STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555400	A. Building B. Wing	07/02/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46995 Based on observation, interview, and record review, the facility failed to notify the responsible party (RP) and physician for one of four sampled residents (Resident 1) when Resident 1 had an unwitnessed fall, which resulted in bleeding and an injury to the lip. This failure delayed prompt medical monitoring, treatment and left the family unaware of the situation. Findings: Resident 1 was admitted to the facility in mid-2024 with diagnoses that included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder, lack of coordination, muscle weakness, and anxiety disorder. Resident 1 is not his own responsible party. During a review of Resident 1's Face Sheet (FS, a document that contains patient information), the FS indicated a family member was the RP. During a review of Resident 1's Order Summary Report [OSR], dated 7/2/24, the OSR indicated, Resident does not have the capacity to make his/her own decisions related to Alzheimer's. During a review of Resident 1's BRIEF INTERVIEW FOR MENTAL STATUS [BIMS], dated 6/12/24, the BIMS showed a score of one, indicating Severe Impairment. During a review of Resident 1's Progress Notes [PN], dated 6/15/24 at 10:00 a.m., the PN indicated, Called [name of after-hour hospital service] for reporting Fall (sic) from last night . During a review of Resident 1's PN dated 6/15/24 at 10:47 a.m. the PN indicated, .got Orders (sic) from [Physician name], activate fall protocol, monitor closely for fall precautions, reassess mouth and face see bleeding stopped completely (sic) . During an observation and interview over the phone on 7/1/24 at 1:48 p.m. with Resident 1's RP regarding a photo taken when: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Resident 1 was at the facility. The photograph had a time stamp on top of the picture indicating that the photograph was taken Yesterday 8:20 p.m. It showed Resident 1 lying on the floor by the foot of the bed. Resident 1 wore turquoise pajamas around the ankles and had an exposed bottom. The photograph showed Resident 1 using one hand to pull the bottom of the pajama shirt over the buttocks. --Resident 1 was not wearing any undergarments. Resident 1's head was resting on the hand closest to the floor. Several dark red substance spots were on the floor next to Resident 1's face. At the top corner of the photo, a pair of black shoes and yellow pants were visible. On the bottom of the image were multiple small pictures of Resident 1 and several unidentified residents. During an interview on the phone on 7/1/24 at 1:49 p.m. the RP indicated while at the facility on 6/15/24, that [Resident 1] had gotten an injury to his mouth .and the MD [medical doctor] was not notified, and the family was not notified .we noticed his lip was swollen, and we started to ask questions. No incidents had been reported to the nurse. They took a photo of [Resident 1], but nobody mentioned the injury or incident .They said it was unwitnessed .If you look at the picture and see how the feet of the staff are turned away from him . it looks very disheartening .a staff member took the photos .someone showed the picture to my sister, and that is how we got it .This is an undignified photo .they did not say who took the picture .staff members took a photo while he was on the ground .I feel like that picture is degrading .they did not call the family or anything. During an interview on 7/2/24 at 9:12 a.m. regarding notifications of resident falls with a Certified Nursing Assistant (CNA 1), CNA 1 stated that when a resident falls, the charge nurse notifies the doctor and responsible party as soon as possible. During an interview on 7/2/24 at 9:20 a.m., with Licensed Nurse 1 (LN 1), LN 1 stated, I (sic) or the unit manager notifies the doctor, responsible party, DON (Director of Nursing), and ADM (Administrator) that the resident has fallen right away. Suppose a resident falls after hours, like in the evening or on the weekend. In that case, we notify [name of acute care facility]. During an interview on 7/2/24 at 9:35 a.m. with LN2, LN 2 stated, I stay with the resident, protect the head, check for injury or bleeding, and then put the resident back to bed after the assessment. Complete vital signs, call the doctor and responsible party, check POLST, begin neuro checks, and check for new orders. During an interview on 7/2/24 at 9:50 a.m. LN 3, LN 3 stated, I should notify the MD and responsible party immediately when a fall happens and not wait until the next day. During an interview on 7/2/24 at 10:36 a.m. with the Assistant Director of Nursing (ADON), the ADON stated, After the resident is assessed, we call the doctor right away, and we inform the responsible party of the fall. If it is a big injury, we can call 911. If the fall happens after 5 p.m. or on the weekend, we call [name of after-hour hospital service]. It is unacceptable to wait until the next day to notify the doctor or the responsible party. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 7/2/24 at 2:14 p.m., with the Director of Nursing (DON) of Resident 1's Electronic Health Record (EHR), the DON stated, The facility's fall process is what we use to assess the residents, get the resident back to bed, check vital signs, start neuro checks, notify the doctor, carry out any new orders, and notify the responsible party. We also document changes in condition, open evaluation, risk management, and updates to the care plan in the progress notes. After the DON reviewed the records in the EHR, the DON confirmed there was no documentation of a fall that occurred on 6/14/24, and no documentation that the doctor or the responsible party was notified on 6/14/24. Neuro checks should have been started in a timely manner. When the morning shift nurse took over the shift, the resident was discovered to have fallen. The doctor and responsible party were notified the next day after the fall had happened. I expect the process to begin immediately and follow the protocol when a fall occurs. Notify the physician and RP. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001 MED-PASS, Inc., the P&P indicated, Our facility promptly notifies the resident, their attending physician, and the resident representative of changes in the resident ' s medical .changes in level of care .residents' rights .

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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. 46995 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from mental abuse by facility staff for one of four sampled residents (Resident 1) when facility staff took a picture of Resident 1 with an unsecured facility cell phone while Resident 1 was lying the floor with his pants around his ankles, without undergarments, and trying to cover his naked buttocks with the edge of his nightshirt. This failure portrayed Resident 1 in an undignified manner and had the potential for multiple staff members, other residents and family members, to view the photograph, which could cause mental anguish to Resident 1. Findings: Resident 1 was admitted to the facility mid-2024 with diagnosis which included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder, lack of coordination, muscle weakness, and anxiety disorder. Resident 1 was not his own responsible party (RP). During a review of Resident 1's Face Sheet (FS, a document that contains patient information), the FS indicated a family member was the RP. During a review of Resident 1's Order Summary Report [OSR], dated 7/2/24, the OSR indicated, Resident does not have the capacity to make his/her own decisions related to: Alzheimer's. During a review of Resident 1's BRIEF INTERVIEW FOR MENTAL STATUS [BIMS], dated 6/12/24 the BIMS indicated, Severe Impairment. During a review of Resident 1's Progress Notes [PN], dated 6/15/24 at 10:00 a.m. the PN indicated, Called [name of after hour hospital service] for reporting Fall (sic) from last night . During an observation and interview on 7/1/24 at 1:48 p.m. with Resident 1's RP, the RP and the Department viewed a photo taken of Resident 1 while at the facility. The RP and the Department acknowledged that the photograph showed Resident 1 lying at the foot of his bed, wearing turquoise pajamas. The bottoms of his pajamas were noted by the RP and the Department to be around Resident 1's ankles, and he was observed to be using one hand to pull the bottom of his pajama shirt over his buttocks. The RP and the Department observed that Resident 1 was not wearing undergarments, shoes, or socks. Resident 1's head was observed to be on the floor with dark red spots of substance on the floor next to his face. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continued observation, the RP and the Department observed a time stamp at the top of the photo that indicated the photo was taken, Yesterday 8:20 p.m. Noted at the bottom of the photo were multiple small pictures of Resident 1 and other unidentified residents. The RP indicated that she had gone to the facility the morning of 6/15/24 to visit Resident 1 and stated, .[Resident 1] had gotten an injury to his mouth .and the MD [medical doctor] was not notified, and the family was not notified .we noticed his lip was swollen and we started to ask questions, no incidents had been reported to the nurse. They took a photo of [Resident 1], nobody mentioned the injury or incident .They said it was unwitnessed .a staff member took the photos . someone showed the picture to my sister, that is how we got it .This is an undignified photo .they did not say who took the picture .staff members took a photo while he was on the ground .I feel like that picture is degrading .they did not call the family or anything. During an interview on 7/2/24 at 9:11 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 was asked the process for when a resident falls. CNA 1 stated, .Nurses take pictures of the fall .they take pictures of the resident ' s position . During an interview on 7/2/24 at 9:36 a.m. with Licensed Nurse (LN 1), LN1 was asked if she would take a picture of a resident on the floor with their pants down with the facility cell phone. LN 1 stated, Oh no, that is a dignity violation. When asked who had access to the facility cell phone LN 1 stated, .the physician and family .sometimes the residents are not able to use the phone, so we take the cell phone to them .we enter the passcode and give it to them . LN 1 stated each unit has a facility cell phone. During an interview on 7/2/24 at 9:49 a.m. with the Unit Manager (UM), the UM was asked the procedure when a resident falls. UM stated, .we do take pictures .where the resident was found, where the position of the resident .the nurse takes pictures with the facility cell phone .we take them how we found them . When asked if staff would take a picture of a resident on the floor with his pants down, the UM stated, It's a facility phone, it's not shared anywhere so they do take pictures with the pants down. The UM was asked who has access to the phone and stated all the nurses and the physician had access to the phone. When asked if the pictures were deleted after they were taken, the UM stated, They stay in the phone, they are not deleted. When asked if staff would show a family member the photo after a resident fell , the UM stated, Sometimes we have to show them. Sometimes they are thinking we are doing nothing. It happened one time . When asked if it was the facility policy to photograph a resident on the ground the UM stated, When I came over here that was the way they did it. That was the way I was trained. The UM stated, The pictures should not be taken with their pants down. They should not be exposed. During an interview on 7/2/24 at 10:21 a.m. with the Director of Social Services (DSS), the DSS was briefly shown the photograph taken by a facility staff member of Resident 1 lying on the ground with his pants down. The DSS stated, That is not a dignified photo. I would not expect those kinds of pictures .our building has dementia residents, although they might not know what is going on, we need to preserve some part of their dignity . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/24 at 10:36 a.m. with the Assistant Director of Nursing (ADON), the ADON was asked the procedure for photographing a resident after a fall. The ADON stated, We ask them [nurses] to take a picture .we use the picture to determine a root cause of the fall. When asked who had access to the facility cell phone, the ADON stated, Residents use the cell phone, or they use the cell phone for video calls. The ADON confirmed multiple people had access to the phones which contained pictures of residents and stated, .It [facility cell phone] does have private pictures on it. The ADON was shown the picture facility staff had taken of Resident 1 and stated, This is not dignified, but it ' s showing his pants were down. It ' s showing the root cause of the fall . The ADON confirmed Resident 1 had pulled the corner of his nightshirt to cover his bare buttocks and stated, He is trying to cover himself; he should have been covered .show him some respect . During a concurrent observation and interview on 7/2/24 at 2:01 p.m. with the Director of Nursing (DON) of the facility cell phone, the DON was asked to open the facility cell phone. The DON picked up the phone from the nurse's station desk. No passcode was needed to open the phone. The DON confirmed the phone was unlocked and unattended. When asked to see the pictures, the phone showed zero photographs. When history of photos was accessed, the phone indicated, syncing paused for 697 items . The DON confirmed all the photos on the phone had been deleted today. During a concurrent observation and interview on 7/2/24 at 2:40 p.m. with the DON, the DON was asked about the process of photographing a resident after they fell , the DON stated, There is no process for taking photographs of the residents after they fall. That is not part of the fall process or policy. The DON was shown the photograph of Resident 1 taken by a staff member, and stated, I would not consider that a dignified picture of a resident. The DON confirmed the photogram showed Resident 1lying on the ground with his pants around his ankles. During an interview on 7/2/24 at 3:06 p.m. with the Director of Staff Development (DSD), the DSD was asked if staff was educated on photographing residents. The DSD stated staff should, never take a picture with a cell phone .if they do, do not take a picture that shows the resident face . When described a photograph where a resident was lying on the ground with their pants down, the DSD stated, I think that would be abuse. During a review of facility's policy and procedure (P&P) titled, Dignity, dated 2/21, the P&P indicated, Residents are treated with dignity and respect at all times. During a review of the facility's P&P titled, Videotaping, Photographing, and Other Imaging of Residents, dated 4/17, the P&P indicated, Residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recording during resident care or other facility activities .Any image or recording taken that may be construed as humiliating or demeaning to a resident or residents is considered abuse and will be reported and investigated as such . During a review of the facility's P&P titled, Resident Rights, dated 2/21, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be free from abuse .privacy and confidentiality . During a review of the facility's P&P titled, Abuse Prevention Program, dated 6/06, the P&P indicated, Our residents have the right to be free from abuse .