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	03/27/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure the facility was free from abuse for one of six sample residents (Resident 1) when Resident 1 was pushed to the floor by Resident 2.This failure resulted in Resident 1 landing on the floor and experiencing left hip pain.During a review of Resident 1's clinical record, the record indicated Resident 1 was admitted January of 2025 with a diagnosis of Dementia (a decline in thinking, memory, reasoning and ability to make decisions).A review of Resident 1 Minimum Data Set (MDS- an assessment tool) dated 3/3/25 indicated Resident 1 had moderate cognitive impairment.A review of Resident 1's progress note, dated 2/6/25 indicated Resident 3 reported that Resident 1 got pushed by Resident 2. The progress note indicated Resident 1 was laying on his back and when Resident 1 started walking he verbalized his left hip area hurt. The progress note indicated the abuse coordinator was notified. A review of Resident 2's clinical record indicated Resident 2 was admitted [DATE] with a diagnosis of Bipolar Disorder (a mental health condition characterized by extreme, often dramatic shifts in mood, energy, and activity levels).A review of Resident 2's MDS dated [DATE] indicated, Resident 2 had severe cognitive impairment.A review of Resident 2's progress notes titled . change of condition. dated 2/6/25, indicated Resident 3 reported that Resident 2 pushed Resident 1 when he entered their room and Resident 1 .fell to the floor on his back. Staff ran up when they hear loud voices. What they found was [Resident 2] standing in the room and [Resident 1] laying on the floor . on his back. When asked what happened both of the parties were not able to explain. Notified Abuse coordinator MD [Medical Doctor] and RP [Responsible Party] notified. Ombudsman notified.A review of Resident 2's IDT (interdisciplinary team) note dated, 2/7/25, indicated, . Per LN [Licensed Nurse] -2/6/25 @ 1450 [2:50 p.m.] - per [Resident 3] . [Resident 2] pushed [Resident 1] when he entered their room and [Resident 1] fell on the floor . on his back. Notified Abuse coordinator, MD, and RP notified. Ombudsman notified.A review of Resident 3 clinical record indicated, Resident 3 was admitted in January of 2025 with a diagnosis of Multiple fractures of ribs, left side, subsequent encounter of fracture of routine healing.A review of Resident 3's MDS Cognitive Patterns, dated 2/17/25 indicated Resident 3 had moderate cognitive impairment.A review of Resident 3's Social Services notes dated 2/7/25 indicated, Resident 3 reported that she witnessed a peer to peer altercation in her room.During a concurrent interview and record review on 3/27/25 at 1:47 p.m. with Director of Nursing (DON) and Administrator (ADM) present on telephone, the DON confirmed a peer to peer altercation occurred on 2/6/25 between Resident 1 and Resident 2. The DON and ADM confirmed there was no documented evidence indicating the peer to peer abuse was reported to the Department.During a review of facility's Policy and Procedure (P&P) titled, .types of abuse., dated September 2025, indicated, .Abuse of any kind against residents is prohibited. Abuse toward a resident can occur as. resident to resident abuse.During a review of facility P&P titled, .Abuse, Neglect. dated April 2025, indicated, .Protect residents from abuse. Investigate and report any allegations within timeframes required by federal requirements.

