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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services and implement measures for the prevention of pressure injuries (painful wounds caused as a result of prolonged pressure or friction) for two of 37 sampled resident (Resident 4 and Resident 32), who were at risk for skin injuries when, Resident 4 obtained a skin tear (a traumatic wound of the top layer of skin) from the use of bolster (part of a mattress cover with raised foam edges on each side of the bed to prevent resident from rolling out of bed), did not implement interventions addressing use of bolster, did not document accurate assessments of the wound every shift as indicated by resident's care plan; and Failed to ensure pressure ulcer risk factors were thoroughly assessed, daily skin checks completed as indicated in the care plan, and interventions were implemented to prevent avoidable wound to Resident 32's elbow.These failures contributed to Resident 4's mid back skin tear progressing into deeper wound requiring surgical excision of damaged tissue and in the development of open wound for Resident 32' left elbow that got infected and had the potential for Resident 4 and Resident 32 to experience pain.A review of the admission Record indicated the facility admitted Resident 4 in 2015 with multiple diagnoses, which included metabolic encephalopathy (brain dysfunction, leading to confusion, memory issues, and personality changes), dementia (a progressive state of decline in mental abilities), and functional quadriplegia (a complete inability to move due to severe disability, or frailty caused by advanced dementia or other health conditions).A review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/29/2025, indicated that the resident had severely impaired abilities remembering things, making decisions, concentrating, or learning. The MDS indicated that Resident 4 was non-ambulatory, totally dependent on staff with all activities of daily living (ADLs - activities related to personal care), and incontinent for bowel and bladder. The MDS section for skin conditions indicated the resident was at risk for developing pressure ulcers or injuries but did not have any open wounds. Resident 4's clinical records were reviewed and indicated the following:A Braden Scale (an assessment tool used to assess skin for breakdown and/or pressure injury), dated 10/4/25, indicated a score of 12. The scoring criteria indicated a score of 10-12 placed the resident At High Risk for pressure ulcer development. The scoring indicated that Resident 4 was unable to communicate discomfort and pain and was unable to make frequent and significant changes and control of body position and frequently slid down in bed or chair. The assessment indicated that resident's medical conditions led to almost constant friction [physical force created when person's skin slides against another surface] and shearing (sliding injury when the skin gets pulled during repositioning causing damage to skin, including skin tears and pressure injuries).At risks for skin breakdown care plan, dated 5/27/23, and revised 12/23/25 indicated the goal was for resident to not have skin breakdown. The care plan listed multiple interventions, which included performing daily body assessments, monitoring for any skin injury, and keeping bed clean, dry, and wrinkle-free. There were no interventions addressing Resident 4's risk for skin injuries due to friction and shearing.A nursing weekly summary dated 11/23/25 at 12:46 p.m., indicated resident's skin was pink .no new skin issues were identified.Impaired skin integrity care plan initiated 11/25/25 addressed a skin tear to Resident 4's mid lower back. One of the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	interventions directed nursing to document location, size (length, width, depth), color, surrounding skin, presence/absence of drainage and/or signs of healing. The care plan did not address bolster mattress overlay and did not include interventions related to the bolster, including frequent checking the resident's skin under bolsters and making sure the resident was not lying directly on bolster straps or Velcro.IDT (Interdisciplinary Team, a group of healthcare disciplines who discuss resident care needs) Skin Management note dated 11/26/25 at 11:48 a.m., indicated that Resident 4 had skin tear to her mid lower back measuring 0.8 by 0.8 cm (centimeters, unit of measurement, length and width respectively).A Skin Issues Note by treatment nurse (TN), who was responsible for assessing residents' skin and managing wounds, dated 11/28/25 indicated Resident 4 developed a new wound, described as abrasion [scrapped off by friction to her midback]. The note did not contain description of the abrasion and there were no measurements to compare with initial skin tear developed 3 days prior and as directed by Resident 4's care plan interventions.Resident 4's nursing progress notes indicated that the resident was hospitalized from [DATE] through 12/3/25 related to respiratory issues and shortness of breath.A Skin Issues Note dated 12/3/25 at 11:18 a.m., indicated Resident 4 was readmitted back to facility and the skin tear/abrasion to her midback was classified as pressure ulcer/injury [localized, pressure-related damage to the skin and/or underlying tissue]. The treatment nurse documented pressure injury (PI) was measuring 2 by 2 cm in length and width. The evaluation note did not contain the wound description and color, appearance of surrounding tissue and presence or absence of drainage as directed by resident's care plan.IDT Skin Management note dated 12/4/25 at 11:14 a.m., indicated that Resident 4's mid back pressure injury was measuring 1.7 by 1.6 by 0.5 (length, width, and depth respectively and was covered with slough (yellowish or whitish dead tissue, delaying healing and harboring bacteria).A Surgical Consult note dated 12/4/25 located in resident's clinical records indicated that Resident 4 developed a traumatic injury to her back due to exposure to bolster straps. The Wound Consultant (WC) documented that Resident 4 had to undergo a surgical procedure to remove dead, damaged, or infected tissue to improve wound healing.During an observation in resident's room on 1/6/26 at 10:30 a.m., Resident 4 was in her bed lying on her back. The resident's bed had a low air loss mattress (a specialized therapeutic mattress with internal air cells that constantly circulate a flow of air, commonly used to heal pressure injuries). Resident 4's eyes were opened but the resident did not reply when greeted and did not provide any answers.Resident 4 was observed in her room and was noted to be in the same position lying on her back on 1/6/26 at 12:55 p.m., 1/7/26 at 10:05 a.m. and 12:35 p.m., 1/8/26 at 4:33 p.m., and 1/9/26 at 9:20 a.m.During an observation and interview in Resident 4's room on 1/6/26 at 1:35 p.m., a Certified Nursing Assistant (CNA 11) stated that the resident was dependent on staff for all ADL's (activities of daily living, which included feeding, personal hygiene, turning, and repositioning). CNA 11 stated the resident was always in bed, except during showers. CNA 11 explained that last month Resident 4 developed skin wound to her back. CNA 11 stated the low air loss mattress was initiated a few weeks ago and that prior to that the resident had a bolster mattress overlay.During an observation and interview on 1/8/26 at 8:05 a.m., the TN and WC were observed in Resident 4's room assessing resident's mid back wound. The WC stated she was informed that Resident 4 developed trauma injury from lying on bolster straps. The WC stated that Resident 4 had very limited mobility and was at high risk for developing skin issues. The WC described Resident 4's wound and explained that the resident had a skin tear first, then excoriation, then turned into deeper wound and got worse, wider and deeper.During a concurrent interview and record review on 1/8/26 at 9:35 a.m., skin assessments and wounds management were discussed with the Director of Nursing (DON) and Administrator (ADM). The DON stated that that the expectation was that nurses were to assess and record accurate skin assessments during daily and weekly summaries and during wound dressing changes. The DON added, They [are] supposed to check residents' skin and document any issues.] The DON stated that IDT meeting determined that bolster straps caused skin tear to Resident 4's mid back, which later deteriorated into deeper wound. The DON was asked what resident centered and resident specific (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	interventions to prevent further damage to her skin tear were implemented after the skin tear was identified. The DON explained, Our standard treatment - cleanse, monitor for infection.I am not sure what other interventions at that time. After the DON reviewed Resident 4's wound photo dated 11/28/25, taken three days after the skin tear was identified, the DON acknowledged that the wound looked deeper, round with uneven edges, had exposed subcutaneous (deeper layer of fat tissue), and no longer looked like skin tear. The DON stated that Resident 4's wound to mid back got worse when the resident returned from brief hospitalization when staff compared the wound photos taken before and after hospitalization. The DON acknowledged that Resident 4's skin notes and wound assessment dated [DATE] did not contain wound descriptions and measurements and had inconsistencies in documentation.During a follow up interview on 1/9/26 at 8:35 a.m., a manual guide for bolster mattress overlay was reviewed and discussed with DON. The DON explained that the bolster had 2 straps with Velcro that go across the bed and Resident 4's mid back skin tear was caused by shearing on the bolster straps when she was pulled up in her bed or repositioned. The DON added that the expectation was that the straps and Velcro were covered with drawsheet and residents had to be handled very carefully to prevent skin injuries. The DON stated that Resident 4's mid back wound could have been avoided if nurses and CNAs assessed the position of the bolster straps every time the resident was repositioned and made sure the resident was not lying directly on the straps or Velcro.2. A review of the admission Record indicated the facility admitted Resident 32 in December of 2025 with multiple diagnoses, which included dementia, communication deficit, and muscle weakness.A review of Resident 32's MDS dated [DATE], indicated that the resident had severely impaired cognitive skills, including remembering things, making decisions, and concentrating. The MDS indicated the resident was at risk for developing pressure injuries, but no open skin wound was identified.A review of Resident 32's care plan initiated 12/9/25 indicated that the resident was at risk for skin breakdown. The care plan interventions directed nursing staff to check resident's skin during daily provision of care.A review of the care plan dated 12/10/25 indicated that Resident 32 had decline in ADL's and required one or two staff's assistance with bed mobility, turning, and repositioning.A review of Resident 32's admission skin assessment dated [DATE] indicated that resident had scattered discoloration and scabs (dry hard covering of dried blood that forms over a wound) to both of his arms, small, scattered scabs to his left lower leg and feet, redness to his heels and had no open wounds.A review of Braden Scale dated 12/16/25 and 12/23/25 were incomplete and did not indicate Resident 32's score.A review of Resident 32's care plan initiated 12/28/25 addressed the open wound to his left elbow with the goal to not develop infection. The interventions directed nursing to staff to assess wound each shift for size, depth, tissue type, drainage, odor, and surrounding skin.A review of nursing progress notes (NPN) dated 12/28/25 at 5:33 a.m., indicated Resident 32 was noted to have an approximately 4 by 4 cm full thickness (deeper wound that goes through the top skin layer into fat tissue or muscle) open wound with exposed subcutaneous (deep layer of skin) tissue on left elbow. Unknown cause. No bleeding present.A review of NPN titled, Skin/Wound Note, dated 12/29/25 at 7 a.m., indicated Resident 32 had two open wounds. The wound to his left forearm measured 0.5 cm in length, 1.2 cm wide, and 0.1 cm deep and the wound to resident's left elbow (identified day prior) had serosanguineous drainage (thin pink or red watery fluid).A review of NPN dated 12/30/25 at 11:59 a.m., indicated a physician order to start antibiotic (a medication to treat infections) for Resident 32's left elbow wound infection.A review of Infection Note dated 1/2/26 at 10:42 a.m., indicated that Resident 32 had redness, warmth, tenderness, slight swelling, and purulent [thick, milky or yellowish pus drainage, indicating an infection] drainage.at wound site to left elbow.A review of the Skin Issues Note dated 1/3/26 at 12:30 p.m., indicated that Resident 32's open wound to left elbow was assessed by WC. The wound description indicated it had 80% of slough tissue (yellowish or whitish dead tissue, delaying healing and harboring bacteria), had moderate amount of serosanguineous drainage, was edematous (swollen) and reddened.During an observation on 1/6/26 at 10:05 a.m., in resident's room, Resident 32 was observed lying in his bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 32 opened his eyes when called by name but did not provide any answers.During an observation and interview on 1/8/26 at 9:09 a.m., in resident's room, the TN and WC assessed Resident 32's wound to left elbow. The TN removed old dressing which was saturated with green-yellow drainage and cleaned the wound. The TN stated she was not aware how the resident developed such deep wound to his elbow in less than 2 weeks and stated that the wound was classified by WC as trauma wound. The TN stated that wound had lots of bloody drainage and looked infected a few days prior but has improved since.During an interview and concurrent record review with DON and ADM on 1/8/26 commencing at 9:23 a.m., the DON stated that residents' skin assessments were done by CNA's when they performed personal care and during showers or bed bath and if the new skin issue was noted, they had to report to the nurse. The DON added that the daily and weekly assessments were done by nurses. The DON stated that it was the expectation that nurses included skin assessment, especially if there was new wound identified. The DON stated that conducting a Braden assessment was done upon admission and then weekly for 5 weeks and it was very important that the assessments were accurate.During a continued interview and record review with DON and ADM on 1/8/26 at 9:23 a.m., the DON acknowledged that Resident 32 did not have open skin wounds upon admission. The DON reviewed Resident 32's bathing flowsheets from 12/10/25 through 1/8/26 and validated that no open areas were identified during bathing activity on 12/26, 12/27, and 12/28/25. The DON stated the flowsheet documentation was not accurate. Upon reviewing daily nursing evaluations dated 12/26/25 and 12/27/25 the DON confirmed that the evaluations indicated the skin was clear. The DON stated that when Resident 32's left elbow wound was identified on 12/28/25, it was already deep with subcutaneous tissue exposed and acknowledged that such wound could not develop overnight. The DON stated she was unable to state if the evaluations were done accurately and added, I was not there. The DON stated that nurses were expected to do a thorough skin assessment in order to identify any skin issues. A review of the facility's policy and procedure (P & P) titled, Pressure Injury Risk Assessment, with the last revision date of 3/25, indicated, The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing.When conducting a skin assessment.document the findings.Develop the resident- centered care plan and the interventions based on the risk factors identified in the assessments, the condition of the skin, the residents' overall clinical condition.The care plan must be modified as the condition changes, or if current interventions are deemed inadequate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was labeled, prepared, stored, served, or distributed in accordance with professional standards of food safety when:Kitchen utensils were stored wet in the clean and ready-to-use bin;unlabeled, undated, opened food items were found in kitchen area;metal pans were stacked wet at the clean and ready-to-use area;mislabeled food items were found in resident refrigerator in medication room; andunlabeled, undated food items were found in Resident 90's room.These failures increased the potential for food-borne illnesses among the census of 157 residents.Findings: 1. During the initial kitchen tour on 1/6/26 at 8:20 a.m., accompanied by the Dietary Manager (DM), there was a large bin labeled, Utensils with multiple wet kitchen utensils stored inside. 2a. During the initial kitchen tour on 1/6/26 at 8:25 a.m., an unlabeled container had a food product stored inside. 2b. During the initial kitchen tour on 1/6/26 at 8:30 a.m., a maple syrup container did not have an expiration date. 2c. During the initial kitchen tour on 1/6/26 at 8:40 a.m., two opened pancake mix bags were not labeled with open date. 3. During a follow up visit to the kitchen on 1/6/26 at 3 p.m., multiple large metal pans used for distributing food were stacked wet at the clean and ready-to-use area. During a concurrent observation and interview on 1/6/26 at 3:05 p.m., with the DM, DM confirmed that kitchen utensils were stored wet in the clean and ready-to-use bin, and metal pans were stacked wet in the clean and ready-to-use area. The DM stated the utensils and metal pans should have been properly dried before storing for use due to the potential growth of mold. During an interview on 1/7/26 at 3:24 p.m., with the DM and Registered Dietitian (RD), the DM and RD both confirmed all opened food items should have been clearly labeled with an open date. They further stated that mislabeling could have led to food-borne illnesses among the residents that were served. During an interview on 1/7/26 at 3:35 p.m., with DM and RD, the DM and RD both confirmed the expectation of clean dish storage was to be: washed, sanitized, and properly dried with no moisture prior to storage. Both further confirmed if metal pans and utensils were stored wet; there could be mold growth. A review of the 2022 Federal Food and Drug Administration (FDA) Food Code, under section 4-901.11, titled Equipment and Utensils, Air-Drying Required, indicated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. A review of the facility's undated Policy and Procedure (P&P) titled, Dishwashing, indicated, Dishes are to be air died in racks before stacking and storing. A review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, indicated, .All food (continued on next page)

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	555400	A. Building B. Wing	01/09/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	items in the storeroom, refrigerator, and freezer need to be labeled and dated.Newly opened food items will need to be closed and labeled with an open date and use by date. 4. During a concurrent observation and interview on 1/6/26 in the Medication Storage Room of Nursing Station 2, at 10:12 a.m. with Licensed Nurse 10 (LN 10), a bag containing six sandwiches was observed in the fridge and labeled, . use by 1-5-26. LN 10 confirmed the date on the bag was past the use-by date and stated, . these [sandwiches] should have been removed. During an interview on 1/8/26 at 3:36 p.m. with the Registered Dietitian (RD), the RD stated that staff are to label all resident food items with a use-by date to ensure that residents are not served food that is expired. The RD further stated that her expectation was that food that is past the use-by date is removed from the fridge to . prevent possible food-borne illness. During an interview on 1/9/26 at 10:30 a.m. with the Director of Nursing (DON), the DON stated it was the policy of the facility that food items have a use-by date and that food items are removed by that date. The DON further stated that her expectation is that nurses check the fridge each shift and remove any food items that are past the use-by date to ensure residents do not receive food that was expired. 5. During an observation on 1/6/26 at 10:28 a.m., in Resident 90's room, personal food items were seen at bedside undated and unlabeled. Resident 90 was noted to have a box of personal food items next to her bed including, a box of canned diet soda, multiple individual chocolate pudding containers, one opened bag of potato chips, one opened bag of crackers, a box of individual zero sugar coffee creamers and numerous unopened dry food items. During an interview on 1/6/26, at 10:30 a.m., with Resident 90, Resident 90 stated, she got the food items delivered to her from her daughter who sent them to the facility. Resident 90 stated, the staff did not label the food items with her name or dates. Resident 90 stated, she had a box of cereal taken from her a few weeks ago by another resident and is concerned about other people taking her food from her room. During a concurrent observation and interview on 1/8/26, at 12:40 p.m., with the Director of Nursing (DON) in Resident 90's room, multiple personal food items were observed unlabeled and undated. DON stated, she will alert staff to label and date Resident 90's food, all personal food items need to be labeled and dated with an expiration date, and Resident 90's food items were not labeled or dated. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage dated 2014, the P&P indicated, 13. Food items and snacks kept on the nursing units must be maintained as indicated below: .b. All foods belonging to residents must be labeled with the resident's name, the item and the use by date.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify trauma triggers for six out of 37 sampled residents (Resident 2, Resident 9, Resident 29, Resident 113, Resident 93, and Resident 152) with post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) or identified traumatic events. This failure had the potential for the residents to experience re-traumatization (re-experience/relives a traumatic event or experiences causing similar stress reactions to a new event), and possible increased symptoms such as restlessness, irritability and social withdrawal. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in December 2023 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- death of brain tissue due to blockage of blood supply to the brain), vascular dementia (cognitive decline due to disrupted blood flow to the brain), depressive disorder (mood disorder causing persistent sadness), and PTSD. A review of Resident 2's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 12/8/25, indicated Resident 2 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 11 out of 15 that indicated Resident 2 had moderate cognitive impairment. A review of Resident 2's Physician Diagnosis Verification (PDV), dated 12/11/23, indicated diagnoses including Post- Traumatic Stress Disorder with Attestation .This verifies that all diagnoses listed are currently active in this facility . A review of Resident 2's Social History Assessment (Admission/Annual), dated 12/13/23 and 3/11/24, indicated .Significant Life Events .difficult or stressful things that sometimes happen to people . for Resident 2 that included transportation accident, combat or exposure to a war-zone, life-threatening illness or injury, severe human suffering, and sudden unexpected death of someone close to you. A review of Resident 2's Care Plan . [Resident 2] demonstrated physical behaviors and high risk for recurrence of behavior with staff and others r/t [related to] Anger, History of harm to others, Poor impulse control, hx [history] peer to peer DX [Diagnosis] .POST-TRAUMATIC STRESS DISORDER ., initiated 4/1/25, indicated .Interventions .Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document . A review of Resident 2's Care Plan . [Resident 2] exhibits repeated physical and verbal aggression toward staff and peers, likely due to cognitive impairment, PTSD triggers ., initiated 9/19/25, indicated .Interventions .Monitor for patterns of behavior and identify triggers (e.g., specific staff, time of day, noise) . A review of Resident 2's Care Plan .Trauma-informed Care: [Resident 2] is at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control . related to combat or exposure to a warzone, PTSD ., initiated 10/29/25, indicated .Interventions . Approach in a calm, reassuring manner Offer a quiet place to calm down .Reorient and redirect as necessary . During an interview on 1/8/26 at 3:00 p.m. with the Social Services Director (SSD), the SSD stated the PTSD assessment is included in the Social History Assessment but acknowledged that there was (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no indication in Resident 2's Social History Assessment (Admission/Annual) on 12/13/23 and 3/11/24 of Resident 2's triggers for PTSD. When asked how triggers for PTSD were identified, the SSD stated that trauma is care planned but did not state how triggers were identified. The SSD stated Care Plans indicate to monitor for signs of distress, provide support and reassurance as needed, respond to needs effectively, and react appropriately to calm them down. When asked why Care Plans for Resident 2 for trauma informed care did not start until 2025 when he had been admitted in December 2023 with diagnosis of PTSD, the SSD stated she was not working at the facility at time of his admit but was not aware of any Care Plans addressing trauma informed care prior to 2025. During an interview on 1/9/26 at 9:25 a.m. with Licensed Nurse (LN) 7, LN 7 stated Resident 2 had a diagnosis of PTSD. LN 7 stated in order to know what a resident's triggers may be for PTSD, need to get to know resident. When asked what triggers a resident may have for PTSD, LN 7 stated she would introduce herself, see how they react, and see what behaviors they may have. LN 7 stated if not familiar with the resident LN may check the Care Plan. During an interview on 1/9/26 at 10:57 a.m. with LN 5, LN 5 stated Resident 2 had behaviors including verbal aggression and not taking his medications. LN 5 stated he would check the medical record to determine if a resident had a diagnosis of PTSD. When asked where in the medical record Resident 2's triggers were, LN 5 stated he was not sure where to locate the triggers in the record. A review of the facility's Policy and Procedure (P&P) titled Trauma Informed Care, revised 3/19, indicated .To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma . Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization .Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers .Implement universal screening of residents for trauma . As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools . A review of the facility's P&P titled Social Assessment, revised 7/14, indicated . A social assessment will be done to help identify the resident's personal and social situation, needs and problems . A review of the admission Record indicated the facility admitted Resident 9 in the summer of 2025 with multiple diagnoses which included dementia (a progressive state of decline in mental abilities) and chronic (persisting for a long time) post-traumatic stress disorder (PTSD). A review of Physician Diagnosis Verification dated 8/11/25 contained Resident 9's diagnosis of PTSD. The physician documented the following, I verify that above medical diagnoses are active and have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatment, nursing monitoring, or risk of death. A review of Resident 9's 'Trauma-Informed Care' care plan indicated the resident was At risk for decreased psychosocial well-being.emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental.social, or spiritual wellbeing related to combat or exposure to a warzone. The interventions included approach resident in a calm, reassuring manner, encourage relaxation techniques, encourage resident to verbalize feelings. The care plan did not contain any triggers or identified behaviors that might be indicators of Resident 9's traumatic events related to combat or warzone. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 9's admission Resident Centered Social History and Discharge Planning Assessment, dated 8/15/25 conducted by the SSD, indicated that the resident was veteran. The section #7 of the assessment titled Significant Life Events/Trauma History, listed 17 difficult or stressful events that sometime happen to people. The document directed staff who conducted the assessment to choose the event from the provided list that might indicate what trauma the resident had experienced. The list contained, .j. Combat or exposure to warzone.k. Captivity. (held hostage, prisoner of war) .m. Severe human suffering. and none of these were checked. The checkmark at the end of assessment indicated, None of the above reported or are known to have occurred. During an interview on 1/8/26 at 3 p.m. with the SSD, the SSD stated she was responsible for conducting residents' social history assessments, including trauma assessment. During an interview on 1/9/26 at 9:17 a.m. with LN 2, LN 2 stated Resident 9 had issues with behaviors, including verbal aggression and refusals of care. LN 2 reviewed Resident 9's clinical record and acknowledged that the resident had a diagnosis of PTSD. When asked where Resident 9's PTSD triggers were documented, LN 2 did not provide the answer. During a concurrent interview and record review with the SSD on 1/9/26 at 12:33 p.m., the SSD was asked to describe the process for identifying the triggers for the residents that have diagnoses of PTSD and had experienced traumatic life events. The SSD stated that the assessment for traumatic events and PTSD was included in the Social History and Discharge Planning Assessment completed upon admission. The SSD reviewed Resident 9's 'Trauma-Informed Care' care plan and stated that Resident 9 was a veteran had experienced combat or warzone. The SSD stated that care plan did not specify any behaviors that Resident 9 might have experienced as a result of combat or warzone and did not identify any triggers related to PTSD. The SSD reviewed Resident Centered Social History and Discharge Planning Assessment, dated 8/15/25 and acknowledged that Resident 9's experience in 'Combat or exposure to warzone' was not marked and the resident's assessment was not completed accurately. A review of Resident 29's admission Record indicated Resident 29 was admitted to the facility in November of 2025 with multiple diagnoses including Schizophrenia (a mental illness that disrupts thought, perception, and emotion, causing symptoms like hallucinations such as hearing or seeing things that are not there), Bipolar disorder (a mental illness causing extreme mood swings) and major depressive disorder (mood disorder causing persistent sadness). A review of Resident 29's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 11/20/25, indicated Resident 29 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 12 out of 15 that indicated Resident 29 had moderate cognitive impairment. A review of Resident 29's Social History Assessment, dated 11/17/25, indicated in . SIGNIFICANT LIFE EVENTS/TRAUMA . that Resident 29 had experienced . sudden unexpected death of someone close to you . institutionalized for bipolar and Schizophrenia . Daughter taken away by CPS [Child Protective Services] A review of Resident 29's Care Plan, initiated on 11/17/25, titled Trauma-informed Care indicated . [Resident 29] is At risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control . related to sudden, unexpected death of someone close to you (husband passed away) . was institutionalized for bipolar disorder and schizophrenia . No triggers identified on care plan. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 113's admission Record indicated Resident 113 was admitted to the facility in April of 2025 with multiple diagnoses including Parkinson's (a brain disorder that makes it hard to control movement, causing symptoms like shaking, stiffness, slow movements, and balance problems) and post-traumatic stress disorder (PTSD-mental health condition triggered by experiencing or witnessing a traumatic event causing symptoms that disrupt daily life). A review of Resident 113's MDS, Cognitive Patterns, dated 11/13/25, indicated Resident 113 had BIMS score of 8 out of 15 that indicated Resident 113 had moderate cognitive impairment. A review of Resident 113's Social History Assessment (Admission/Annual), dated 4/30/25, indicated in . Significant Life Events . difficult or stressful things that sometimes happen to people . that he experienced . combat or exposure to a war-zone . A review of Resident 113's Care Plan, initiated on 10/29/25, titled Trauma-informed Care indicated . [Resident 113] is At risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control . related to combat or exposure to a warzone, dx [diagnosis] of PTSD . No triggers identified on care plan. During an interview on 1/8/26 at 3 p.m. with the Social Services Director (SSD), the SSD stated the PTSD assessment is included in the Social History Assessment. When asked how triggers for PTSD are identified, the SSD stated that trauma is put in a care plan. The SSD could not provide a document where triggers for PTSD or trauma was captured. The SSD stated care plans indicate to monitor for signs of distress, provide support and reassurance as needed. During an interview and concurrent record review on 1/9/26 at 9:39 a.m. with the Director of Nursing (DON), the DON stated the PTSD assessment is done by the Social Services Director (SSD). When asked how triggers for PTSD/Trauma are identified, the DON stated that triggers are put in a care plan. The DON further explained that it is the duty of all medical staff to get to know the residents and find out what their triggers are and document it in the care plan. When asked how triggers for PTSD/Trauma are identified, the DON stated that triggers are put in a care plan. The DON verified, in a concurrent record review, that Resident 29 and Resident 113 did not have triggers indicated in either of their care plans. During an interview on 1/9/26 at 9:49 a.m. with Licensed Nurse (LN) 8, LN 8 stated Resident 113 had a diagnosis of PTSD. LN 8 stated that he knew Resident 113 had PTSD but did not know what his triggers were. LN 8 stated that triggers for PTSD/Trauma should be in the care plans. A review of the facility's Policy and Procedure (P&P) titled Trauma Informed Care, revised 3/19, indicated . To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma . Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization . Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers . Implement universal screening of residents for trauma . As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools . A review of the admission Record indicated Resident 93 was admitted to the facility in September 2021 with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and PTSD. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 93' s care plan dated 4/24/25 indicated, Psychosocial-Emotional/Trauma-informed Care: [Resident 93] is at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills .related to [PTSD]. History of Domestic violence with husband many years ago. The care plan did not indicate the trigger(s) for Resident 93's PTSD. A review of Resident 93's Resident Centered Social History and Discharge Planning assessment dated [DATE] signed by the Social Services Director (SSD) indicated [Resident 93] had a very stressful event or experience. The event/trauma was described as history of domestic violence with husband many years ago. The assessment did not include triggers for the stressful event. During an interview on 1/8/26 at 3:01 p.m. with the SSD, the SSD stated she was responsible in conducting the Resident Centered Social History and Discharge Planning Assessment. The SSD confirmed the assessment did not include the triggers for the event/trauma. During a concurrent interview and record review with the Director of Nursing (DON) on 1/9/26 at 9:39 a.m., the DON stated her expectation was for the facility to identify the history of residents with PTSD. The DON further stated the SSD should initiate the assessment, and if staff identified triggers, these triggers should be added to the care plan. The DON confirmed Resident 93's care plan did not indicate the triggers. A review of the Facility Assessment (FA) updated 8/1/25 indicated, the facility provides general care for mental health and behavior. The FA further indicated specific care or practices were provided to Manage the medical conditions . identify and implement interventions to help support individuals with issues such as dealing with .PTSD. A review of Resident 152's clinical record indicated Resident 152 was admitted February of 2025 and had diagnoses that included dementia (memory loss that interferes with daily functions), PTSD, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily lives). A review of Resident 152's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/3/25, indicated Resident 152 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 152 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 152's SOCIAL HISTORY ASSESSMENT, dated 2/7/25, indicated, C. Significant Life Events .10. Combat or exposure to a war-zone (in the military or as a civilian) .Happened to me. The assessment did not indicate the trigger(s) for Resident 152's PTSD. A review of Resident 152's care plan, revised 10/29/25, indicated, Psychosocial- Emotional/Trauma: [Resident 152] is At risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to history of combat or exposure to a warzone, DX [diagnosis] of PTSD. The care plan did not indicate the trigger(s) for Resident 152's PTSD. During a concurrent interview and record review on 1/8/26 at 11:18 a.m. with the Social Services Director (SSD), Resident 152's clinical records were reviewed. The SSD confirmed that there was no (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PTSD trigger(s) identified for Resident 152 in his social history assessment and care plan. The SSD agreed that they would not know what to avoid for Resident 152 not to get re-traumatized if the trigger(s) was not identified. During an interview on 1/8/26 at 3:42 p.m. with Licensed Nurse (LN) 11, LN 11 stated she was the nurse assigned to Resident 152 for the shift and she was not sure if Resident 152 had PTSD diagnosis. LN 11 also stated she had no idea what were Resident 152's trauma trigger(s). LN 11 further stated Resident 152's trauma triggers should have been identified for them to care for him better and prevent him from re-experiencing the traumatic event. During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated the trigger points of residents with PTSD should be identified so they could plan their care properly and prevent re-traumatization. A review of the facility's policy and procedures (P&P) titled, Trauma Informed Care, revised 3/2019, indicated, Resident-Care Strategies .1. As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools.

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 157 when:1. Two facility staff did not wear required personal protective equipment (PPE) when transferring, assisting with personal care, and handling the foley catheter (a tube inserted through the urethra into the bladder to drain urine) for Resident 38 who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use);2. A clean resident's personal items delivery cart had a thick layer of dust on the inside surface;3. Staff did not wear PPE when transferring Resident 32 who was on EBP and when handling the foley catheter; 4. Resident 125's room did not have EBP sign posted outside the room for a resident who had an indwelling urinary catheter. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure to germs, and may cause infection to Resident 38, Resident 32, and Resident 125.1. A review of Resident 38's clinical record indicated Resident 38 was admitted June of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions), neuromuscular dysfunction of bladder (the nerves and muscles in the urinary bladder don't work together properly), obstructive and reflux uropathy (occurs when the urine cannot drain through the urinary tract), retention of urine (caused by a blockage or a failure of the bladder to squeeze hard enough to expel all of the urine), catheter use, and muscle weakness. A review of Resident 38's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/17/25, indicated Resident 38 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 2 out of 15 which indicated Resident 38 had severely impaired cognition. A review of Resident 38's MDS Bladder and Bowel Status, dated 11/17/25, indicated Resident 38 uses indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time). A review of Resident 38's care plan, revised 2/19/25, indicated, Enhanced Barrier Precautions: [Resident 38] requires enhanced barrier precautions during high-contact resident care activities due to the presence of: Indwelling device(s) (urinary catheter) .Utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities (e.g. [for example], dressing .transferring, hygiene .brief changes .device care .). A review of Resident 38's active physician's order, dated 6/4/25, indicated, Indwelling Urinary (Foley) Catheter .related to .NEUROMUSCULAR DYSFUNCTION OF BLADDER .change catheter when dislodge. every 24 hours as needed. A review of Resident 38's active physician's order, dated 9/28/25, indicated, Enhanced barrier precautions every shift for foley catheter. A review of the list of residents on EBP, provided by the Director of Staff Development (DSD), on 1/6/26 at 9:38 a.m. indicated Resident 38 was on EBP due to his foley catheter. During an observation on 1/6/26 at 3:43 p.m. in Resident 38's room, two facility staff were observed changing Resident 38's shirt, placing his briefs on, transferring Resident 38 from the shower chair to his bed, and handling Resident 38's foley catheter while only wearing gloves and not wearing a gown. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After which, the staff went to empty Resident 38's catheter bag into a urinal while only wearing gloves. There was an EBP signage posted outside of Resident 38's room which indicated, STOP .ENHANCE BARRIER PRECAUTIONS .PROVIDERS AND STAFF MUST .Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing .Transferring .Providing Hygiene .Changing briefs .Device care or use: .urinary catheter . During a subsequent interview on 1/6/26 at 3:55 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 confirmed that she and another staff were only wearing gloves when they changed Resident 38's shirt, placed his briefs on, transferred him from the shower chair to his bed, and handled his foley catheter. CNA 3 further confirmed she emptied Resident 38's catheter bag into a urinal while only wearing gloves. CNA 3 stated she was aware that Resident 38 was on EBP and they should have worn gown to prevent possible infection of Resident 38. During a phone interview on 1/8/26 at 1:44 p.m. with the Infection Preventionist (IP), the IP stated that staff should be wearing both gloves and gown when providing high-contact care to a resident who was on EBP to prevent spreading germs and prevent the risk of the resident getting infection. During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that staff should follow EBP and wear both gloves and gown when transferring, assisting with personal care, and handling the foley catheter of a resident who was on EBP. A review of the facility's policies and procedures (P&P) titled, Enhanced Barrier Precautions, revised 12/2025, indicated, 2. Enhanced barrier precautions apply when: .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained .7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .8. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include: a. dressing .c. providing hygiene or grooming; d. changing briefs .e. transferring .i. device care or use (.urinary catheter .) . 2. During an observation on 1/6/26 at 11:57 a.m. at Station 1, a staff was observed delivering clean resident clothes to resident rooms using a cart covered with reddish mesh tarp. The delivery cart was checked, and thick layers of dust were observed on the inside surface of the cart. During a subsequent interview on 1/6/26 at 11:59 a.m. with Laundry Staff (LS), LS confirmed that the delivery cart had thick layers of dust on its inside surface. The LS stated staff cleans the delivery carts daily. The LS further stated the delivery cart should always be clean to prevent contamination of clean resident clothes. During an interview on 1/7/26 at 8:42 a.m. with the Laundry Director (LD), the LD stated staff were supposed to be cleaning the delivery cart before and after they use it. The LD further stated there should not be any dust inside the clean linen carts because if the carts are dirty, it can cause bacteria to grow and get the resident's sick. During a phone interview on 1/8/26 at 1:44 p.m. with the IP, the IP stated laundry staff should always be cleaning the delivery carts after use to prevent the buildup of dust which could cause infection. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/26 at 9:13 a.m. with the DON, the DON stated delivery carts have to be covered and should always be cleaned to prevent contamination of the clean clothes and to prevent infection. A review of the facility's P&P titled, Departmental (Environmental Services) – Laundry and Linen, revised 1/2014, indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen .7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. 3. A review of the admission Record indicated the facility admitted Resident 32 earlier this year with multiple diagnoses, which included dementia, communication deficit, and retention of urine. A review of Resident 32's MDS, dated [DATE], indicated Resident 32 had an indwelling urinary catheter. A review of the clinical records contained a physician order dated 12/15/2025, which indicated, Enhanced Barrier Precautions every shift for Indwelling Catheter. During an observation on 1/6/26 at 12:40 p.m., observed a bright orange signage posted on the wall next to Resident 32's room entrance which indicated, Enhanced Barrier Precautions [EBP] STOP. The signage indicated that everyone must wear gloves and gown for High-Contact Resident Care Activities, including transferring and providing care to urinary catheters. During a continued observation and interview on 1/6/26 at 12:59 p.m., CNA 16 was observed entering Resident 32's room. CNA 16 put gloves on but did not wear isolation gown before assisting Resident 32's transfer from wheelchair to the bed. CNA 16 was observed grabbing the urinary catheter from wheelchair and attaching it to the bed frame. CNA 16 then transferred the resident and rearranged resident's linen and blanket. After the task was completed, CNA 16 was asked what the EBP signage posted outside the room indicated. CNA 16 acknowledged that Resident 32 was on EBP but was not able to explain the reason for precautions. CNA 16 explained, It indicates that we have to sanitize our hands, wear gloves, and isolation gown every time we are providing resident's care. CNA 16 acknowledged that he did not follow the facility's process and did not wear a protective gown. During an interview on 1/9/26 at 9 a.m., the DON stated that it was the expectation for staff to have an isolation gown and gloves every time they have direct contact with resident or residents care equipment for residents who were on EBP precautions, including handling resident's urinary catheter. 4. A review of Resident 125's admission Record indicated Resident 125 was admitted to the facility in September 2025 with multiple diagnoses including dementia (a condition that causes memory loss, also thinking and reasoning decline, that interferes with daily life), obstructive and reflux uropathy (blockage in the urinary tract preventing urine flow), and benign prostatic hyperplasia (enlargement of the prostate gland leading to urinary issues and difficulty emptying the bladder). A review of Resident 125's Minimum Data Set (MDS- federally mandated assessment tool), Bowel and Bladder, dated 9/30/25 indicated Resident 125 had an indwelling urinary catheter. A review of Resident 125's MDS, Bowel and Bladder, dated 12/29/25, indicated Resident 125 had an indwelling urinary catheter. (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 125's orders dated 9/24/25, 10/13/25, 11/25/25, 12/23/25, indicated order for Indwelling Urinary Catheter S/P (Status Post) TURP (Transurethral Resection of the Prostate-surgery to treat an enlarged prostate) and urinary retention (inability to completely empty the bladder). A review of Resident 125's Care Plan, initiated 9/24/25, revised 11/18/25 .Enhanced Barrier Precautions: Resident requires enhanced barrier precautions .due to the presence of indwelling device . (.urinary catheter) not known to be infected or colonized with any MDRO . indicated Interventions . Place EBP notification/signage near resident room doorway to alert staff/visitors of precautions . initiated 11/18/25. During an observation on 1/6/26 at 9:04 a.m., observed Resident 125 in bed asleep with an indwelling catheter bag covered with blue bag. There was no sign at door that indicated EBP were needed in Resident 125's room. During a concurrent observation and interview on 1/6/26 at 10:33 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 confirmed that Resident 125 had an indwelling urinary catheter. CNA 7 confirmed there was no sign at door that indicated EBP and stated was not sure that EBP were needed. During an interview on 1/6/26 at 10:40 a.m. with Licensed Nurse (LN) 6, LN 6 acknowledged that Resident 125 had an indwelling urinary catheter and did not have EBP sign at door. LN 6 stated Resident 125 should be on EBP due to indwelling urinary catheter and should have had sign at door. LN 6 stated that there is a risk of spreading infection if there was no sign at door to indicate EBP needed. During an interview on 1/8/26 at 11:16 a.m. with the Director of Nursing (DON), the DON stated if resident had indwelling urinary catheter should be on EBP and had to have signage at the door indicating EBP needed. A review of the facility's Policy and Procedure (P&P) titled Enhanced Barrier Precautions, revised 12/25, indicated . Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDRO) to residents .Enhanced barrier precautions apply when: .A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to covered or contained .Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies .Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE [Personal Protective Equipment] required .

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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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 protect one out of 37 sampled residents' (Resident 42) right to be free from elderly financial abuse by a family member/legal representative when Resident 42 experienced financial abuse by her sister who was also her conservator (a court-appointed individual who manages the financial and/or personal affairs for someone unable to do so themselves).This failure resulted in Resident 42 experiencing financial abuse, and possible serious psychosocial harm.Findings:A review of Resident 42's clinical record indicated Resident 42 was admitted May of 2023 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), dementia (memory loss that interferes with daily functions), and need for assistance with personal care.A review of Resident 42's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/24/25, indicated Resident 42 was rarely/never understood.A review of the complaint letter forwarded by the Department of Justice, dated 7/23/25, indicated, [Resident 42] is currently residing at [name of the facility] .She was previously conserved by [resident 42's sister]. [Resident 42] was admitted to SNF [Skilled Nursing Facility] in May 2023. [Resident 42's sister] has not paid the share-of-cost of the facility since March 2024. Sutter County Public Conservator's office was able to access bank records which show [Resident 42's sister] withdrawing [Resident 42]'s full monthly income (minus $25/month for bank fees) .During a concurrent interview and record review on 1/7/26 at 10:12 a.m. with the Business Office Assistant (BOA), Resident 42's records were reviewed. The BOA confirmed that Resident 42's sister/responsible person (RP) has not paid Resident 42's share of cost (SOC- a specific monthly dollar amount some people must pay for healthcare services before Medi-Cal starts paying) from the time it started generating. The BOA explained that usually, the RP will send a check to the facility to pay the resident's share of cost. The BOA also stated she remembers calling Resident 42's sister every week or every other week, but she would not respond at all. The BOA stated she suspected Resident 42 was getting financially abused and that was when she told the Social Services Director (SSD) that Resident 42's sister was not returning their calls and had not paid Resident 42's share of cost for months.During a concurrent interview and record review on 1/7/26 at 10:22 a.m. with the Business Office Manager (BOM), Resident 42's records were reviewed. The BOM confirmed that Resident 42's sister was the conservator upon her admission to the facility. The BOM also confirmed that Resident 42's share of cost had not been paid since March of 2024. The BOM stated she believed the conservator would handle the resident's money. The BOM also stated she reached out to the SSD on 4/22/25 through their internal communication system regarding their suspected financial abuse of Resident 42. The BOM explained that when they suspect financial abuse, they reach out to social services department first and they will be the ones to report the suspicion. A review of the internal communication message sent by the BOM on 4/22/25 at 8:42 a.m. to the SSD indicated, I [BOM] was wondering if you [SSD] can do a financial abuse [report] for patients [Resident 42] .please.During an interview on 1/7/26 at 11:14 a.m. with the SSD, the SSD stated Resident 42's sister was originally her conservator and they could not reach Resident 42's sister for some time, so she reached out to the Sutter County's Public Guardian's Office about the issue on 1/30/25. The SSD further stated she did not suspect financial abuse at that time because all she knew was they could not contact Resident 42's sister and she had some remaining balances.A review of Resident 42's Social Service Note, dated 1/30/25, indicated, Writer [SSD] called Sutter County Public Guardians office (530) [PHONE NUMBER] and spoke with [Sutter County Public Guardians office staff] .Writer explained to him that writer has a resident within the SNF who is under a probate conservatorship through sutter county with a family member as the conservator, however we have not been able to reach the family (continued on next page)

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	555400	A. Building B. Wing	01/09/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member in some time, and writer would like to know if a referral would be appropriate in this instance .He [Sutter County Public Guardians office staff] stated that he was in court recently and the judge brought up residents [Resident 42] case as a referral for public guardians office, so they are actually already going to be starting the process of investigating and preparing to petition to transfer the conservatorship from resident's sister to the sutter county public guardians office .A review of the facility's transaction report indicated Resident 42 had an unpaid share of cost total of $15,594 from March 2024 to January 2025.During an interview on 1/8/26 at 10:46 a.m. with the Administrator (ADM), the ADM stated that reaching out to the Sutter County's Public Guardian's Office regarding Resident 42's case was enough action on their part. The ADM further stated he was made aware about Resident 42's issue before the SSD reached out to the Sutter County's Public Guardian's Office but could not remember the exact date when.During an interview on 1/8/26 at 11:05 a.m. with the ADM, the ADM agreed that it was a red flag when Resident 42's conservator was not answering calls and was not paying Resident 42's share of cost for months. The ADM stated there was no evidence of fiduciary [elderly financial] abuse that was why they did not report Resident 42's issue. The ADM also stated that when they reached out to the Public Guardian's Office regarding Resident 42's case, they were told it was a case were they would normally change the conservatorship. The ADM further stated the facility's policy was to protect all residents from any form of abuse including financial abuse. During a concurrent interview and record review on 1/8/26 at 12:46 p.m. with the ADM, Resident 42's records were reviewed. The ADM confirmed that Resident 42 started generating share of cost in March of 2024 and Resident 42's conservator did not pay any of it. The ADM stated that they tried to call Resident 42's conservator multiple times but could not reach her. The ADM further stated they received a letter on 5/15/25 from the Public Guardian's office which indicated that Resident 42's conservatorship was changed from her sister to the Public Guardian's Office and the facility started getting paid for Resident 42's share of cost in August of 2025.A review of the facility's transaction report indicated Resident 42 had an unpaid share of cost total of $21,412 from March 2024 to May 2025.During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that all residents in their facility should be free from any form of abuse.During a phone interview on 1/14/26 at 2:39 p.m. with an Adult Protective Services Supervisor (APSS), the APSS stated they received a referral from Sutter County Public Conservator's office about Resident 42's change of conservatorship. The APSS further stated that after Sutter County Public Conservator's office gained access to Resident 42's account, they had found fraudulent activities (intentional deception or unethical acts to gain an unauthorized benefit like money) in Resident 42's account. A review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2025, indicated, Residents have the right to be free from abuse .The resident abuse, neglect and exploitation prevention program consists of a facility -wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse .by anyone including, but not necessarily limited to: .f. family members; g. legal representatives .

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	555400	A. Building B. Wing	01/09/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from physical restraints (physical devices, or equipment that restricted resident movement or ability to get out of bed including bed rails) for one of 37 sampled residents (Resident 149), when the facility did not:Obtain a physician's order for the use of bed rails; 2. Obtain approval from resident or resident's representative (RP) for the use of bed rails; 3. Conduct bed rail assessment prior to placing the quarter side rails and, 4. Develop a care plan to mitigate the risks for entrapment (being caught in or trapped).These failures placed Resident 149 at increased risk for complications of restraint use such as decline in functioning and potential to cause physical harm from entrapment. Findings:A review of Resident 149's admission Record indicated the facility admitted Resident 149 in 2023 with multiple diagnoses, which included Alzheimer's disease (disease characterized by a progressive decline in mental abilities), muscle weakness, and lack of coordination.A review of Resident 149's Order Summary Report contained physician order dated 8/15/25 which indicated Resident 149 was not capable of understanding rights and responsibilities.A review of Resident 149's clinical records contained a Bed Rail and Entrapment Risk Observation/Assessment, dated 5/16/25. The document indicated that bed rails were not currently in use and were not considered to be used. The medical conditions for the use of the bed rails which included the resident's physical mobility limitations, and safety concerns were blank.A review of Resident 149's Order Summary Report did not contain physician order for the use of bilateral bed rails.A review of Resident 149's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/10/25, indicated that the facility did not use any physical restraints, including bed rails while the resident was in bed or in chair.During an observation on 1/6/26 at 9:05 a.m., Resident 149 was observed sleeping in bed with both upper bed rails up. During an observation on 1/8/26 at 10:33 a.m., Resident 149 was observed sleeping in bed with both upper side rails up.During an interview on 1/9/26 at 8:40 a.m., the Director of Nursing (DON) stated that the facility utilized bed side rails to assist with mobility for some residents. The DON explained that prior to using bed side rails, nursing staff were to obtain physician's order for bed rails, obtain consent from resident or resident's RP while explaining the risks for using bed rails, and conduct screening for the safe use of bed side rails.During a concurrent observation and interview in Resident 149's room on 1/9/26 at 8:50 a.m., Resident 149 was sleeping in his bed. The DON validated that the resident had bilateral upper side rails up padded with blue cushioned pads. The DON explained the facility used bed side rails because Resident 149 was impulsive and was at high risk for falls.During a follow up interview and record review on 1/9/26 at 8:50 a.m., the DON stated there should be a physician's order and consent when the facility started using the bilateral side rails for Resident 149, but there was none. The DON acknowledged that no documented consent from Resident 149's RP for the use of bilateral side rails were found in the resident's clinical records. The DON explained that that bed side rail assessment dated [DATE] was not completed because the assessment indicated that no bed side rails were planned to be utilized. The DON stated there was no care plan with resident specific interventions addressing bed side rails developed. The DON stated that without proper documentation in place, the bed side rails were considered as physical restraints.A review of the facility's policy and procedure (P & P) titled, Physical Restraint Application, with revision date of 10/25, indicated, The purpose of this procedure is to provide safety.to the resident to prevent injury.when the resident has medical symptoms that warrant the use of restraints. The P&P explained that any device that has the effect on the resident of restricting freedom of movement.could be considered a restraint. The P&P indicated the process and directed staff to verify physician's order for the use of restraints and review the resident's care plan to assess for any special needs of the resident.

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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 implement policies and procedures (P&P) for ensuring the reporting of a reasonable suspicion of abuse in accordance with section 1150B of the Act for one out of 37 sampled residents (Resident 42) when Resident 42 was suspected for elderly financial abuse by her conservator (a court-appointed individual who manages the financial and/or personal affairs for someone unable to do so themselves) and was not reported to the state agency, local ombudsman, adult protective services, and law enforcement officials.This failure resulted in a delayed investigation of the suspicion of Resident 42's financial abuse and placed Resident 42 at risk of experiencing further financial abuse, and possible serious psychosocial harm.Findings:A review of Resident 42's clinical record indicated Resident 42 was admitted May of 2023 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), dementia (memory loss that interferes with daily functions), and need for assistance with personal care.A review of Resident 42's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/24/25, indicated Resident 42 was rarely/never understood.A review of the complaint letter forwarded by the Department of Justice, dated 7/23/25, indicated, [Resident 42] is currently residing at [name of the facility] .She was previously conserved by [resident 42's sister]. [Resident 42] was admitted to SNF [Skilled Nursing Facility] in May 2023. [Resident 42's sister] has not paid the share-of-cost of the facility since March 2024. Sutter County Public Conservator's office was able to access bank records which show [Resident 42's sister] withdrawing [Resident 42]'s full monthly income (minus $25/month for bank fees) .During a concurrent interview and record review on 1/7/26 at 10:12 a.m. with the Business Office Assistant (BOA), Resident 42's records were reviewed. The BOA confirmed that Resident 42's sister/responsible person (RP) has not paid Resident 42's share of cost (SOC- a specific monthly dollar amount some people must pay for healthcare services before Medi-Cal starts paying) from the time it started generating. The BOA explained that usually, the RP will send a check to the facility to pay the resident's share of cost. The BOA also stated she remembers calling Resident 42's sister every week or every other week, but she would not respond at all. The BOA stated she suspected Resident 42 was getting financially abused and that was when she told the Social Services Director (SSD) that Resident 42's sister was not returning their calls and had not paid Resident 42's share of cost for months.During a concurrent interview and record review on 1/7/26 at 10:22 a.m. with the Business Office Manager (BOM), Resident 42's records were reviewed. The BOM confirmed that Resident 42's sister was the conservator upon her admission to the facility. The BOM also confirmed that Resident 42's share of cost had not been paid since March of 2024. The BOM stated she believed the conservator would handle the resident's money. The BOM also stated she reached out to the SSD on 4/22/25 through their internal communication system regarding their suspected financial abuse of Resident 42. The BOM explained that when they suspect financial abuse, they reach out to social services department first and they will be the ones to report the suspicion. A review of the internal communication message sent by the BOM on 4/22/25 at 8:42 a.m. to the SSD indicated, I [BOM] was wondering if you [SSD] can do a financial abuse [report] for patients [Resident 42] .please.During an interview on 1/7/26 at 11:14 a.m. with the SSD, the SSD stated Resident 42's sister was originally her conservator and they could not reach Resident 42's sister for some time, so she reached out to the Sutter County's Public Guardian's Office about the issue on 1/30/25. The SSD also stated she did not suspect financial abuse at that time because all she knew was they could not contact Resident 42's sister and she had some remaining balances. The SSD explained that if there was suspicion of financial abuse, they would report it to Adult Protective Services, California Department of Public Health, and to the Ombudsman. The SSD confirmed there (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no report made regarding Resident 42's case.A review of Resident 42's Social Service Note, dated 1/30/25, indicated, Writer [SSD] called Sutter County Public Guardians office (530) [PHONE NUMBER] and spoke with [Sutter County Public Guardians office staff] .Writer explained to him that writer has a resident within the SNF who is under a probate conservatorship through sutter county with a family member as the conservator, however we have not been able to reach the family member in some time, and writer would like to know if a referral would be appropriate in this instance .He [Sutter County Public Guardians office staff] stated that he was in court recently and the judge brought up residents [Resident 42] case as a referral for public guardians office, so they are actually already going to be starting the process of investigating and preparing to petition to transfer the conservatorship from resident's sister to the sutter county public guardians office .During an interview on 1/8/26 at 10:46 a.m. with the Administrator (ADM), the ADM stated their process, if there was a suspicion of any form of abuse was, he would get notified first, then they would report the suspicion, and they would do their own investigation. The ADM also stated that reaching out to the Sutter County's Public Guardian's Office regarding Resident 42's case was enough action on their part. The ADM further stated he was made aware about Resident 42's issue before the SSD reached out to the Sutter County's Public Guardian's Office but could not remember the exact date when.During an interview on 1/8/26 at 11:05 a.m. with the ADM, the ADM agreed that it was a red flag when Resident 42's conservator was not answering calls and was not paying Resident 42's share of cost for months. The ADM stated there was no evidence of fiduciary [elderly financial] abuse that was why they did not report Resident 42's issue. The ADM further stated the facility's policy was to report all suspicion of any form of resident abuse including financial abuse. During a concurrent interview and record review on 1/8/26 at 12:46 p.m. with the ADM, Resident 42's records were reviewed. The ADM confirmed that Resident 42 started generating share of cost in March of 2024 and Resident 42's conservator did not pay any of it. The ADM stated that they tried to call Resident 42's conservator multiple times but could not reach her. The ADM further stated they received a letter on 5/15/25 from the Public Guardian's office which indicated that Resident 42's conservatorship was changed from her sister to the Public Guardian's Office and the facility started getting paid for Resident 42's share of cost in August of 2025.During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that all suspicion of resident abuse should all be reported for it to be investigated thoroughly.A review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2025, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .Reporting Allegations to the Administrator and Authorities .1. If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman .d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials .4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures (P&P) for ensuring the reporting of a reasonable suspicion of abuse in accordance with section 1150B of the Act for one out of 37 sampled residents (Resident 42) when Resident 42 was suspected for elderly financial abuse by her conservator (a court-appointed individual who manages the financial and/or personal affairs for someone unable to do so themselves) and was not investigated.This failure resulted in Resident 42 experiencing further financial abuse, and possible serious psychosocial harm.Findings:A review of Resident 42's clinical record indicated Resident 42 was admitted May of 2023 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), dementia (memory loss that interferes with daily functions), and need for assistance with personal care.A review of Resident 42's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/24/25, indicated Resident 42 was rarely/never understood.A review of the complaint letter forwarded by the Department of Justice, dated 7/23/25, indicated, [Resident 42] is currently residing at North Pointe Care Center .She was previously conserved by [resident 42's sister]. [Resident 42] was admitted to SNF [Skilled Nursing Facility] in May 2023. [Resident 42's sister] has not paid the share-of-cost of the facility since March 2024. Sutter County Public Conservator's office was able to access bank records which show [Resident 42's sister] withdrawing [Resident 42]'s full monthly income (minus $25/month for bank fees) .During a concurrent interview and record review on 1/7/26 at 10:12 a.m. with the Business Office Assistant (BOA), Resident 42's records were reviewed. The BOA confirmed that Resident 42's sister/responsible person (RP) had not paid Resident 42's share of cost (SOC- a specific monthly dollar amount some people must pay for healthcare services before Medi-Cal starts paying) from the time it started generating. The BOA explained that usually, the RP will send a check to the facility to pay the resident's share of cost. The BOA also stated she remembers calling Resident 42's sister every week or every other week, but she would not respond at all. The BOA stated she suspected Resident 42 was getting financially abused and that was when she told the Social Services Director (SSD) that Resident 42's sister was not returning any of their calls and had not paid Resident 42's share of cost for months already.During a concurrent interview and record review on 1/7/26 at 10:22 a.m. with the Business Office Manager (BOM), Resident 42's records were reviewed. The BOM confirmed that Resident 42's sister was the conservator upon her admission to the facility. The BOM also confirmed that Resident 42's share of cost had not been paid since March of 2024. The BOM stated she believed the conservator would handle the resident's money. The BOM also stated she reached out to the SSD on 4/22/25 through their internal communication system regarding their suspected financial abuse of Resident 42. The BOM explained that when they suspect financial abuse, they reach out to social services department first and they will be the ones who would report the suspicion. A review of the internal communication message sent by the BOM on 4/22/25 at 8:42 a.m. to the SSD indicated, I [BOM] was wondering if you [SSD] can do a financial abuse [report] for patients [Resident 42] .please.During an interview on 1/7/26 at 11:14 a.m. with the SSD, the SSD stated Resident 42's sister was originally her conservator and they could not reach Resident 42's sister for some time, so she reached out to the Sutter County's Public Guardian's Office about the issue on 1/30/25. The SSD also stated she did not suspect financial abuse at that time because all she knew was they could not contact Resident 42's sister and she had some remaining balances. The SSD explained that if there was suspicion of financial abuse, they would report it to Adult Protective Services, California Department of Public Health, and to the Ombudsman, then it would be investigated. The SSD confirmed there was no investigation done regarding Resident 42's case.A review of Resident 42's Social Service Note, dated 1/30/25, indicated, Writer [SSD] called Sutter (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	County Public Guardians office (530) [PHONE NUMBER] and spoke with [Sutter County Public Guardians office staff] .Writer explained to him that writer has a resident within the SNF who is under a probate conservatorship through sutter county with a family member as the conservator, however we have not been able to reach the family member in some time, and writer would like to know if a referral would be appropriate in this instance .He [Sutter County Public Guardians office staff] stated that he was in court recently and the judge brought up residents [Resident 42] case as a referral for public guardians office, so they are actually already going to be starting the process of investigating and preparing to petition to transfer the conservatorship from resident's sister to the sutter county public guardians office .During an interview on 1/8/26 at 10:46 a.m. with the Administrator (ADM), the ADM stated their process, if there was a suspicion of any form of abuse was, he would get notified first, then they would report the suspicion, and they would do their own investigation. The ADM also stated that reaching out to the Sutter County's Public Guardian's Office regarding Resident 42's case was enough action on their part. The ADM further stated he was made aware about Resident 42's issue before the SSD reached out to the Sutter County's Public Guardian's Office but could not remember the exact date when.During an interview on 1/8/26 at 11:05 a.m. with the ADM, the ADM agreed that it was a red flag when Resident 42's conservator was not answering calls and was not paying Resident 42's share of cost for months. The ADM stated there was no evidence of fiduciary [elderly financial] abuse that was why they did not report Resident 42's issue. The ADM further stated the facility's policy was that all allegations of resident abuse should be thoroughly investigated. During a concurrent interview and record review on 1/8/26 at 12:46 p.m. with the ADM, Resident 42's records were reviewed. The ADM confirmed that Resident 42 started generating share of cost in March of 2024 and Resident 42's conservator did not pay any of it. The ADM stated that they tried to call Resident 42's conservator multiple times but could not reach her. The ADM further stated they received a letter on 5/15/25 from the Public Guardian's office which indicated that Resident 42's conservatorship was changed from her sister to the Public Guardian's Office and the facility started getting paid for Resident 42's share of cost in August of 2025.During an interview on 1/8/26 at 4:12 p.m. with the ADM, the ADM stated they did not investigate Resident 42's issue after they talked to the Public Guardian's office.During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that all suspicion of abuse should be investigated thoroughly to prevent further abuse from happening to the residents.A review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2025, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .Investigating Allegations .1. All allegations are thoroughly investigated. The administrator initiates investigations.

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise resident's care plans (documents that summarizes resident's needs, goals, and care/treatment) for one of 37 sampled residents (Resident 4), after the physician discontinued orders for resident's splint (a device to immobilize joint) and fluid restriction (means limiting person's intake of liquids due to health conditions).These failures increased the potential to result in confusion in the delivery of care and services to Resident 4 and the resident continued to receive care and treatment that was discontinued. A review of the admission Record indicated that the facility admitted Resident 4 in 2015 with multiple diagnoses, which included metabolic encephalopathy (brain disfunction, leading to confusion, memory issues, and personality changes), dementia (a progressive state of decline in mental abilities), muscle weakness, and contracture of muscle in right hand (a condition when tissue under the palm thickens and fingers are curled, which limits person's ability to use their hand).A review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/29/2025, indicated that the resident had severely impaired cognitive skills (mental abilities, including remembering things, making decisions, concentrating, or learning) and limitations to upper extremities. The MDS indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - activities related to personal care).A review of the MDS dated [DATE], the section for special treatments, procedures, and programs indicated that a splint was applied to Resident 4.During an observation on 1/6/26 at 10:30 a.m., Resident 4 was in her bed, holding her hands close to her chest. Resident 4 had a splint (a device to support her right hand's fingers). No water was observed on resident's nightstand or bedside table.A review of Resident 4's flow sheets from 12/11/25 through 1/8/26 indicated that the splint was applied to resident's right hand every day.During a review of the Resident 4's care plan, initiated 11/27/24 with the last revision date of 12/23/25, the care plan indicated that Resident 4 required splinting to her right hand for 2 hours a day 7 days a week.A review of Resident 4's physician order indicated for splint to right upper extremity was discontinued on 12/2/25.A review of Resident 4's physician orders for diet dated 12/29/25 indicated that resident received pureed (pudding like texture) diet and her liquids were mildly thick consistency (like cream soup, used for residents with swallowing difficulties).A review of Resident 4's clinical records contained a flow sheet for daily fluid intakes from 12/11/25 through 1/8/26 indicating that the resident was on strict fluid restriction of 1.5 liters (unit of measurements) in 24 hours.A review of Resident 4's care plan initiated 4/2/24 with the last revision date of 12/23/25 indicated that the resident was at risk for altered nutrition related to dementia with inability to care for herself and fluid restriction. One of the care plan interventions indicated that the resident was on fluid restriction of 1.5 liters.A review of Resident 4's physician orders indicated that the physician ordered strict fluid restriction 1.5 liters on 7/13/24 and had discontinued the order on 10/31/25.During an interview on 1/8/26 at 8:30 a.m., with the Director of Nursing (DON), the DON stated that residents' care plans were required to be reviewed and revised after residents' change of condition and when the physician discontinued the order. The DON explained that the facility usually reviewed and revised residents' care plans every month to ensure the effectiveness of care plan interventions.During a concurrent interview and record review on 1/8/26 at 9:10 a.m., Resident 4's active orders and flowsheets for right hand splinting and fluid restriction were reviewed with Licensed Nurse (LN 2). LN 2 confirmed that the resident's flow sheets indicated the resident was on fluid restriction and splinting of her right hand. LN 2 stated, I don't see any physician's order for splinting and fluid restrictions.During an interview on 1/8/26 at 9:20 a.m., with Certified Nursing Assistant (CNA 8) in Resident 4's room, CNA 8 stated that Resident 4 was non-verbal and dependent on staff with feeding and ADLs. CNA 8 stated Resident 4 was on fluid restriction and explained that all fluids given with medications, meals, and in between meal were to (continued on next page)

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	555400	A. Building B. Wing	01/09/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be calculated and should not exceed what the physician ordered. CNA 8 stated she was not aware that the order for fluid restriction for Resident 4 was discontinued. CNA 8 uncovered Resident 4's right hand with splint on and stated that Restorative Nursing Assistants (RNA's) applied the splint in the morning and removed it 2 hours later.During an interview on 1/8/26 at 9:30 a.m., (RNA 1) explained that Resident 4 had her splint placed to her right hand every day and removed after 2 hours. RNA 1 stated that the therapy communicated to RNAs regarding new orders and when the orders were discontinued. RNA 1 stated she was not aware that the order for Resident 4's right hand splint was discontinued.During an interview and concurrent record review with Unit Manager (UM) on 1/8/26 at 9:38 a.m., UM stated that Resident 4's order for strict fluid restriction was discontinued on 10/31/25 and the order for splint was discontinued on 12/2/25. Upon reviewing the flow sheets for the resident's splint and fluid restriction, the UM acknowledged that the order for discontinuation of fluid restriction was not carried out. The UM verified that licensed staff did not revise or update Resident 4's care plans addressing resident's splint and fluid restriction. The UM agreed that not updating and/or not revising resident's care plans had the potential to provide inappropriate care to Resident 4.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 3/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy indicated that care plan interventions were chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The policy indicated that the assessments of residents were ongoing, and care plans were to be revised as information about the residents and the residents' conditions changed.

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	555400	A. Building B. Wing	01/09/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure two out of 37 sampled residents (Resident 13 and Resident 146) were assisted with nail care as part of his Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 13 and Resident 146 had long fingernails with blackish substance underneath. This failure had the potential for Resident 13 and Resident 146 to sustain skin injury and/or to acquire an infection and not achieve their highest practicable well-being.Findings:1. A review of Resident 13's clinical record indicated Resident 13 was admitted March of 2026 and had diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), muscle weakness, and need for assistance with personal care.A review of Resident 13's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 12/15/25, indicated Resident 13 was rarely/never understood. A review of Resident 13's MDS Functional Abilities, dated 12/15/25, indicated Resident 13 needed substantial/maximal assistance with showering/bathing herself and with personal hygiene and supervision or touching assistance with eating.A review of Resident 13's care plan, revised 9/16/25, indicated, ADL/Mobility: [Resident 13] is at risk for ADL/mobility decline and requires assistance related to fluctuating ADLs, mood problems, pain, behavior disturbance r/t [related to] schizophrenia .A review of Resident 13's care plan intervention, dated 9/14/25, indicated, Nails: Trim nails with bathing schedule.A review of the facility's shower schedule indicated Resident 13 was scheduled for shower or bathing every Wednesdays and Saturdays of the week.During a concurrent observation and interview on 1/6/26 at 10:56 a.m. with Resident 13, at the activity area, Resident 13 had long fingernails with blackish substance underneath. Resident 13 stated she wanted her fingernails to be cleaned and trimmed properly.During an observation on 1/6/26 at 12:32 p.m. of Resident 13, in Resident 13's room, Resident 13 was observed eating her lunch meal and still had long fingernails with blackish substance underneath.During a concurrent observation on 1/7/26 at 9:39 a.m. with Resident 13, in Resident 13's room, Resident 13 still had long fingernails with blackish substance underneath.During a concurrent observation and interview on 1/7/26 at 12:55 p.m. with Licensed Nurse (LN) 1, in Resident 13's room, LN 1 confirmed that Resident 13 had long fingernails with blackish substance underneath. LN 1 also confirmed that Resident 13 was able to eat on her own. LN 1 stated Resident 13's fingernails should be trimmed and cleaned to prevent Resident 13 from getting infection or getting skin injuries from her long fingernails.2. A review of Resident 146's clinical record indicated Resident 146 was initially admitted August of 2024 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), diabetes (elevated sugar in the blood), lack of coordination, and muscle weakness.A review of Resident 146's MDS Cognitive Patterns, dated 11/17/25, indicated Resident 146 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 7 out of 15 which indicated Resident 146 had severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 146's MDS Functional Abilities, dated 11/17/25, indicated Resident 146 needed supervision or touching assistance with eating and was dependent with showering/bathing self and with personal hygiene.A review of Resident 146's care plan, revised 3/16/25, indicated, ADL/Mobility: [Resident 146] .has actual .is at risk for ADL/mobility decline and requiresassistance related to anticipated declines in condition due to disease process, behavioral symptoms, chronic disease progression, cognitive impairment,fluctuating ADLs, medical condition .Hygiene: Assist of .A review of the facility's shower schedule indicated Resident 146 was scheduled for shower or bathing every Wednesdays and Saturdays of the week.During a concurrent observation and interview on 1/6/26 at 10:03 a.m. with Resident 146, in Resident 146's room, Resident 146 had long fingernails with blackish substance underneath. Resident 146 stated he wanted his fingernails to be cleaned and trimmed properly.During an observation on 1/6/26 at 12:30 p.m. of Resident 146, in Resident 146's room, (continued on next page)

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	555400	A. Building B. Wing	01/09/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 146 was observed eating his lunch meal and still had long fingernails with blackish substance underneath.During a concurrent observation and interview on 1/7/26 at 12:47 p.m. of Resident 146 with Certified Nurse Assistant (CNA) 5, in Resident 146's room, Resident 146 was observed eating his lunch meal and still had long fingernails with blackish substance underneath. CNA 5 confirmed the observations. CNA 5 stated Resident 146's fingernails should be trimmed and cleaned. CNA 5 stated staff should do nail care to every resident every day and especially during shower days. CNA 5 further stated nail care should be done to all residents to prevent possible skin tears or infection.During a concurrent interview and record review on 1/9/26 at 8:41 a.m. with LN 3, Resident 13 and Resident 146's clinical records were reviewed. LN 3 confirmed that Resident 13 and Resident 146 had no documented refusals of nail care. LN 3 stated CNAs should be doing nail care for residents who are not diabetic, and nurses should be doing nail care for all residents with diabetes. LN 3 further stated she would expect that all resident's nails would be trimmed and cleaned properly to prevent the risk of skin injury and infection.During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated she would expect that resident nail care would be done during shower days and every Sundays. The DON further stated all residents' fingernails should be trimmed and cleaned properly because of the risk of skin injury, hygiene issues, and possible infection. A review of the facility's policy and procedures (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 4/2025, indicated, Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .5. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (.grooming .) .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure one out of 37 sampled residents (Resident 38) received care in accordance with professional standards of practice, and facility's policy and procedure (P&P when Resident 38's foley catheter (a tube inserted through the urethra into the bladder to drain urine) bag was left on the floor.This failure had the potential for Resident 38 to develop infection and possible foley catheter complications.Findings:A review of Resident 38's clinical record indicated Resident 38 was admitted June of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions), neuromuscular dysfunction of bladder (the nerves and muscles in the urinary bladder don't work together properly), obstructive and reflux uropathy (occurs when the urine cannot drain through the urinary tract), retention of urine (caused by a blockage or a failure of the bladder to squeeze hard enough to expel all of the urine), catheter use, and muscle weakness.A review of Resident 38's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/17/25, indicated Resident 38 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 2 out of 15 which indicated Resident 38 had severely impaired cognition. A review of Resident 38's MDS Bladder and Bowel Status, dated 11/17/25, indicated Resident 38 uses indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time).A review of Resident 38's active physician's order, dated 6/4/25, indicated, Indwelling Urinary (Foley) Catheter .related to .NEUROMUSCULAR DYSFUNCTION OF BLADDER .change catheter when dislodge. every 24 hours as needed.A review of Resident 38's care plan, revised 11/18/25, indicated, [Resident 38] has indwelling device and is At risk for complications with urinary system (FOLEY CATHETER) related to .indwelling catheter, urinary retention . A review of Resident 38's care plan intervention, revised 10/1/25, indicated, Indwelling Catheter: provide catheter care and empty catheter every shift and as needed.During an observation on 1/6/26 at 9:24 a.m. of Resident 38, in Resident 38's room, Resident 38 was observed lying on bed, awake, and was connected to a urinary catheter tubing attached to a urinary catheter bag. The urinary catheter bag was observed on the floor.During a concurrent observation and interview on 1/6/26 at 12:51 p.m. with Licensed Nurse (LN) 2, in Resident 38's room, Resident 38's urinary catheter bag was still on the floor. LN 2 confirmed the observation. LN 2 stated the urinary catheter bag should not be left on the floor because it may cause infection and to avoid urinary complications.During a concurrent observation and interview on 1/8/26 at 10:32 a.m. with Certified Nurse Assistant (CNA) 4, in Resident 38's room, Resident 38's urinary catheter bag was again on the floor. CNA 4 confirmed the observation. CNA 4 stated the urinary catheter bag should be hanging and off the floor to prevent possible back flow of the urine and risk for infection.During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated urinary catheter bags should always be hanging and off the floor because of the risk of infection and to prevent the urine from flowing back which could cause urinary complications.A review of the facility's P&P titled, Catheter Care, Urinary, revised 8/2025, indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .2. Be sure the catheter tubing and drainage bag are kept off the floor.

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	555400	A. Building B. Wing	01/09/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure proper handling and delivery of respiratory care consistent with the facility's policy and procedures (P&P) and the professional standards of practice for 1 of 8 sampled residents when:Resident 130's oxygen tubing/nasal cannulas (a medical device connected to an oxygen source used to deliver supplemental oxygen directly into the airways) were not labeled with the date it was first used.This failure had the potential to result in unsafe and unsanitary delivery of oxygen to Resident 130.Findings:A review of Resident 130's clinical record indicated Resident 130 was admitted in June of 2025 and had diagnoses that included chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems) and muscle weakness.A review of Resident 130's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 1/23/2130, indicated Resident 130 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 130 had moderately impaired cognition.A review of Resident 130's active physician's orders indicated, . Oxygen- @ [at] 0.5-3 Liters/Min [lpm- unit of measurement for oxygen administration] via Nasal Cannula (Routine) (Medical DX [diagnosis] COPD/SOB [shortness of breath] and . Ipratropium- Albuterol Solution [inhalation medication] 0.5-2.5 3MG/ML (milligram/milliliter- units of measure) 1 application inhale orally via nebulizer [a machine that turns liquid medication into inhalable mist] mist three times a day for COPD . MD orders further indicated to, . Change humidifier bottle and tubing daily every night . and . Change nasal cannula every night every Wed [Wednesday] .During a concurrent observation and interview on 1/7/26 at 9:55 a.m. with Resident 130, in Resident 130's room, Resident 130 was observed using an oxygen concentrator at 3 lpm delivered via oxygen tubing/nasal cannula. Resident 130's oxygen tubing/nasal cannula was not labeled with the date when it was first used. On further observation, it was noted that Resident 130's nasal cannula connected to the oxygen tank on her wheelchair and the tubing connected to the nebulizer also did not have a label indicating when it was first used. Resident 130 confirmed that the oxygen tubing for the nebulizer, oxygen tank on the wheelchair and the oxygen concentrator were not labeled. Resident 130 was unable to confirm when the oxygen tubing was replaced last and could not recall when the nurses normally changed the oxygen tubing.During a concurrent observation and interview 1/7/26 at 9:57 a.m. with Licensed Nurse 9 (LN 9) in Resident 130's room, LN 9 confirmed that Resident 130's oxygen tubing/nasal cannulas (on the oxygen concentrator, the nebulizer on the side of the bed and on the oxygen tank on her wheelchair) were not labeled with the date it was first used. LN 9 stated, It [oxygen tubing/nasal cannula] should have been dated by whoever first opened it . since I do not know when that was, I will have to replace it now and date it . LN 9 further explained that oxygen tubing should be changed and labeled with date first used, every week to prevent infections.During an interview on 1/9/26 at 10:35 a.m. with the Director of Nursing (DON), when asked what her expectations were for labeling of oxygen tubing, the DON stated, Per our policy, the tubing is to be replaced every 7 days . I expect the nurse to label the tubing with date opened . The DON further stated that her expectation was that nurses change tubing for all oxygen delivery systems every seven days and label it with date, resident identifier and nurses' initials.A review of the facility's Policy and Procedure (P&P), the P&P titled, Departmental (Respiratory Therapy)- Prevention of Infection dated November 2025, indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection Control Considerations Related to Oxygen Administration: 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed .

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	555400	A. Building B. Wing	01/09/2026

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to provide food in accordance with the physician's prescribed diet for one out of 37 sampled residents (Resident 146) when Resident 146 who was on 2 gram (gm/g- unit of measurement) low salt diet (a dietary restriction that limits the intake of salt to 2 grams for the whole day) received a salt packet during the 1/6/26 lunch meal.This failure had the potential to negatively affect Resident 146's medical condition and for Resident 146 not to achieve his highest practicable well-being.A review of Resident 146's clinical record indicated Resident 146 was initially admitted August of 2024 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), diabetes (elevated sugar in the blood), and hypertension (high blood pressure).A review of Resident 146's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/17/25, indicated Resident 146 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 7 out of 15 which indicated Resident 146 had severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 146's MDS Nutritional Status, dated 11/17/25, indicated Resident 146 had therapeutic diet (specific meal plan prescribed by a doctor and planned by a dietitian to treat or manage a medical condition) while he was a resident in the facility. A review of Resident 146's MDS Functional Abilities, dated 11/17/25, indicated Resident 146 needed supervision or touching assistance with eating.A review of Resident 146's care plan, revised 3/16/25, indicated, Hypertension: [Resident 146] has a diagnosis of hypertension .Provide diet as ordered .A review of Resident 146's active physician's order, dated 5/29/25, indicated, 2 Gm Low Sodium [salt] diet .Minced and Moist texture .Moderately Thick consistency pureed fruits and veggies .A review of Resident 146's progress notes, dated 1/6/26, indicated, Resident [Resident 146] noted with +5lbs [increase of five pounds] in 1mo [one month] .No edema noted or SOB [shortness of breath] per nursing. Resident receives multiple meds [medications] that causes weight gain .Ongoing monitoring of PO [oral] intake and weight trends as needed.During a concurrent observation and interview on 1/6/26 at 12:14 p.m. with Resident 146, in Resident 146's room, Resident 146 was observed eating his lunch meal and there was a packet of iodized salt observed in Resident 146's meal tray. Resident 146's meal ticket was checked and indicated, Diet: 2g Na [salt]. Resident 146 stated he did not request the salt packet, and it was just served together with his meal.During a concurrent observation and interview on 1/6/26 at 12:16 p.m. with Certified Nurse Assistant (CNA) 1, in Resident 146's room, CNA 1 confirmed that Resident 146 was served with a salt packet in his lunch meal. CNA 1 stated nurses would check the meal tray, and CNAs would just pass them to the residents. CNA 1 further stated they provide salt packets to residents with 2g Na diet order.During a concurrent observation and interview on 1/6/26 at 12:25 p.m. with Licensed Nurse (LN) 1, in Resident 146's room, LN 1 confirmed that Resident 146 was served with a salt packet in his lunch meal even though his meal ticket indicated, Diet: 2g Na [salt]. LN 1 stated Resident 146 should not be provided with extra salt. LN 1 further stated Resident 146's salt intake should be limited to control his blood pressure or any cardiac issues he has. During an interview on 1/9/26 at 8:50 a.m. with the Registered Dietician (RD), the RD stated a resident who was on 2-gram Sodium diet should only have 2 grams of salt intake for the whole day. The RD also stated CNAs should be aware that Residents with 2g Na diet should not be provided with salt packet in their meal tray. The RD further stated she would expect Resident 146 to not be provided with salt packet in the meal tray because high salt intake could affect Resident 146's medical condition. During an interview on 1/9/26 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that the resident's prescribed diet should always be followed because the resident's medical condition would be affected and could get worse. A review of the facility's policy and procedures (P&P) titled, Therapeutic Diets, dated 10/2025, indicated, Therapeutic diets are (continued on next page)

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	555400	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Care Center	500 Jessie Avenue Sacramento, CA 95838

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed by the attending physician to support the resident's treatment and plan of care .A review of the facility's P&P titled, DIET ORDERS, dated 2023, indicated, Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe and homelike environment was provided when horizontal blinds in three (room [ROOM NUMBER], 26 and 35) of 53 rooms were broken, for a census of 157. This failure had the potential to cause injury and unsafe condition to vulnerable residents residing in these rooms. During an observation conducted on 1/6/26 at 9:14 a.m., the horizontal blinds in room [ROOM NUMBER] were broken. There were 5 residents in this room. Further observation was conducted on 1/6/26 at 1:16 p.m., the horizontal blinds in room [ROOM NUMBER] had broken edges. There were 4 residents in this room. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on 1/6/26 starting at 1:17 p.m., the ADON confirmed the blinds in room [ROOM NUMBER] and room [ROOM NUMBER] were broken. The ADON stated maintenance made rounds daily and the staff who found the broken blinds should write in the maintenance log. During an interview with the Certified Nursing Assistant 12 (CNA 12) on 1/6/26 at 1:21 p.m., CNA 12 stated when she came in today the blinds in room [ROOM NUMBER] was already broken and she did not write a note in the maintenance log. The CNA 12 further stated she was responsible for half of the residents in room [ROOM NUMBER] and she did not notice the blinds were broken. During an observation made on 1/8/26 at 7:31 a.m. while nurse surveyor (NS) was in the parking lot in front of the building, the broken blinds in one of the rooms was visible. During a concurrent observation and interview with the Maintenance Supervisor (MS) on 1/8/26 at 1:27 p.m., the MS stated he made rounds daily and oversees the maintenance of the building. The MS and NS checked rooms [ROOM NUMBERS]. The MS stated he just replaced the broken blinds in room [ROOM NUMBER] yesterday (1/7/26) and MS confirmed the blinds in room [ROOM NUMBER] was broken and had not been replaced. The NS showed the pictures of the broken blinds taken on 1/6 and 1/8/26 and the MS stated if the blinds were broken, they have to fix it to make it homelike. During a concurrent observation and interview with CNA 14 on 1/8/26 at 4:21 p.m., CNA 14 confirmed the blinds in room [ROOM NUMBER] were broken. The CNA further stated the blinds were already broken when she came in and CNA 14 had observed the resident closest to the window always grabbing on the blinds. During an interview with the Director of Nursing (DON) on 1/9/26 at 9:33 a.m., the NS showed the pictures of the broken blinds to the DON. The DON stated, does not look good and it was not safe if the blinds were broken. The DON further stated her expectation was for staff to report broken blinds or equipments to Maintenance Supervisor and the problem should be written in the maintenance log. The DON added maintenance would check the log daily. During an observation conducted on 1/7/26 at 10:11 a.m., the horizontal blinds in room [ROOM NUMBER] were broken. No residents were in the room at this time. During a follow-up observation on 1/7/26 at 1:14 p.m., there were still no residents in room [ROOM (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NUMBER]. A photo of the broken blinds was obtained. During a concurrent observation and interview with Certified Nursing Assistant 15 (CNA 15) on 1/8/26 at 3:50 p.m., CNA 15 confirmed the blinds in room [ROOM NUMBER] were broken. The CNA further stated she was unaware of how long the blinds have been broken. CNA 15 stated this should have been reported to Maintenance staff. During an interview on 1/9/26 at 9:49 a.m., with Licensed Nurse 8 (LN 8), LN 8 stated that broken blinds should be reported to be fixed by maintenance. LN 8 further stated that broken blinds are a safety risk. During an interview with the Director of Nursing (DON) on 1/9/26 at 9:33 a.m., a picture of the broken blinds was reviewed with the DON. The DON stated it is a safety hazard to have broken blinds in the residents' rooms. The DON further stated her expectation was for staff to report broken blinds or equipment to the Maintenance Supervisor (MS) and to also log the incident into the maintenance log in the nurses' stations. A review of the facility's policy and procedure revised February 2021 and titled, Homelike Environment indicated, Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect .homelike setting .

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, six out of 53 rooms (Rooms 15, 16, 22, 23, 24, and 25) had more than four residents in each room. This failure had the potential to impact resident's care and privacy.During the Entrance Conference with the Administrator (ADM) on 1/6/26 starting at 8:17 a.m., the ADM stated the facility will renew existing room waiver (specific regulatory flexibility) to have more than four residents in six rooms (Rooms 15, 16, 22, 23, 24, and 25). During a review of the facility letter, dated 1/6/26, the letter indicated six rooms would accommodate more than four residents per room. The letter further indicated, These rooms all provide adequate space for resident care, storage, as well as privacy. During multiple observations conducted on 1/6/26 starting at 8:45 a.m., there were 5 residents in rooms 22, 23, 24, and 25. The beds were separated with privacy curtains, and each resident had bedside table. During multiple observations and interviews conducted on 1/6/26 starting at 9:01 a.m., there were 6 residents in rooms [ROOM NUMBERS]. The rooms were not cluttered. There was enough space for residents to move in and out of their rooms, and there was enough space for assistive devices and resident's care equipments. Resident 117, Resident 85, and Resident 38 verbalized there was enough space in the room. During an interview with Licensed Nurse 4 (LN 4) on 1/6/26 at 3:28 p.m., LN 4 stated she had room [ROOM NUMBER] with 6 residents. The LN 4 further stated there was no issues with space and there was enough space to maneuver assistive devices and respond to emergencies. During an interview with LN 5 on 1/6/26 at 3:34 p.m., LN 5 stated he had worked in rooms [ROOM NUMBERS]. The LN 5 further stated there was enough space for residents and assistive devices and there were no complaints from family. During an interview with Certified Nursing Assistant 3 (CNA 3) on 1/6/26 at 3:55 p.m., CNA 3 stated she was familiar with rooms [ROOM NUMBERS]. The CNA 3 further stated there was enough space to maneuver assistive devices and there were no issues. During an interview with CNA 6 on 1/6/26 at 4:11 p.m., CNA 6 stated she was familiar with room [ROOM NUMBER] with 6 residents. The CNA 6 further stated most of the residents in this room used assistive devices, some residents used wheelchair and walker and there was enough space. During an interview with LN 1 on 1/7/26 at 11:05 a.m., LN 1 stated she was assigned to rooms with 4-5 residents. The LN 1 further stated they have residents in rooms [ROOM NUMBER] using assistive devices for transfers and staff had enough room to provide care. During an interview with CNA 12 on 1/8/26 at 9:30 a.m., CNA 12 stated she worked in rooms (rooms 23, 24, 25) with 5 residents. The CNA 12 further stated she provided privacy to residents by closing the door and pulling the privacy curtains during care. The CNA 12 confirmed there was enough space for equipments and each resident had privacy curtain, bedside table, and meal tray. During an interview with CNA 13 on 1/8/26 at 3:59 p.m., CNA 13 stated she worked in rooms (rooms [ROOM NUMBERS]) with 5 residents. The CNA 13 further stated she closed the curtains when providing care and there was enough space to care for the residents.The room waiver is recommended for continuation per facility request, as contingent upon compliance with federal regulations at Resident Rights (483.10) and Physical Environment (483.90).

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, two out of 53 resident rooms (room [ROOM NUMBER] and 16) did not meet the minimum requirement of 80 square feet (sq ft; unit of measurement) per resident.This failure had the potential for residents in rooms [ROOM NUMBERS] to not have enough space for care and privacy which could impact the residents well being. During an initial tour of the facility on 1/6/26, starting at 9:01 a.m., rooms [ROOM NUMBERS] were observed to have six beds in each of the rooms. During observation, the rooms were uncluttered, residents were able to move in and out of the rooms, and there was enough space for beds, wheelchairs, side tables, and other residents' care equipment.During an interview on 1/6/26 at 9:01 a.m. with Resident 117 in room [ROOM NUMBER], Resident 117 stated he was okay with his room and has enough space for him and when staff are taking care of him. Resident 117 further stated he had no concerns about having 5 other residents in the room.During an interview on 1/6/26 at 9:02 a.m. with Resident 85 in room [ROOM NUMBER], Resident 85 stated there was enough space for him in the room and when staff are taking care of him. Resident 85 further stated he had no concerns about having 5 other residents in the room.During an interview on 1/6/26 at 9:24 a.m. with Resident 38 in room [ROOM NUMBER], Resident 38 stated his room has enough space for him and for his assistive devices.During an interview on 1/6/26 at 3:28 p.m. with Licensed Nurse (LN) 4, LN 4 stated she was assigned to room [ROOM NUMBER] today and she does not have any issue with the room space. LN 4 further stated there was sufficient space in room [ROOM NUMBER] to give nursing care and respond to emergencies.During an interview on 1/6/26 at 3:34 p.m. with LN 5, LN 5 stated he was assigned to rooms [ROOM NUMBERS] today and there was enough space for six residents in each room. LN 5 also stated two residents in room [ROOM NUMBER] needed mechanical lift and staff can maneuver it inside the room. LN 5 further stated there were no complaints from residents' families regarding the space.During a concurrent observation and interview on 1/6/26 at 3:55 p.m. with Certified Nursing Assistant (CNA) 3, in room [ROOM NUMBER], CNA 3 was observed transferring a resident from a shower chair to the resident's bed using a stand-up lift together with another CNA. CNA 3 stated they were able to operate the stand-up lift inside room [ROOM NUMBER] without any hindrance or issues with space. CNA 3 also stated most of the residents in rooms [ROOM NUMBERS] needed assistance and use assistive devices. CNA 3 further stated rooms [ROOM NUMBERS] have enough space to maneuver and use assistive devices.During an interview on 1/6/26 at 4:11 p.m. with CNA 6, CNA 6 stated room [ROOM NUMBER] has 6 residents in the room and most of them use assistive devices. CNA 6 further stated room [ROOM NUMBER] has enough space for staff to provide care to residentsDuring a concurrent observation and interview on 1/7/26 at 9:13 a.m. with the Maintenance Supervisor (MS), the usable living space for each resident in rooms [ROOM NUMBERS] was measured and calculated. The MS confirmed that rooms [ROOM NUMBERS] measured 70.56 sq ft per resident. The MS acknowledged that both rooms were below the minimum requirement of 80 square feet per resident.A review of the facility's request letter to renew existing waivers, dated 1/6/2024, provided by the Administrator (ADM), the letter indicated that rooms [ROOM NUMBERS] had six beds each with less than 80 sq ft space per resident. The letter further indicated, These rooms all provide adequate space for resident care, storage, as well as privacy.The room waiver is recommended for continuation per facility request, as contingent upon compliance with federal regulations at Resident Rights (483.10) and Physical Environment (483.90).