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	09/13/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 43247 Based on observation, interview, and record review, the facility failed to provide care to maintain vision for one of 37 sampled residents (Resident 143), when Resident 143 was not sent to the hospital for an acute onset vision loss. This failure had the potential to cause deterioration of vision leading to increased fall risk and greater loss of independence. Findings: A review of Resident 143's Admission Record indicated Resident 143 was admitted to the facility in January 2024 with multiple diagnoses including dementia (loss of memory, problem solving, and thinking abilities), malignant neoplasm of endometrium (cancer in the lining of the uterus), and diabetes (too much sugar in the blood). A review of Resident 143's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 7/29/24, indicated Resident 143 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 2 out of 15 that indicated Resident 143 was severely cognitively impaired. A review of Resident 143's SBAR [Situation, Background, Assessment, Recommendation] Communication Form [document used to communicate change in condition] dated 7/27/24 at 4 p.m., indicated .Vision problem .Increased confusion or disorientation .Needs more assistance with ADLs [Activities of Daily Living] . The res [resident] has more confusion than usual today. While she was walking in the hallway, she could not see what was in front of her and she could hit on it. The nurse assessed her vision by let her count the fingers, but she was unable to focus and she was watching somewhere else and talking something those [sic] does not make sense . A review of Resident 143's Progress Note, dated 7/27/24 at 5:40 p.m., indicated .The res [resident] has more confusion than usual today. While she was walking in the hallway, she could not see what was in front of her and she could hit on it. The nurse assessed her vision by let her count the fingers, but was unable to focus and she was unable to follow the direction .[Name of physician] notified . A review of Resident 143's Progress Note, dated 7/27/24 at 8:15 p.m., indicated .[Name of physician] called with new orders .If the condition is getting worse send the PT [patient] to [name of hospital] . (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

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	09/13/2024

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 143's Progress Note, dated 7/30/24, indicated .On monitoring for visual problem .still has difficulty of vision but can identify objects in front and side by side in short distance . A review of Resident 143's Progress Note, dated 8/2/24, indicated .Per [Name of Nurse Practitioner] .Refer resident to optometrist for vision consult . A review of Resident 143's Progress Note, dated 8/13/24, indicated .the ophthalmologist diagnosed pt having retinal detachment with giant tear, bilateral, the res is referred to retina specialist, the decision for surgery is left to retina specialist and RP [Responsible Party] . A review of Resident 143's Progress Note, dated 8/19/24, indicated .pt [patient] is back from surgery consultant appointment .pt has total retinal detachment with macular hole in both eyes . A review of the facility's Doctor Summary Sheet, for facility optometry group, dated 2/12/24, did not indicate any recommendations or ophthalmology referral needed for Resident 143. A review of Resident 143's Optometry Department Referral for Services/ Recommendations, dated 8/8/24, indicated .Staff members report significant change in visual function since last exam 6 months ago only remarkable finding was cataract ou [cloudy lens in both eyes] .Referral to in-house ophthalmologist . A review of Resident 143's ophthalmology Examination, dated 8/13/24, indicated .Retinal detachment with giant retinal tear, bilateral OU .Assessment: Complete detachment ou, pt has difficulty reporting time of onset . During a telephone interview on 9/9/24 at 12:20 p.m. with Resident 143's Responsible Party (RP), the RP stated around the end of July 2024, Resident 143 was not able to see. The RP stated she asked the facility to send Resident 143 to the hospital, but they did not send her. The RP stated Resident 143 had an optometry appointment on 8/8/24 and ophthalmology appointment on 8/13/24. The RP stated Resident 143 had bilateral detached retinas and macular holes. During a telephone interview on 9/9/24 at 12:36 p.m. with Resident 143's Family Member (FM), the FM stated the head nurse told him, on 7/27/24, she was not sure if Resident 143 could see. The FM stated the nurse stated, Not sure what happened. Called doctor. Pretty sure she didn't have a stroke. Ordered some tests. The FM stated he observed Resident 143 shuffling her feet. The FM stated the week prior she was walking as usual and could see. During an interview on 9/11/24 at 3:33 p.m. with Resident 143, asked if she had any eye problems. Resident 143 stated it is worse when she is moving around. During an interview on 9/11/24 at 3:38 p.m. with Licensed Nurse (LN) 1, LN 1 stated on 7/27/24 Resident 143's vision worsened. LN 1 stated neuro (neurological) checks were done due to vision loss. LN 1 stated Resident 143 had check up with ophthalmologist, but not sure what assessment showed. During an interview on 9/11/24 at 4:12 p.m. with LN 6, LN 6 stated Resident 143's family reported vision loss. LN 6 stated Resident 143 had a Change in Condition on 7/27/24 and the physician ordered labs. LN 6 stated that Resident 143 has retinal detachments due to diabetes and medical history. (continued on next page)

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 09/13/2024

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

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 9/12/24 at 1:11 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated that family reported Resident 143's vision was worse. The DON stated that she did not know if vision loss was sudden or not and did not think she was having a stroke. The DON stated Resident 143 has diabetes and may have had chronic eye problems related to diabetes. The physician was notified and optometry appointment was scheduled. The ADM stated Resident 143 was not sent to the hospital because the vision loss was chronic. During a telephone interview on 9/12/24 at 1:30 p.m. with the Medical Doctor (DR), the DR stated Resident 143 had change in her vision, but due to her dementia was not sure what that complaint meant. The DR stated that Resident 143's diabetes was well controlled and did not have significant retinopathy (abnormal blood vessels in the retina of the eye that can cause vision problems). The DR stated Resident 143 had blurry vision and her confusion was up and down so there was concern for stroke or retinal issues. The DR stated labs were ordered and Resident 143 was monitored. The DR stated if there is concern for TIA (transient ischemic attack-brief blockage of blood flow to the brain) or acute vision loss, should send out right away. The DR stated in Resident 143's case not able to determine, due to dementia, if it was acute vision loss or blurry vision, but if acute vision loss, that is an emergency and should be sent to hospital for retinal tear detachment. The DR stated Resident 143's RP was contacted and asked if she wanted to watch and wait or send her out and was okay with monitoring that day. During a telephone interview on 9/12/24 at 1:51 p.m. with LN 7, LN 7 stated on 7/27/24 Resident 143 seemed like she could not see and was more confused. LN 7 stated that Resident 143 could not see her fingers when held up. LN 7 stated Resident 143's family member was present and stated that Resident 143 could not see. LN 7 stated she wanted to send Resident 143 to the hospital. LN 7 stated she called the DR and the DR called back with lab orders. LN 7 stated she could not send out without MD order. LN 7 stated she asked the RP if she wanted to send Resident 143 to the hospital. LN 7 stated she told RP, If you want to send her out, will send her right away. LN 7 stated the RP said it was up to the doctor. During a telephone interview on 9/12/24 at 2:50 p.m. with Nurse Practioner (NP), the NP stated he was notified of Resident 1's vision loss by phone and saw Resident 143 later that day. The NP stated he did not know if the vision loss was acute, but did not think she needed to be sent to the acute care hospital. The NP stated Resident 143 was referred to ophthalmology but it took a long time to get an appointment. A review of the facility's Policy and Procedure (P&P) titled Change in a Resident's Condition or Status, revised 2/21, indicated .The nurse will notify the resident's attending physician or physician on call when there has been a (an): .significant change in the resident's physical/emotional/mental condition .need to transfer the resident to a hospital treatment center .A significant change of condition is a major decline or improvement in the resident's status that: .will not normally resolve itself without intervention by staff . ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument .