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	07/10/2024

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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45718 Based on observation, interview, and record review, the facility failed to protect 2 of 6 sampled residents (Resident 2 and Resident 4) from abuse when: 1. Resident 1 pulled Resident 2's walker causing him to fall, and 2. Resident 3 punched Resident 4 on the face during an altercation. These failures resulted in Resident 2 sustaining a right intertrochanteric fracture (broken hip bone) and underwent hip arthroplasty (a surgery to replace the broken hip bone with an artificial implant) and Resident 4 had the potential to experience physical injury and emotional distress. Findings: 1.A review of Resident 1's admission record indicated he was admitted to the facility summer of 2024 with multiple diagnoses that included Dementia with agitation (impaired ability to remember, think, or make decisions). A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 6/20/24, indicated, he had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). His behavior assessment section indicated he exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred every 1 to 3 days. A review of Resident 1's care plan indicated, [Resident 1] has potential to demonstrate physical behaviors r/t [related to] Anger, Dementia, History of harm to others .Date Initiated: 06/21/2024 .will not harm self or others .Interventions included .Monitor/document report to MD [Medical Doctor] of danger to self and others . When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress . A review of Resident 2's admission record indicated he was admitted to the facility spring of 2024 with multiple diagnoses that included Alzheimer's Disease (a brain disorder that affects memory, thinking, and behavior). (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 - Actual harm Residents Affected - Few	A review of Resident 2's MDS dated [DATE], indicated, he had severe cognitive impairment. His functional status indicated Resident 2 had no limitation in range of motion on both upper and lower extremities. His MDS Significant Change in Status Assessment (post fall) dated 7/8/24, indicated he had developed a limitation in range of motion on his lower extremity. A review of Resident 2's Progress notes, dated 6/29/2024, indicated, While trying to enter the facility from the smoking area, pt [patient, Resident 1] and [Resident 2] were having a verbal disagreement then pt was aggressive towards [Resident 2]. pt pulled [Resident 2's] walker and caused him to fall on his back. [Resident 2] has skin tear on right elbow and pain on hip . A review of Resident 2's Nurse's notes, dated 6/29/2024, indicated, [name] radiology dept [department] could not give a eta [estimated time of arrival] when the x-rays will be done as no tech has been assigned at this time. Will transport to [name of hospital] . A review of Resident 2's Nurse's notes, dated 6/30/2024, indicated, [Hospital's name] called for an update resident admitted with rt [right] femur fx [fracture]. A review of Resident 2's Physician History and Physical, dated, 7/5/2024 indicated, Patient lives at a facility apparently per staff report patient had altercation with another resident took the patient's walker and pushed into the ground patient landed on his back did not strike his head. In the ED [emergency department] x-rays revealing right intertrochanteric fracture underwent R hip arthroplasty on 7/1/24 . During a concurrent observation and interview on 7/10/24 at 12:36 p.m., Resident 2 was sitting on his wheelchair, eating lunch by the nurse's station. He stated he could not remember the incident and he could not remember why he was admitted to the hospital. He stated, he should go back to bed because his hip was hurting. During a concurrent observation and interview on 7/10/24 at 12:40 p.m., the Certified Nursing Assistant (CNA 1) stated Resident 1 was recently transferred to the behavior room where residents were monitored every 15 minutes. He stated, Resident 1 was in station 2 as he liked to walk around. CNA 1 was observed going to station 2 to look for Resident 1. Resident 1 was then seen coming in the door in station 2 from the backyard alone. CNA 1 pointed to where Resident 1 was and proceeded to going back to the behavior room. Resident 1 walked to his room and talked about his wife but at times was unable to maintain meaningful conversation. Resident 1 stated he could not remember the incident. During an interview on 7/10/24 at 1:28 p.m., the Licensed Nurse (LN1) stated, she was at the nurses' station when she heard screaming and argument between Resident 1 and Resident 2. Resident 2 was in his room and Resident 1 was coming in the door from the smoking patio. Resident 1 was standing in front of Resident 2 when Resident 1 pulled Resident 2's walker. Resident 1 picked Resident 2's walker and was about to hit him on his head and by that time, LN 1 stated, she ran towards them and stopped him. Resident 2 lost balance and fell . LN 1 stated, Resident 2 was on the floor, bleeding from right elbow and he was saying his leg hurt. LN 1 stated Resident 1 had behaviors, sometimes he could walk around quietly then suddenly if something upsets him, he will punch you. She further stated, Resident 1 gets aggressive at times; he would punch without saying anything. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/10/24 at 3:57 p.m., the LN 2 stated, Resident 2 was standing on the doorway of his room when Resident 1 pushed the walker into him causing him to fall. LN 2 stated, she did not think he was trying to take Resident 2's walker. She stated, Resident 1 was upset, and he pushed Resident 2. LN 2 stated, it was just that one push and Resident 2 fell and by that time the staff were able to separate the residents. The LN 2 further stated, she has not seen Resident 1 being physically aggressive, but his son informed them that can be physically aggressive. She stated, they monitor both residents for behaviors that they noticed during the shift. She stated, we keep an eye on everyone not just these two residents. During a telephone interview on 7/12/24 at 1:09 p.m., the Director of Nursing (DON) stated, Resident 1 and Resident 2 were having a verbal disagreement in the hallway when Resident 1 pulled Resident 2's walker away from him that caused Resident 2's fall and he had a broken femur where he needed surgery for the fracture. The DON stated Resident 1 had behaviors and he had a care plan for the behavior. She also stated, Resident 1 had a monitoring for aggression but was not on every 15 minutes monitoring. The DON further stated, we try to monitor them [the residents] closely but sometimes it [altercations] can't be avoided. She stated, she expected the residents to be monitored closely to avoid these altercations from happening and if there was a care plan, she expected the staff to follow the care plan. 2. A review of Resident 3's admission record indicated, he was admitted to the facility winter of 2023 with multiple diagnoses that included Dementia, unspecified severity, without behavioral disturbance, mood disturbance and anxiety. His MDS, dated [DATE], indicated he had moderate cognitive impairment. A review of Resident 4's admission record indicated he was admitted to the facility summer of 2024 with multiple diagnoses that included Dementia, unspecified severity, with other behavioral disturbance. His MDS dated [DATE] indicated he had severe cognitive impairment. His behavior assessment indicated he exhibited both physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days. A review of Resident 4's care plan indicated the following: [Resident 4] has potential to demonstrate verbally aggressive behaviors r/t Dementia .Date Initiated: 04/30/2024 .[Resident 4] will not harm self or others through the review date interventions included: Monitor and Document observed behavior and attempted interventions in chart. When [Resident 4] becomes agitated: Intervene before agitation escalates; Guide away from source of distress . [Resident 4] has potential to demonstrate physical behaviors r/t [related to] Dementia .Date Initiated: 04/30/2024 .[Resident 4] will not harm self or others through the review date. Date Initiated: 04/30/2024, interventions included: When [Resident 4] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation. A review of Resident 4's Nurse's notes, dated 7/9/24, indicated, Resident had a Peer to peer physical alteration [sic] with roommate. Staff heard yelling coming from the resident's room Get out of here and another No you get out of here. When the staff arrived to the room, they found the resident and roommate in front of each other and both had their hands up in the air toward each other . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 7/10/24 at 12:11 p.m., Resident 4 was sleeping on his bed when a CNA came in to wake him up to ask him if he wanted to eat lunch. Resident 4 woke up and stated he wanted to eat lunch. Resident 4 then sat on his bed. He had a beard and mustache. When asked about the incident with his previous roommate, he stated, He hit me and he pointed on the right side of his face. He stated he could not remember the reason, but he punched me, I don ' t remember why .he's not here in the room now . There was no redness observed on his face. During a concurrent observation and interview on 7/10/24 at 12:30 p.m., Resident 3 was standing by his bed. Resident 3 stated, he was trying to open the cupboard and his previous roommate said it was his. Resident 3 stated, I told him it's mine, he swore at me, and he said f**** you .I punched him on the face .Yeah, I hit him on the right side of his face .He said f*** you .I ' m telling you that the clothes is mine. So I, told him the clothes is mine .I punched him right on his face .He had a beard .His face is scary. Resident 3 further stated, he was aggressive to me, he told me this is not yours; this is mine (referring to his clothes) . During an interview on 7/10/24 at 1:41 p.m., the LN 3 stated the Director of Staff Development (DSD) was the one who heard the screaming and saw both Residents in the room with both resident's arms up in front of each other looking like it's a striking pose. The LN stated, Resident 3 stated Resident 4 told him to get out of his room and that was when he punched Resident 4 on his face. During an interview on 7/10/24 at 2:00 p.m., the DSD stated she was in the hallway talking to one of the residents when she heard shouting, get out of here, the other resident was saying no, you get out of here, it was loud and shouting. The DSD then ran into the room and both residents were in the position trying to hit each other, there was a space in between them, and she stood in front of them. The DSD stated she told them to stop but they continued to try to hit each other, she then shouted for help. The DSD further stated, Resident 4 told her Resident 3 hit him but could not point exactly where he was hit. During a telephone interview on 7/12/24 at 1:09 p.m., the DON stated, both residents had behaviors. Resident 3 was territorial and aggressive and the same thing with Resident 4 who also had verbal aggression. The incident was not witnessed it was after they heard the commotion then they tried to stop the incident, and nobody witnessed how it happened. The DON further stated, she expected the staff to monitor residents closely to avoid these altercations from happening. If there was a care plan she expected the staff to follow it. A review of Facility policy titled, Resident-to-Resident Altercations, revised September 2022, indicated, 1. Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents . A review of Facility policy titled, Resident Rights, revised February 2021, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect . A review of Facility policy titled, Abuse Prevention Program, revised August 2006, Our residents have the right to be free from abuse .Our facility is committed to protecting our residents from abuse by anyone including .other residents .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 36681 Based on observation, interview, and record review, the facility failed to ensure the fluid intake for one of 8 sampled residents (Resident 8) was accurately monitored and communicated to the physician. This failure increased the potential for Resident 8 to experience signs of fluid overload (too much fluid in the body) such as swelling of the feet and weight gain. Findings: A review of the Admission Record indicated Resident 8 was admitted in 12/2023 with diagnoses including dementia (progressive decline affecting how a person thinks, behave and perform everyday tasks) with behavioral disturbance and chronic congestive heart failure (a heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). A review of Resident 8's physician's orders indicated the following: - Fluid Restriction 2000 ml [milliliters, unit of measurement] or 2 liters per 24 hours [per day] dated 3/8/24; and - Fluid Restriction 1000 ml (1 Liter) per day dated 4/13/24. A review of Resident 8's electronic Medication Administration Record (eMAR) indicated the following fluid intake: - The eMAR for April indicated Resident 8 consumed over 1 liter of fluids for 5 out of 7 days and there was no documented fluid intake from 4/21 to 4/30/24; - The eMAR for May indicated Resident 8 consumed over 1 liter of fluids for 21 days and he consumed less than 1 liter for 9 days; -The eMAR for June indicated Resident 8 consumed over 1 liter of fluids for 21 days and he consumed less than 1 liter for 7 days; -The eMAR for July indicated Resident 8 consumed over 1 liter of fluids for 12 days and he consumed less than 1 liter for 17 days; and -The eMAR for August indicated Resident 8 consumed over 1 liter of fluids for 4 days from 8/1 to 8/7. There was no documented evidence the physician was informed of Resident 8's noncompliance with the fluid restriction order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/8/24 at 2 p.m., Resident 8 was sitting in the middle of his bed inside his room. Resident 8 had small plastic cups filled with yellow and pink colored liquid at bedside. Resident 8 stated he gained 4 pounds in one day due to the swelling on his right leg. In a follow-up observation and interview on 8/8/24 at 2:55 p.m., Resident 8 was lying in bed with both legs elevated. Resident 8 had five small cups filled with light pink and yellow liquid, 1/3 cup of water, and an unopened 500 ml bottle of soda at bedside. Resident 8 stated he did not drink much and he drunk 4 cups (480 ml) the whole day. In an interview on 8/8/24 at 3:03 p.m., the Certified Nursing Assistant (CNA) stated she had been assigned to Resident 8 for over a month. The CNA further stated Resident 8 was able to ambulate and get water from the nurses station. The CNA confirmed one small cup was equivalent to 120 ml and CNA provided 3 cups of 120 ml (360 ml) plus the water or milk at dinner. The CNA added she was not told by the licensed nurse how much fluids Resident 8 should take on her shift. In an interview on 8/8/24 starting at 3:31 p.m., the Licensed Nurse (LN) confirmed Resident 8 was on fluid restriction. The LN further confirmed there were 2 orders for fluid restriction and the kitchen provided 2 liters of fluids for Resident 8. The LN stated Resident 8 was non-compliant with his fluid restriction and was able to get water from other sources such as the bathroom or from his roommates. The LN stated Resident 8 had no fluid restriction care plan and he was not monitored for his noncompliance with the restricted amount. In an interview on 8/8/24 at 4:10 p.m., the Director of Nursing (DON) confirmed Resident 8 had 2 orders for fluid restriction. The DON stated she clarified with the Registered Dietitian (RD) and the RD told her it was 2 liters per day. The DON further stated she did not know where Resident 8's fluid restriction order of 1000 ml came from. In a telephone interview on 8/14/24 at 10:16 a.m., the DON stated her expectation was for the licensed staff to clarify with the physician if there were 2 orders for fluid restriction. The DON further stated the licensed staff should follow the physician's order and if the resident is non-compliant, the physician should be notified. The DON confirmed there was no documented evidence Resident 8's fluid restriction order was clarified and the physician notified of his noncompliance with fluid restriction. A review of the facility's policy & procedure (P & P) revised October 2010 and titled, Encouraging and Restricting Fluids indicated, The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids . Verify that there is a physician's order for this procedure . Follow specific instructions concerning fluid intake or restrictions . When resident has been placed on restricted fluids, remove the water pitcher and cup from the room. If the resident refuses to have the water pitcher removed, notify the supervisor and in turn, the physician. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P & P revised March 2022, and titled, Care Plans, Comprehensive Person-Centered, indicated, . The comprehensive, person-centered care plan: . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical . well-being . services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.