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	01/02/2025

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. 38834 Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 1) from abuse, when Licensed Nurse 1 (LN 1) hit resident in the face causing face abrasions. This failure resulted in Resident 1 experiencing unnecessary pain, fear, and mental anguish and had the potential to cause further psychosocial harm to the resident. Findings: A review of the Admission Record indicated the facility admitted Resident 1 in 2017 with multiple diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety, and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/24/24, indicated a BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 7, which indicated that the resident had a moderately impaired cognition. A review of the ' Altered Behavior ' care plan initiated 5/28/23 indicated Resident 1 had behaviors with potential for verbal and physical aggression. One of the care plan interventions directed staff to observe the resident for clinical indicators that may lead to increase in aggressive behaviors, such as infection or pain and to maintain a calm, slow, understandable approach with the resident. A review of Resident 1 ' s ' Non-compliance with nursing care ' care plan dated 5/28/23 directed nursing to Respect resident rights to refuse treatment/medication/care [and] if refusing care .leave resident and return later to reoffer. A review of the Resident 1 ' s clinical records contained an ' Alert Charting, ' nursing progress notes, dated 2/5/24 at 5:30 p.m., which indicated, Notified by CNA [Certified Nursing Assistant] that patient [Resident 1] has abrasion on right side of her face. Writer found the resident crying in her room .first aid was provided . administered Tylenol for possible pain. (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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Interdisciplinary Team Meeting (IDT, a group of healthcare disciplines who discuss resident care needs) note dated 2/6/24, at 10:31 a.m., indicated, Resident noted with abrasion to her right side of face on 2/2/24 at 1530 [3:30 p.m.] .Was in dining room .Resident was physically and verbally aggressive and resistive with staff [LN 1] while receiving medication, tried to hit staff [LN 1] and staff [LN 1] retaliated back which caused abrasion to her [Resident 1 ' s] face. A review of the ' Psychosocial Note,' written by social services staff, dated 2/7/24, at 7:14 a.m., indicated, Resident came .crying, and repeatedly stating I got attacked by a nurse. The details of the alleged incident was not clearly understood due to resident constantly crying .Throughout the resident sharing the encounter, she cried profusely. Resident had to be re-focused several times. During an interview with CNA 1 on 1/2/25, at 2:50 p.m., CNA 1 stated she was in the dining room when the abuse incident happened. CNA 1 stated, I heard very loud commotion and then the screams followed. I saw a nurse [LN 1] standing next to [Resident 1] .sitting in wheelchair. The resident had several bracelets on her wrist. I saw the nurse pulled the bracelets off and the next thing I hear the resident screams, the nurse hit me, the nurse hit me. CNA 1 recalled seeing scratches on resident ' s face, all across her face. During a telephone interview on 1/3/25, at 10:15 a.m., CNA 2 stated she witnessed the incident on 2/5/24 in the dining room. CNA 2 stated that LN 1 attempted to administer medications to Resident 1 and the resident said, no. CNA 2 stated LN 1 insisted on giving the pills and the resident became agitated and pushed the nurse away. The nurse did the same- she pushed the resident . I saw her hand on resident ' s face . Then I looked back, I saw resident ' s face was scratched and some blood was sipping. CNA 1 stated the resident was screaming loudly that the nurse hit her. During an interview and a concurrent record review on 1/2/25, at 1:50 p.m., the Administrator (ADM) confirmed the abuse incident and added that it was witnessed. The ADM stated that nearly all of the facility residents have behavioral issues and the staff had been trained how to deescalate situations when residents get agitated and aggressive. The ADM validated that LN 1's behavior was unacceptable which led to her termination. A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2001, indicated, Residents have the right to be free from abuse .This includes but is not limited to freedom from . verbal, mental or physical abuse .The resident abuse, neglect and exploitation prevention program consists of facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse .Develop and implement policies and protocols to prevent .abuse or mistreatment of residents . Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems .Implement measures to address factors that may lead to abusive situation .Instruct staff regarding appropriate ways to address .conflicts .