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	08/01/2024

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 - 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. 48445 Based on interview, and record review, the facility failed to protect one of six sampled residents (Resident 2) from abuse when the hospitality aide [HA] got upset and slapped Resident 2 on the cheek repeatedly. This failure had the potential to cause injury, fear and distress to Resident 2. Findings: During a review of Resident 2's admission record, Resident 2 was admitted in September 2023 with diagnoses that included dementia (loss of thinking, remembering, and reasoning skills), depression (persistent feeling of sadness and loss of interest), muscle weakness, lack of coordination, and need for assistance with personal care. Resident 2's Minimum Data Set (MDS, an assessment tool) indicated Resident 2 had severe cognitive impairment, exhibited physical and other behavioral symptoms not directed toward others, and required supervision or touch cueing assistance while eating. During a review of Resident 2's care plan initiated on 11/30/23, the care plan indicated, The resident is/has potential to be physically aggressive amongst peers r/t Anger, Dementia, Depression, poor impulse control. The care plan further indicated, When resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. During a review of a facility submitted document titled REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE [SOC 341], dated 7/31/24, the document indicated, It was alleged that a hospitality aide was rough with a patient .The hospitality Aide has been suspended pending the completion of the investigation. During an interview on 8/1/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated, It was reported to me by a CNA [Certified Nursing Assistant], saw the [HA] .repeatedly slapping the resident. The DON stated the HA was trying to help Resident 2 in eating and the HA told the DON that he was having a bad day, so the HA slapped the resident but not repeatedly. The DON further stated, Expectation for staff is to keep residents safe .those actions were not acceptable. Not acceptable at all. (continued on next page)

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 - Few	During a telephone interview on 8/2/24 at 10:54 a.m. with Licensed Nurse 2 (LN 2), LN 2 stated, [Resident 2] had a tendency of being restless, hitting staff, smashing the arm rest of wheelchair .The CNA told me she heard noise several times and then [CNA] opened the door to take a look and said [CNA] saw [HA] hitting the resident. During a telephone interview on 8/2/24 at 1 p.m. with the HA, the HA stated, What happened was I was about to feed [Resident 2], I was a little bit upset trying to get the food in, she was holding the spoon and gripping onto it, I was trying to tug it away. I got her finger out of it, that made me upset, my hand kind of grazed her .I kind of just reacted. When I grabbed the spoon back, the food went onto me, and I got upset. Honestly, I shouldn't have done that. The HA confirmed he touched Resident 2's cheek and stated, It was more like a tap, like how you tap a toddler .I reacted in a really bad way .I honestly should not have done it and should have left the room. During a telephone interview on 8/2/24 at 2:08 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, Never ever do those things .You can't hit someone .As human, you can't do that. During a telephone interview on 8/2/24 at 3:07 p.m. with the Administrator, the Administrator stated, as he was leaving the facility, he saw HA leaving and HA said he was not doing very well, just had an outburst and got kind of rough. The Administrator further stated HA said he had a terrible day and had a bunch of things happen and that he was rough with the resident. During a review of the facility's policy and procedure (P&P) titled, ALLEGED ABUSE AND ELDER JUSTICE ACT, revised 7/2011, the P&P indicated, It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source and misappropriation of resident property . PREVENTION .B. The Administrator and Director of Nursing (DON) shall identify, intervene and correct in situations in which abuse, neglect, or misappropriation of resident property is more likely to occur.