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	05/27/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure five of seven sampled residents (Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) were free from abuse, when: 1. Resident 2 threw a cup of coffee onto Resident 3;2. Resident 1 pushed his walker into the back of Resident 4's legs;3. Resident 1 put his lit cigarette butt on Resident 5's face;4. Resident 1 hit Resident 2's face with his fist; and5. Resident 7 hit Resident 6 in the back of the head with his hand. These failures had the potential to negatively impact Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6's highest practicable physical, mental, and psychosocial well-being.Findings: 1. A review of an admission record indicated Resident 2 was admitted to the facility with a diagnosis of schizophrenia (a serious mental health condition that affects how people think, feel, and behave and includes delusions or hallucinations). A review of Resident 2's Minimum Data Set (MDS, an assessment tool), dated 3/2/26, indicated Resident 2's Brief Interview of Mental Status (BIMS) score was three out of 15 with severe cognitive impairment. A review of Resident 2's Care Plan (CP), revised 1/16/26, indicated Resident 2 was at risk for behavioral disturbances related to history of physical aggression due to schizophrenia. A review of an admission record indicated Resident 3 was admitted to the facility with diagnoses including schizoaffective disorder (a chronic mental health condition combining the symptoms of schizophrenia such as hallucinations or delusions with a mood disorder), borderline personality disorder (a mental health condition characterized by profound difficulty regulating emotions), and anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that is out of proportion to the actual situation). A review of Resident 3's MDS, dated [DATE], indicated a BIMS score of 15 out of 15 with intact cognition. A review of Resident 3's Behavioral Health Note, dated 4/7/26, indicated at approximately 9:45 a.m. on 4/7/26 Resident 3 was standing conversing with another resident when he was questioned by Resident 2 regarding staring. The note further indicated Resident 2 became agitated and threw coffee onto Resident 3. During an interview on 5/26/26 at 12:06 p.m. with Resident 3, Resident 3 stated he was in the dining hall talking to another resident when Resident 2 came up to him and asked him why he was staring at him. Resident 3 further stated Resident 2 held a cup filled with coffee in his hand, then Resident 2 threw the contents of the cup towards him and the coffee landed on his face, neck, and clothing. During an interview on 5/26/26 at 9:46 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she witnessed Resident 2 taking the cup of coffee he was holding and throwing it towards Resident 3. CNA 2 further stated Resident 3 became upset and grabbed a nearby chair and pushed it towards Resident 2. During an interview on 5/26/26 at 11:48 a.m. with Mental Health Worker (MHW) 2, MHW 2 stated he saw Resident 2 with a cup of coffee in his hand when Resident 2 threw it towards Resident 3. MHW 2 further stated Resident 3 got a chair and pushed it towards Resident 2's body. 2. A review of an admission record indicated Resident 1 was admitted to the facility with diagnoses including schizoaffective disorder and personal history of traumatic brain injury (any past physical damage to the brain caused by an external force). A review of Resident 1's MDS, dated [DATE], indicated a BIMS score of 14 out of 15 with intact cognition. A (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 - Some	review of an admission record indicated Resident 4 was admitted to the facility with diagnoses including schizophrenia, dementia (an umbrella term for a decline in mental abilities severe enough to interfere with daily life), and depression (mood disorder that causes persistent feeling of sadness and loss of interest). A review of Resident 4's MDS, dated [DATE], indicated a BIMS score of five out of 15 with severe cognitive impairment. A review of Resident 4's Health Status Note, dated 4/20/26, indicated on 4/20/26 at 12:30 a.m. Resident 4 was walking towards his room when Resident 1 followed him and pushed his walker forward and made contact with the back of Resident 4's legs. A review of Resident 1's Behavioral Health Note, dated 4/20/26, indicated Resident 1 pushed his walker in the direction of Resident 4, and the walker made physical contact with the back of Resident 4's legs. The note further indicated Resident 1 was verbally aggressive when checked on by staff in his room after the incident and shouted to be left alone. During an interview on 6/2/26 at 11:25 a.m. with CNA 4, CNA 4 stated Resident 1 and Resident 4 were both walking in the hallway, and Resident 1 was walking behind Resident 4 using his walker. CNA 4 further stated she saw Resident 1 intentionally pushing his walker forward into the back of Resident 4's legs. CNA 4 also stated Resident 1 had often showed aggressive behaviors towards other residents. 3. A review of an admission record indicated Resident 5 was admitted to the facility with diagnoses including schizoaffective disorder, anxiety disorder, and depression. A review of Resident 5's MDS, dated [DATE], indicated a BIMS score of 14 out of 15 with intact cognition. A review of Resident 1's Interdisciplinary (IDT) Note, dated 4/28/26, indicated on 4/25/26 at approximately 4 p.m. Resident 1 was observed ambulating toward the cigarette disposal area, and without any apparent trigger turned and made contact with Resident 5's face with a cigarette butt. During an observation 5/26/26 at 11:42 a.m. in the hallway outside Resident 5's room, Resident 5 was observed with a small dark scar under his right eye. During an interview on 5/26/26 at 11:42 a.m. with Resident 5, Resident 5 stated he was sitting outside in the smoking area when Resident 1 abruptly came towards him and put his lit cigarette butt on Resident 5's face under his right eye. Resident 5 further stated he felt heat and a burning sensation. During an interview on 5/26/26 at 8:43 a.m. with CNA 1, CNA 1 stated he was outside for a staff monitored smoke break at approximately 4 p.m. and observed Resident 5 sitting down. CNA 1 further stated he then observed Resident 1 walking towards Resident 5's direction and abruptly putting his cigarette butt onto Resident 5's face. During an interview on 5/27/26 at 11:35 a.m. with MHW 1, MHW 1 stated residents were out smoking when he observed Resident 1 walking towards the cigarette disposal, then intentionally moving his walker towards Resident 5 and pressing his cigarette butt onto Resident 5's face under his right eye. 4. A review of Resident 2's Health Status Note, dated 4/25/26, indicated at approximately 3 p.m., two staff members reported that Resident 2 was the victim of peer-to-peer physical altercation and sustained physical contact to the cheek when Resident 1 struck Resident 2 with a hand while both were lined up waiting for a smoke break. A review of Resident 2's IDT Note, dated 4/28/26, indicated on 4/25/26 at approximately 3:30 p.m., Resident 1 made physical contact with Resident 2's cheek using his hand while both were in close proximity to each other waiting for the smoke break. During an interview on 5/26/26 at 8:42 a.m. with CNA 1, CNA 1 stated he was standing in the hallway when he saw Resident 1 and Resident 2 in line next to each other to go outside for a smoke break. CNA 1 further stated he saw Resident 1 abruptly standing from his sitting walker and punching Resident 2 in the face with his right fist. During an interview on 5/27/26 at 11:37 a.m. with MHW 1, MHW 1 stated he was standing with CNA 1 when he saw Resident 1 standing from his sitting walker, then swinging his right fist towards Resident 2's face and hitting Resident 2's cheek. MHW 1 further stated this incident occurred right before the incident with the cigarette butt happened. 5. A review of an admission record indicated Resident 7 was admitted to the facility with diagnoses including schizophrenia, bipolar disorder (a lifelong mental health condition that causes extreme emotional highs and lows), depression, and pervasive developmental disorder (now known as autism spectrum disorder, a lifelong neurological and developmental condition that affects how a person communicates, interacts, behaves, and learns). A review of Resident 7's MDS, dated [DATE], (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated a BIMS score of zero out of 15 indicating Resident 7 was unable to participate in the BIMS assessment due to severe cognitive impairment. A review of an admission record indicated Resident 6 was admitted to the facility with diagnoses including schizoaffective disorder and bipolar disorder. A review of Resident 6's MDS, dated [DATE], indicated a BIMS score of 14 out of 15 with intact cognition. A review of Resident 6's IDT Note, dated 4/30/26, indicated Resident 6 was involved in a peer-to-peer altercation on 4/29/26 at approximately 9:30 p.m. when he was approached from behind by a peer (Resident 7) and was struck on the back of the head. The note also indicated Resident 6 expressed concern about safety within the facility and indicated discomfort around the involved peer. The note further indicated Resident 6 reported that Resident 7 was observed standing outside his room earlier, which caused distress. During an interview on 5/26/26 at 12:22 p.m. with Resident 6, Resident 6 stated he was waiting in line for snacks in the dining hall when Resident 7 came and hit him in the back of his head with a fist and ran away. During an interview on 5/27/26 at 10:02 a.m. with Licensed Nurse (LN) 2, LN 2 stated he saw Resident 6 in the dining room standing in line during snack time when Resident 7 run up behind Resident 6 and hit him in the back of the head with his hand. LN 2 further stated Resident 7 started yelling at Resident 6 until they were both separated. During an interview on 5/27/26 at 11:15 a.m. with Assistant Director of Nursing (ADON), ADON stated the expectation was all residents should be free from any forms of abuse. During an interview on 5/27/26 at 11:20 a.m. with Behavior Health Nurse Director (BHNP), BHNP stated any type of abuse should not have occurred and all residents should have been kept safe. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, 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 . protect residents from abuse by anyone including other residents .