| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555459 | A. Building<br>B. Wing | 07/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gramercy Court | 2200 Gramercy Drive<br>Sacramento, CA 95825 |

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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect one of five sampled residents (Resident 1) from abuse when Resident 2 slapped Resident 1 on the left cheek. This failure resulted in Resident 1 experiencing feelings of unsafety, disrespect and physical pain.Findings:Review of Resident 1's admission Records indicated Resident 1 was admitted in Summer of 2024 with diagnoses which included a mental health condition that affected how people think, feel and behave and Type 2 Diabetes. A review of Resident 1's Brief Interview for Mental Status (BIMS), dated 6/2/25, the BIMS indicated Resident 1 had a score of 12 out of 15 which indicated Resident 1 had a moderate cognitive impairment.A review of Resident 1's Interdisciplinary Team (IDT) Note dated 7/14/25 indicated, At approximately 1540 [3:40 p.m.] on 7/13/25, MHW [Mental Health Worker] reported they had heard a slapping sound and saw this resident's [Resident 1] peer strike him on the left side of the face.Resident [Resident 1] stated. I backed my wheelchair up to turn around to go out the door then I accidentally ran over peer's [Resident 2] foot. He [Resident 2] then slapped me instantly on the left side of my face. It began to hurt and sting, my pain is about 8/10.A review of Resident 1's Health Status [HS] Note dated 7/13/25 indicated, MHW 2 reports that he was escorting visitors of 709 to Patio 3 when he witnessed 720B [Resident 2] slap 721B [Resident 1] in the face.During an interview on 7/17/25 at 1:46 p.m., with Resident 1, Resident 1 stated, I was sitting on my wheelchair and the [NAME] was there, I rolled back and rolled over his foot. He yelled then he slapped me on my face. He was close to me. Resident 1 stated that he felt unsafe and disrespected by Resident 2 at the time of the event. Resident 1 also reported that his left cheek was in pain at that time. During an interview on 7/17/25 at 1:20 p.m., with MHW, MHW confirmed he witnessed Resident 2 slapped Resident 1 on his left cheek and stated, It was loud and it's like the ones from the slapping competition. He added it was loud enough that the whole unit heard when Resident 2 slapped Resident 1's face. MHW also stated, He was holding his face, and it looks like he was hurt.During an interview with the Director of Nursing (DON) on 7/17/25 at 11:25 a.m., The DON confirmed that incident between Resident 1 and Resident 2 was witnessed by staff during the residents smoke break. The DON stated, That incident should have not happened because we have staff there. The DON also confirmed that the incident involving Resident 1 and Resident 2 was a safety concern and that the residents safety and supervision was a facility priority.During a review of the facility policy and procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, the P&P indicated, Residents have the right to be free from abuse.This includes.physical abuse.Protect residents from abuse.by anyone including. other residents.During a review of the facility P&P titled, Resident-to-Resident Altercations dated September 2022, the P&P indicated, All altercations including those that may represent resident-to-resident abuse.Behaviors that may provoke a reaction by residents or others includes.physical aggressive behavior, such as hitting, kicking, grabbing, scratching. |

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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