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48445 Based on interview and record review, the facility failed to ensure the comprehensive care plan was implemented and monitored for effectiveness for one of six sampled residents (Resident 1) when there was no documented evidence Resident 1's hip protectors were applied as directed by the care plan to minimize the impact of falls. This failure decreased the facility's potential to minimize the serious consequences of falls for the resident. Additionally, Resident 1 had a witnessed fall and sustained a hip fracture. Findings: During a review of Resident 1's admission records, Resident 1 was admitted in [DATE] with diagnoses that included Dementia (loss of thinking, remembering, and reasoning skills), protein calorie malnutrition (reduced availability of nutrients that leads to changes in body composition and function), and unsteadiness on feet. Resident 1's Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had severe cognitive impairment. During a review of Resident 1's progress notes dated [DATE], the notes indicated, Resident had unwitnessed fall with injury full thickness lacerction [sic, a laceration is a deep cut] 3.0 by 0.5cm [centimeters, a unit of measurement] on left side of forehead .res [resident] was wandering room to room [NAME] [sic] a staff member heard nose [sic] and entered the room found res sitting on floor near bed. During a review of Resident 1's care plan initiated on [DATE], the care plan indicated, The resident has had an actual fall with minor injury; 3cm x 5 cm laceration to left forehead Poor balance, poor communication/comprehension, unsteady gait, noncompliant to therapy, poor safety awareness . Interventions .Hip protectors as per resident allows . During a review of Resident 1's Interdisciplinary Team (IDT) Notes dated [DATE], the notes indicated, Resident had unwitnessed fall was sitting on the floor near left side of bed with skin injury .Behavior pattern .: poor safety awareness, ambulates till exhaustion .current intervention(s): hip protectors as per resident allows. During a review of Resident 1's progress notes dated [DATE], the notes indicated, Resident had a witnessed fall .witnessed by CNA No head injury c/o [complaint of] rt [right] hip pain, no shortening or rotation, guarding rt hip . During a review of Resident 1's IDT Notes dated [DATE], the notes indicated, Resident had witnessed fall was on the floor .on [DATE] @ 06:21 pm [afternoon] .Resident status prior to event .was wandering around . Preventive measures prior to event (From Care Plan): Na [not applicable] .Resident was sent out to [name of hospital] on [DATE] and got report from RP [responsible party] stated resident has a rt hip fracture and they are electing to have her placed on hospice comfort care with no surgery. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's hospital discharge summary dated [DATE], the summary indicated, Assessment: Patient presents with a fall and imaging shows findings consistent with a right femoral neck fracture (a break in bone that happens one to two inches [a unit of measurement] from the hip joint) . During a review of Resident 1's progress notes dated [DATE], the notes indicated, Called to pronounce: [DATE] 20:00 [8 p.m.]. Resident does not arouse to verbal or tactile stimuli. No heart sounds, absent carotid pulse, absent spontaneous breathing. No breath sounds. Pupils fixed and dilated and nonreactive to light . During a review of Resident 1's discharge summary dated [DATE], the summary indicated, .Her health was stable until she sustained a fall and resultant femoral neck of the hip fracture .She died several days later .as a direct result of complications from her hip fracture, that her demise was expected and not suspicious in nature .DEATH CERTIFICATE INFORMATION: .Immediate Cause of Death: femoral neck fracture. During a concurrent interview and record review on [DATE] at 3:46 p.m. with the Director of Nursing (DON), the DON stated, No orders for hip protector, no need for order, hopefully the CNAs are aware. I usually put it under the tasks to see if it is being done or applied. With this case, I'm not sure if it was applied, not sure if she was wearing one at the time of the incident. It can lessen the injury .I'm going to document everything, if the resident is wearing it, that's my expectation from the nurses .No documentation if the hip protector intervention was implemented .Nobody documented that they applied the hip protector. During a telephone interview on [DATE] at 11:34 a.m. with Licensed Nurse 1 (LN 1), LN 1 stated, I have not seen hip protectors yet. When asked if the facility have it, LN 1 stated, I don't think so. During a telephone interview on [DATE] at 2:08 p.m. with the Assistant Director of Nursing (ADON), the ADON confirmed hip protectors was in the care plan and stated, They didn't document that thing if resident didn't allow hip protector .It should be documented .Expectation is to document if the hip protector was in place .But it wasn't added in the tasks so I can't blame the staff. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised ,d+[DATE], the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . During a review of the facility's P&P titled Falls and Fall Risk, Managing, revised ,d+[DATE], the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .Resident-Centered Approaches to Managing Falls and Fall Risk .7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. [example given] hip padding .as applicable) to try to minimize serious consequences of falling.