STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gramercy Court	2200 Gramercy Drive 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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to protect the right to be free from physical abuse for three of four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4), when: 1. On 12/13/25, Resident 1 spat at Resident 2 in the hallway;2. On 12/24/25 in the dining room, Resident 1 slapped Resident 3 on the back of the head; and3. On 12/26/25 in the dining room, Resident 1 slapped Resident 4 on the face. This failure compromised the residents' ability to maintain their highest practicable physical, emotional and psychological well-being.Findings: 1. During a review of Resident 1's admission Record (AR), dated 1/8/26 (print date), the AR indicated Resident 1 was admitted to the facility in December of 2025 with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and age-related cognitive (process of acquiring knowledge and understanding through thought process) decline. During a review of Resident 1's progress note (PN), dated 12/13/25, the PN indicated, At 1600 [4 p.m.] [Resident 1] was standing in the hallway using a walker. [Resident 2] was positioned in front of [Resident 1] and speaking loudly to himself.[Resident 1] became upset by the behavior and spat on [Resident 2]. During a review of Resident 2's AR, dated 1/8/26, the AR indicated Resident 2 was admitted to the facility in May of 2025 with diagnoses that included schizoaffective disorder and depression (a mood disorder causing persistent sadness, loss of interest). During a concurrent observation and interview on 1/7/26 at 12:43 p.m. with Resident 2, Resident 2 was observed walking and talking in the hallway. When asked if he had been involved in any altercation with other residents, Resident 2 stated, It was about a month ago when he spit on me. When asked if he felt safe in the facility, Resident 2 stated, I'm more worried about the staff here. During a phone interview on 1/8/26 at 9:04 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 confirmed he witnessed the incident on 12/13/25 between Resident 1 and Resident 2 as they met in the hallway and Resident 1 spat at Resident 2. CNA 1 further stated that when staff intervened, Resident 2 was questioning why Resident 1 spat at him, and Resident 2 remained silent and looked stunned. 2. During a review of Resident 3's AR, dated 1/9/26, the AR indicated that Resident 3 was admitted to the facility in April of 2024 with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought) and dementia (a progressive state of decline in mental abilities due to reduced blood flow to the brain). During a review of Resident 3's PN, dated 12/24/25, the PN indicated, [Resident 1 was observed standing from his wheelchair and approaching another resident table where [Resident 3] who was seated and drinking coffee. [Resident 1] subsequently stood up and then slapped [Resident 3] on the back of his head. During a concurrent observation and interview on 1/7/26 at 12:56 p.m. with Resident 3, Resident 3 was not answering questions clearly, mumbled and difficult to understand. When asked if he was involved with any altercations with other residents, Resident 3 stated, I was hit on the back of head by some guy. I don't remember exactly when. During an interview on 1/8/26 at 11:09 a.m. with the Social Services Assistant (SSA), the SSA stated that on 12/24/25 at (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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(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 - Some	around 9 a.m., he saw how Resident 1 hit Resident 3 on the back of the head with an audible sound when both residents were by the shared table in the dining room. The SSA further stated that Resident 3 looked shocked and confused, and Resident 1 stated that he slapped Resident 3 because he was looking at him in a weird way. 3. During a review of Resident 4's AR, dated 1/8/26, the AR indicated that Resident 4 was re-admitted to the facility in March of 2024 with diagnoses that included schizoaffective disorder and posttraumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 4's PN, dated 12/26/25, the PN indicated, .[Resident 4] was just sitting close to the nurse station attending the group, when [Resident 1] walked towards [Resident 4] sat down next to her and suddenly lay his hand on her and landed on her R [right] side face. Resident were separated right away. During a concurrent observation and interview on 1/7/26 at 2:41 p.m. with Resident 4, Resident 4 walked from the dining room to her room. When asked what her name was, Resident 4 introduced himself with a different name. When asked if she was involved in altercations with other residents, Resident 4 was not able to elicit an appropriate response and recanted a story not related to the question. When asked if she was safe in the facility, Resident 4 stated, I'm afraid that there will be fire.The man in the bathroom slapped me, he didn't do it, it's my word against everybody else. During an interview on 1/7/26 at 4:50 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated that on 12/26/25, she saw how Resident 4 was sitting by the nurse's station, and Resident 1 approached Resident 4 and slapped her on the face with an audible slap sound. LN 1 further stated that Resident 4 cried and said that Resident 1 slapped her. During an interview on 1/8/26 at 3:04 p.m. with the Director of Nursing (DON), the DON confirmed that the incident on 12/13/25 between Resident 1 and Resident 2, the incident on 12/24/25 between Resident 1 and Resident 3, and the incident on12/26/25 between Resident 1 and Resident 4 were witnessed and constituted physical abuse. The DON further stated that she expected facility residents to be free from physical and verbal abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 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.