STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the rights to be free from physical abuse for two of four sampled residents (Resident 2 and Resident 3), when: 1. Resident 1 entered Resident 2's room, touched Resident 2's belongings, ate his food, and swung her arms at Resident 2 when Resident 2 tried to intervene; and2. Resident 1 approached Resident 3 in the dining room and hit her on the back. These failures resulted in Resident 2 and Resident 3 sustaining pain and injury from physical contact and voicing their safety concerns.Findings:1. During a review of Resident 1's admission Record (AR), dated 9/5/25, the AR indicated Resident 1 was admitted to the facility in mid-2025 with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia with behavioral disturbance (a condition where cognitive decline is accompanied by significant behavioral changes). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 7/14/25, the MDS indicated Resident 1 had severe impaired cognition. During a review of Resident 1's care plan (CP), initiated on 8/25/25, the CP indicated, [Resident 1] has a change in condition: pt [patient] hit another resident.Resident's change in condition will improve or resolve by next review. During a review of Resident 1's CP, initiated on 6/9/25, the CP indicated, [Resident 1] at risk for altered nutritional status r/t [related to]: dementia, wanders around facility & snacks often. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for August of 20025, the MAR indicated, Monitor patient Q shift [every shift] for wandering.Start date 06/09/2025. During a review of Resident 1's Nursing Progress Notes (NPN), dated 8/29/25 at 7:30 p.m the NPN indicated, [At] 1930 [Resident 2] called staff that this [Resident 1] was touching all of his belongings and this res tried to scratch him, and [Resident 2] tried stopping this [Resident 1] and came outside the room and asked for staff help. Per [Resident 1] I don't know, no, I don't remember. Staff immediately redirected the [Resident 1]. Upon assessment [Resident 1] alert and verbally responsive to care. During a review of Resident 2's AR, dated 9/5/25, the AR indicated Resident 2 was admitted to the facility in mid-2025 with diagnoses which included depression and chronic pain. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognition. During a review of Resident 2's NPN, dated 8/29/25 at 7:30 p.m., the NPN indicated, [At] 1930 [Resident 2] called this writer that someone [Resident 1] is in his rm [room] touching all his belongings and eating his chips and that [Resident 1] tried to scratch him when he was trying to let her stop what [Resident 1's] been doing. This writer went to the room and saw [Resident 1] picking up the chips on the floor and eating it.skin check was done on [Resident 2], slight redness noted on [Resident 2's] right neck. [Resident 2] asked for a PRN [as needed pain medication]. During a concurrent observation and interview on 9/5/25 at 9:40 a.m. in Resident 2's room, Resident was alert and verbally responsive, and stated that about five days ago, as he entered his room, he saw his grocery bags open and Resident 1 eating his [Resident 2's] chips. Resident 2 stated that he asked Resident 1 to get out of his room, but Resident 1 approached him and started swinging her arms at him. Resident 2 further stated that Resident 1 moved her arms erratically and hit him on his face and neck, and it was burning afterwards, but he backed out of the room and called for help. Resident 2 further stated that he felt that he was abused, and he was scared whenever Resident 1 was around. Resident 2 stated that he had to refrain from activities more and stay in his room to ensure his safety and the security of his belongings. During a phone interview on 9/5/25 at 11:06 a.m. with Licensed Nurse 1 (LN 1), LN 1 indicated that on 8/29/25 he was in a different room providing care to another resident as Resident 2 called for help, and stated Resident 1 was in his room. LN1 stated that when he came to Resident 2's room, he saw Resident 1 inside the room eating chips. LN 1 further stated that Resident 2 was stating that Resident 1 tried scratching him. LN 1 stated that when he assessed Resident 2, he saw redness on his neck. LN 1 confirmed that Resident 1 had instances of aggression and was known to wander around. During an interview on 9/5/25 at 1:59 p.m. with the Director of Nursing (DON), the DON confirmed that Resident 1 was known to be moving around and entering different residents' rooms, and she had prior incidents of aggressive behavior. The DON confirmed that Resident 1 entered Resident 2's room on 8/29/25, and Resident 2 was found with redness to the neck after the incident. The DON further stated that she expected residents to be free from physical and verbal abuse. 2. During a review of Resident 3's AR, dated 9/5/25, the AR indicated Resident 3 was admitted to the facility in the middle of 2024 with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the