

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  03/04/2026
NAME OF PROVIDER OR SUPPLIER  North Pointe Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observation, interview, and record review the facility failed to report injuries of unknown origin (IUO) to the Department as required by the regulations for one of four sampled residents (Resident 1) when Resident 1 was noted with a scald injury (a type of burn injury caused by hot liquids that causes damages to the skin and tissue) to his right hand of unknown origin/cause. This failure resulted in a delay of investigation by the Department. A review of Resident 1's clinical record indicated Resident 1 was admitted in June of 2024 with a diagnosis of Alzheimer's Disease (a progressive irreversible brain disorder that destroys memory and thinking skills over time). A review of Resident 1's MDS (minimum data set - an assessment tool) dated 12/22/25 indicated Resident 1's score was NA indicating no cognition score could be determined. During an observation on 3/4/26 at 11:55 a.m. in the dining room area, Resident 1 was observed sitting up in his wheelchair with a bandage observed on his right hand. A review of Resident 1's physician order dated 2/27/26 indicated, .updated tx (treatment) right dorsal hand Scald injury [sic. Cleanse] . apply bacitracin (type of wound medication ointment) ointment with xeroform cover dry dressing. every day shift for Blister until 03/12/2026. A review of Resident 1's progress notes dated 2/19/26 indicated, . Staff notified this writer of blisters to the right hand . with unknown cause . noted with facial grimacing when touched . A review of Resident 1's IDT skin management note dated, 2/19/26 indicated, right dorsal hand scald injury 8.0 x 6.0 x 0.1 cm . The appearance is consistent with a scald injury. The cause of the injury is presumed as there is no documentation of this. During an interview on 3/4/26 at 12:41 p.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed she was the treatment nurse for the facility. LN 1 confirmed that the wound provider indicated Resident 1's wound was a scald injury. LN 1 confirmed Resident 1 had an injury of unknown cause. During an interview on 3/4/26 at 1:37 p.m. with Director of Nursing (DON), the DON confirmed there was not a witness to the incident that occurred with Resident 1 and Resident 1 did sustain an injury of unknown origin. The DON further confirmed the wound doctor categorized the injury as a scald. During an interview on 3/4/26 at 2:20 p.m. with Administrator (ADM), the ADM confirmed Resident 1's injury was of unknown cause. ADM confirmed he did not report the incident of unknown origin to the department thus delaying department investigation. During a review of facility Policy and Procedure (P&amp;P) titled, . Identifying Types of Abuse. dated September 2025, the P&amp;P indicated, . Physical abuse includes . injuries that are non-accidental or unexplained . During a review of facility P&amp;P titled, . Unusual Occurrence Reporting ., dated December 2025, indicated, . As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety or welfare of our residents, employees or visitors . Our facility will report the following events to appropriate agencies . Allegation of abuse, neglect and misappropriation of resident property . Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations .</p>

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
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