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	07/29/2025

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. (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	Based on interviews and record review, the facility failed to protect one of four (4) sampled residents' (Resident 1) right to be free from physical abuse when a facility staff member pushed Resident 1 on his face causing him to fall on the ground. This failure resulted in an emergency hospital transfer of Resident 1 for further evaluation.Findings:Resident 1 was admitted to the facility in July of 2025 with diagnoses which included symptoms affecting memory, cognition, social abilities and muscle weakness. A review of Resident 1's Order Summary Report (ORS) indicated, Resident [Resident 1] does not have the capacity to make his/her decisions.A review of Resident 1's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 7/24/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment.A review of Resident 1's Care Plan (CP), dated 7/25/25, indicated, Resident [Resident 1] involved in an accident where they became physically aggressive toward staff during care, striking staff in the face. Staff reaction allegedly resulted in resident falling.A review of Resident 1's Progress Notes (PN), dated 7/25/25, indicated, The Change in Condition/s reported on this CIC [Change in Condition] Evaluation are/were; Altered Mental Status Falls.Resident [Resident 1] was observed walking in the hallway noted restlessness. Noted exhibited physical aggressive behavior toward staff. Upon resident agitation toward staff, Resident fall to the floor.noted none [sic] responsive verbally, unable to move hands and foot, unable to open eye at his baseline.A review of Resident 1's PN, dated 7/25/25, indicated, Alert Charting.Resident [Resident 1] was not responding per his baseline.911 called. Resident [Resident 1] sent to [hospital name] for further evaluation.A review of Resident 1's PN dated 7/25/25, indicated, IDT summary of event and investigation.the CNA [Certified Nursing Assistant 1] was redirecting the patient [Resident 1] back to their room. The patient [Resident 1] became agitated and punched the CNA [CNA 1] in the face. The CNA [CNA 1] pushed the resident [Resident 1] to the ground.sent to [hospital's name] for further evaluation.During an interview on 7/29/25 at 12:07 p.m., with the Director of Staff Development (DSD), the DSD stated that physical abuse could be committed by both residents and staff and it included actions such as pushing, punching, biting, and kicking. The DSD further stated that staff must avoid these behaviors and confirmed that CNA 1's actions towards Resident 1 were a form of physical abuse, compromising patient safety.During an interview with the License Nurse (LN) 1 on 7/30/25 at 1:15 p.m., LN 1 stated, I saw the resident turn around and hit the CNA in the face. Then the CNA grabbed the resident by the face and pushed the resident, and both fell on the ground. LN 1 further stated, We did not see if he hit his head or not, but it was a hard fall, there was a loud impact. LN 1 also stated that Resident 1 was not responding during her assessment. LN 1 also stated, 911 could not find anything wrong with him, but he was not waking up.During an interview with the Director of Nursing (DON) on 7/29/25 at 11:26 a.m., the DON stated, I expect the staff to follow the abuse policy. Staff should treat them with kindness, patience, approached and redirect them with respect. The DON stated that CNA 1 had received an abuse training and stated, (CNA 1) should have known how to deal with residents with dementia. The DON confirmed that CNA 1 did not follow both the abuse training and the facility's abuse policy, thereby placing Resident 1's safety at risk.Review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/21 indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse.Protect residents from abuse.facility staff.Establish and maintain a culture of compassion for all residents and particularly those with behavioral, cognitive, and emotional problems.