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to report allegations of abuse to the Department as required by the regulations when one of six sample residents (Resident 1) was pushed to the floor by Resident 2.This failure to report allegations of abuse resulted in delay in conducting investigation by the Department. During a review of Resident 1's clinical record, the record indicated Resident 1 was admitted January of 2025 with a diagnosis of Dementia (a decline in thinking, memory, reasoning and ability to make decisions).A review of Resident 1 Minimum Data Set (MDS- an assessment tool) dated 3/3/25 indicated Resident 1 had moderate cognitive impairment (moderate problems with thinking and memory).A review of Resident 1's progress note, dated 2/6/25 indicated, Per Resident 3, Resident 1 got pushed by Resident 2, when he came to a room and out of nowhere Resident 2 pushed Resident 1 to the floor. When staff approached because of screaming, Resident 1 was laying on his back. Resident 1 stated that his left hip area hurts. The abuse coordinator was notified. There was no documentation indicating the department was notified of the abuse incident. A review of Resident 2's clinical record indicated Resident 2 was admitted [DATE] with a diagnosis of Bipolar Disorder (a mental health condition characterized by extreme, often dramatic shifts in mood, energy, and activity levels).A review of Resident 2's MDS dated [DATE] indicated, Resident 2 had severe cognitive impairment (profound decline in mental ability that interferes with daily life).A review of Resident 2's progress notes titled . change of condition. dated 2/6/25, indicated, Resident 2 pushed Resident 1 and Resident 1 fell to the floor on his back. There was no documented evidence indicating the Department was notified of the abuse incident.A review of Resident 2's IDT (interdisciplinary team) note dated, 2/7/25, indicated, . Per LN [Licensed Nurse] -2/6/25 @ 1450 [2:50 p.m.] - per [Resident 3], [Resident 2] pushed [Resident 1] when he entered their room and [Resident 1] fell on the floor in front other on his back. Notified Abuse coordinator, MD [Medical Doctor], and RP [Responsible Party] notified. Ombudsman notified.A review of Resident 3 clinical record indicated, Resident 3 was admitted in January of 2025 with a diagnosis of Multiple fractures of ribs, left side, subsequent encounter of fracture of routine healing.A review of Resident 3's MDS Cognitive Patterns, dated 2/17/25 indicated Resident 3 had moderate cognitive impairment.A review of Resident 3's Social Services notes, dated 2/7/25 indicated, .Resident [Resident 3] reported that she witnessed a peer to peer altercation in her room. Resident verbalized she was uncomfortable at the time and expressed her concerns with a staff member.During a concurrent interview and record review on 3/27/25 at 1:47 p.m. with Director of Nursing (DON) and Administrator (ADM) present on telephone, the DON confirmed a peer to peer altercation occurred on 2/6/25 between Resident 1 and Resident 2. The DON and ADM confirmed there was no documented evidence indicating the peer to peer abuse was reported to the Department.During a review of facility's Policy and Procedure (P&P) titled, .types of abuse., dated September 2025, indicated, .Abuse of any kind against residents is prohibited. Abuse toward a resident can occur as. resident to resident abuse.During a review of facility P&P titled, .Abuse, Neglect. dated April 2025, indicated, .Protect residents from abuse. Investigate and report any allegations within timeframes required by federal requirements.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure facility residents were free from accident and safety hazards when a personal items (one broken pair of glasses, dentures, and hearing aides) cart was left unlocked in the hallway for a total census of 160.This failure had the potential for residents to access the cart without staff supervision. During an observation on 3/27/26 12:40 p.m. in hallway near room [ROOM NUMBER], the Personal Items cart was observed with three nursing staff present. The 3 nursing staff left the cart unlocked.During an observation on 3/27/25 at 12:45 p.m. at the personal items cart, the cart was unlocked and three residents were observed walking by the cart.During a concurrent observation and interview on 3/27/26 at 12:47 p.m. with Certified Nurse Assistant 1 (CNA 1), CNA 1 confirmed that she checked out resident dentures from the personal items cart. CNA 1 confirmed three nursing staff were present at the cart when CNA 1 left the cart after logging her item. CNA 1 confirmed the personal item cart was unlocked and contained items such as a pair of broken glasses, resident dentures, and resident hearing aides with no staff present and was easily accessible to facility residents. CNA 1 stated that the cart should be locked at all times and if a resident were to access the items, they could harm themselves by cutting themselves with the glasses or breaking the dentures, if not supervised appropriately. CNA 1 confirmed the presence of three residents wandering near the personal items cart.During an interview on 3/27/26 at 12 p.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed that all medication and personal item cart should be locked to prevent access to residents. LN 1 confirmed that accessing the personal item cart could result to an accident for residents who wander about the facility.During an interview on 3/27/26 at 1:47 p.m. with Director of Nursing (DON), the DON stated the expectation is for all carts to be locked in the facility. The DON further confirmed that if a resident did access the facility cart items it could have led to an accident resulting in resident harm and it could have led to missing resident items. The DON confirmed that there were missing pages and dates in the personal item log binder and that items were not monitored accurately by staff.During a review of facility P&P titled, .Safety/Supervision. dated July 2019, indicated, .make the environment as free from hazards as possible. Safety risks and environmental hazards are identified on an ongoing basis. and try to prevent avoidable accidents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision of assistive devices.