, I told [Resident 2] stay away from me. This was not the first time that [Resident 2] attacked me. Resident 1 confirmed she felt scared of [Resident 2]. During a concurrent observation and interview on 9/9/25 at 1:19 p.m. in Resident 2's room with the Treatment Nurse (TN), Resident 2 made a fist of both hands, and stated, Come here and I will hit you in the face. The TN witnessed the behavior and redirected Resident 2.During a concurrent interview and record review on 9/9/25 at 1:51 p.m. with the Social Services Director (SSD), Resident 2's clinical record was reviewed. The SSD confirmed Resident 2 had aggressive behavior and got agitated for no reason at all. The SSD confirmed Resident 2 had incidents of being abusive and stated when Resident 2 remained abusive, other residents could isolate themselves for fear and could stop attending activities. The SSD stated that when other residents were fearful of roaming around the facility freely, the residents could become more depressed and lonelier and remained in their rooms for fear of Resident 2's aggressive/abusive behavior. The SSD stated, No resident should be subjected to any kind of abuse.During an interview on 9/9/25 at 2:30 p.m. with the Director of Nursing (DON), the DON stated no one should be subjected to any kind of abuse. During a review of the facility's policy and procedure (P&P) titled Resident Rights and Abuse Prevention Policy and Procedure Manual dated 4/2021, the P&P indicated, 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