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	09/26/2025

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 - 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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse by Resident 2 for one of three sampled residents (Resident 1) when Resident 2, who had a history of verbal threats struck Resident 1 in the face.This failure resulted in Resident 2 striking Resident 1 causing lacerations to Resident 1's eyebrow, nose and cheek, caused pain, and had the potential for Resident 1 to experience emotional distress.Findings:A review of the admission Record indicated the facility admitted Resident 1 in May 2025 with multiple diagnoses which included dementia (a progressive state of decline in mental abilities).A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/11/25 indicated the resident was cognitively impaired (decline in mental ability).A review of Resident 1's care plan addressing cognitive impairment dated 9/25/25 indicated that resident had decreased ability to make self-understood and understand others and impaired decision making. The nursing measures directed staff to anticipate Resident 1's needs and meet them promptly.A review of Resident 1's care plan titled Injury, dated 9/10/25 indicated the resident had injury to his face as evidenced by lacerations to right eyebrow, abrasion with swelling on nose bridge area and discoloration on right periorbital area [tissues surrounding eye] with swelling d/t [due to] alleged abuse.During an observation in the presence of Licensed Nurse (LN 1) on 9/25/25, at 12:15 p.m., Resident 1 was sitting in wheelchair in the dining room getting ready to eat his lunch. Resident 1 was observed with swollen nose, dry scab on the bridge of the nose and on his right eyebrow. Resident 1's nose area and right periorbital (eye area) had large fading yellow-purplish bruises. During an interview on 9/25/25 at 12:15 p.m., Resident 1 was asked what happened to his face and the resident was not able to provide any details. Resident 1 was asked if he had a fall and injured himself or he obtained the injury when someone hit him, and the resident was not able to explain what happened.A review of Resident 1's clinical records contained a document titled, SBAR Summary for Providers [Situation, Background, Assessment, and Recommendation, a communication form] dated 9/10/25, at 9:47 a.m., informing resident's physician that the resident experienced a change in condition (COC) on 9/10/25 at 10 a.m. The COC document indicated, At approximately 09:30 [9:30 a.m.], resident reported to staff that another male individual allegedly struck him. Resident stated, he hit me because he said I was making noise, but I wasn't. The document indicated that Resident 1 had laceration [a tear or rip in the skin] on his right eyebrow measuring 2 cm (centimeters, unit of measurement) in width, 3 cm in length, and 0.5 cm deep, laceration[to his nose 2 cm wide and 3 cm long, and laceration to cheek 1 cm wide and 2 cm long. The note indicated, Resident c/o [complained of] pain [sic] the bridge nose. The COC note indicated that the resident was sent to emergency department to be evaluated per physician order.A review of Resident 2's admission record indicated the facility admitted him in the spring of 2025 with multiple diagnoses including dementia, anxiety and depression.A review of Resident 2's MDS dated [DATE] indicated the resident was cognitively impaired. The MDS indicated that Resident 2 had behaviors of verbally threatening, screaming, and/or cursing at others, and had physical behaviors of pushing and hitting others. A review of Resident 2's care plan dated 3/4/25 indicated that resident had potential to demonstrate physical behaviors (can strike or hit) and verbal behaviors (by stating I will punch you r/t [related to] anger, dementia, depression, history of harm to others, poor impulse control. The care plan goal indicated, Will not harm self or others. The 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 the nursing progress notes (NPN) indicated that Resident 2 had multiple episodes of aggressive behaviors toward Resident 1 who was his roommate.The NPN dated 8/3/25 at 12:36 p.m., indicated, Patient [Resident 2] is being really aggressive towards the roommates. He [Resident 2] told him [Resident 1] to get out of my property otherwise you will be responsible for consciences [sic].The NPN dated 8/4/25 at 8:42 a.m., indicated, Patient [Resident 2] exhibiting aggressive behavior with staff and roommates. The NPN dated 8/11/25 at 4 a.m., indicated, .resident was agitated and stated get him [Resident 1] out or I will hurt him.The NPN dated 8/20/25 at 7:59 a.m., and 1:48 p.m., contained communication notes to physician indicating that Resident 2 was 'Verbally aggressive and attempting to be physically aggressive towards roommate.pt [Patient, Resident 2] attempting to kick our [sic] roommate from room and cussing at him.Attempted to push roommate out of room and said Get that [expletives] out of here.The NPN dated 9/6/25 at 1:34 p.m., contained communication note informing physician that Resident 2 went to bathroom