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46995 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was monitored timely for neurological changes (injury or changes that result from an injury to the head that affect the brain) after an unwitnessed fall. This failure had the potential for Resident 1 to have neurological deterioration that was not assessed or monitored by staff. Findings: Resident 1 admitted to the facility mid-2024 with diagnoses which included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder, lack of coordination, muscle weakness, and anxiety disorder. Resident 1 was not his own responsible party. During a review of Resident 1's Face Sheet (FS, a document that contains patient information), the FS indicated a family member was the responsible party (RP). During a review of Resident 1's Progress Notes [PN], dated 6/15/24 at 10:00 a.m. the PN indicated, Called [name of after hour hospital service] for reporting Fall (sic) from last night . During a review of Resident 1's electronic health record (EHR) for the date of 6/14/24, the EHR did include any documentation of a fall, progress note about the fall, initiation of neurological assessment, change of condition documentation, physician notification, or RP notification. During an observation and interview on 7/1/24 at 1:48 p.m. with Resident 1's RP, of a photo taken of Resident 1 while at the facility, lying on the floor at the foot of his bed, with his head on the floor. The RP and the Department observed several dark red spots of substance on the floor next to Resident 1's face. There is a time stamp at the top of the photo that indicated the photo was taken, Yesterday 8:20 p.m. Resident 1's head was on the floor. The RP had gone to the facility the morning of 6/15/24 to visit Resident 1 and stated, . they took a photo of [Resident 1] .they said it was unwitnessed . During an interview on 7/2/24 at 9:20 a.m. with Licensed Nurse (LN 1), LN 1 was asked how soon neurological monitoring (neuro-checks) were started after a fall. LN 1 stated, Immediately, it starts off every 15 minutes at first and then kind of spreads out . During an interview on 7/2/24 at 9:36 a.m. with LN 2, LN2 was asked how soon neuro-checks were started after a fall. LN 2 stated, Neuro-checks start immediately after we check the vital signs. We do every 15 minutes, then every two hours . During an interview on 7/2/24 at 9:49 a.m. with the Unit Manager (UM), the UM was asked how soon neuro-checks were started after a fall. The UM stated, They start when the fall happens . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/24 at 10:36 a.m. with the Assistant Director of Nursing (ADON), the ADON was asked the process for an unwitnessed fall. The ADON stated, .neuro-checks start right away from when someone is on the floor. Start every 15 minutes and lasts for 72 hours . During a concurrent interview and record review on 7/2/24 at 2:40 p.m. with the Director of Nursing (DON) of Resident 1's electronic health record (EHR), the DON was asked the protocol for fall monitoring. The DON stated, .We notify the doctor and RP .we open a change of condition, risk management, we document in the progress notes . When asked when neuro-checks were started the DON stated, They get started right away, as soon as we find the resident on the floor . When asked if there was any documentation of Resident 1's fall on 6/14/24 in the EHR, the DON stated, There is no documentation .there is no doctor or RP notification . obviously the nurse prior did not do anything and the next nurse who came on started the neuro-checks . The DON confirmed the neuro-checks were started the day after the fall and her expectations was to start monitoring immediately following a fall. During an interview on 7/2/24 at 3:29 p.m. with LN 4, LN 4 was asked about Resident 1's fall. LN 4 stated, I was working that day .the CNA [certified nursing assistant] left the room .I left the room .the CNA ran back to tell me there was a resident on the floor .The protocol here is to let the UM know. The UM went into the room. I did not do anything else because it was not my resident. I left the room . During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, .the staff will identify interventions related to the resident ' s specific risk and causes to try to prevent the resident from falling and try to minimize complications from falling .