Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 36681 Based on interview and record review, the facility failed to ensure the representative or Responsible Party (RP) was informed of the skin discoloration for one resident (Resident 1), for a census of 155. This failure resulted in Resident 1's RP not being informed of the skin changes. Findings: A review of Resident 1's clinical record indicated she was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that affects memory, thinking, and behavior) and Bipolar II disorder (pattern of depressive episodes [sadness or hopelessness] and hypomanic episodes [persistently elevated or irritable mood]). A review of Resident 1's 'Nurse's Note' dated 5/24/24 at 08:24, indicated, .RP was very [sic] expressing her concerns that [Resident 1] has bruises on her arm from wrist to her neck . This note was written by the Director of Nursing (DON). A review of Resident 1's '72-hour Charting' dated 5/23/24 at 16:46 [4:46 p.m.]' indicated, Body skin assessment done: Res [Resident 1] has scattered old purplish discoloration to bilateral forearms. Lt [left] forearm skin tear Tx [treatment] was done then turned to the skin discoloration. In an interview on 6/7/24 starting at 12:34 p.m., the DON stated it was Resident 1's daughter who told the facility regarding Resident 1's discoloration to bilateral forearms on 5/23/24. The DON further stated the discoloration was not reported prior to 5/23/24. The DON added her expectation was for the Certified Nursing Assistant to report any skin changes immediately and any new discoloration should be reported since this was a change in condition. A review of the facility's policy revised September 2013 and titled, Change in a Resident's Condition or Status indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36681 Based on observation, interview, and record review, the facility failed to provide supervision to ensure safety for 2 of 3 sampled residents (Resident 1 and Resident 2) when Resident 1 and Resident 2 had a verbal and physical altercation in the back yard. This failure resulted in Resident 1 sustaining a scratch on the cheek and Resident 2 had skin tear to left hand. Findings: A review of Resident 1's clinical record indicated she was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that affects memory, thinking, and behavior) and Bipolar II disorder (pattern of depressive episodes [sadness or hopelessness] and hypomanic episodes [persistently elevated or irritable mood]). A review of Resident 1's SBAR [Situation, Background, Appearance, Review and Notify] dated 5/23/24, indicated, .Was told by staff that [Resident 1] had a verbal altercation with [Resident 2] that turned into physical altercation. [Resident 2] was yelling at the] [Resident 1] and pulled her hair and slapped her on the face. Staff was then able to separate residents away from each other. [Resident 1] had a scratch that was bleeding on the [sic] her left cheek that has stopped . A review of Resident 2's clinical record indicated she was admitted to the facility with diagnoses including unspecified dementia (can cause loss of ability to think, remember, and limited social skills) with anxiety (feelings of fear). A review of Resident 2's '72-hour Charting' on 5/23/24 at 19:48 [7:48 p.m.] indicated, Received report that resident had verbal altercation with [Resident 1] at the backyard and turned into physical altercation. [Resident 2] was yelling at [Resident 1] and pulled her hair and slapped her on the face . [Resident 2] has tiny skin open to Lt [left] hand Tx [treatment] done . In an interview on 6/7/24 at 8:56 a.m., the Director of Nursing (DON) stated there was no staff assigned at the back yard when the incident occurred between Resident 1 and Resident 2. In a concurrent observation and interview on 6/7/24 at 9:17 a.m., Resident 1 was inside her room. Resident 1 did not respond when she was asked if she can recall any incident with other residents. In a concurrent observation and interview on 6/7/24 starting at 10:22 a.m., Resident 2 was in the back yard sitting in a bench with 2 other residents. Resident 2 was unable to recall any incident with other residents. (continued on next page)

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	555400	A. Building B. Wing	06/28/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 6/7/24 at 11:19 a.m., the Certified Nursing Assistant 1 (CNA 1) stated he was taking a break in his car when the incident occurred and there was no staff present in the back yard. The CNA 1 further stated if there was somebody there, the altercation could have been resolved sooner. The CNA 1 agreed that the altercation could have been prevented if a staff member was assigned to supervise the residents. In a telephone interview on 6/20/24 at 2:04 p.m., the ADON stated Resident 1 required supervision all the time due to episodes of hitting herself. A review of the facility policy revised December 2007 and titled, Safety and Supervision of Residents indicated, .Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs .