STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Roseville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1161 Cirby Way Roseville, CA 95661	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation, interview, and record review, the facility failed to provide an environment free of hazards when one of five sampled residents, (Resident 1)'s, bed malfunctioned and the head of bed dropped suddenly. This failure resulted in Resident 1 experiencing neck pain. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in February 2023 with multiple diagnoses including wedge compression fracture of T11-T12 vertebra (a fracture in the the front of the vertebra located on the thoracic spine) and abnormalities of gait and mobility (difficulty walking). A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 3/3/23, indicated she had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 11 out of 14 that indicated she was moderately cognitively impaired. Further review of Resident 1's MDS, Functional Status, dated 3/3/23, indicated she required limited assistance by staff to guide limbs for transfers and bed mobility. A review of Resident 1's Treatment Encounter Note, date of service 3/14/23, indicated Pt [Patient] c/o [complaining of] posterior neck and back pain. Pt said on friday her head bang on bed due to bed malfunction and since then having severe pain, x-ray reports came out negative A review of Resident 1's Weekly Summary Notes, dated 3/19/23, indicated .Went for MRI [magnetic resonance imaging- an imaging test] of the neck due to c/o pain related to jarring of the bed with result of strained neck per resident report . A review of Resident 1's Physician Progress Note (Narrative), dated 3/15/23, indicated .F/u [follow up] vertebral fracture/neck pain/ER [emergency room] visit. Was sent to the ER per her request due to worsen left sided neck pain. MRI showed multilevel degenerative changes of the cervical spine without central canal stenosis or neural foraminal narrowing [spaces of the bones of the spine become smaller] . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Nurse's Note, dated 3/14/23, indicated [Provider] ordered send to ER for MRI of C-S [cervical spine] C/O worsening pain . A review of Resident 1's Radiology Interpretation, date of exam 3/13/23, indicated .Impression: Minor djd [degenerative joint disease] with straightening and disc djd in lower C [cervical] spine . A review of Resident 1's result of X ray of cervical spine done at ER, dated 3/14/23, indicated .No definite acute fractures . A review of Resident 1's result of MRI of cervical spine done at ER, dated 3/15/23l, indicated .Multilevel degenerative changes of the cervical spine [deterioration of the discs of the spine] A review of Resident 1's After Visit Summary, dated 3/15/23, from ER visit, indicated .Diagnosis Neck pain . Imaging Tests MRI Cervical Spine .XR Cervical Spine .Read the attached information Cervical Sprain [a stretch or tear in one or more of the ligaments of the neck] . During an interview on 4/10/24 at 11:30 a.m. with the Administrator (ADM), the ADM stated Resident 1 was admitted to the facility for vertebral fracture and rib fractures after a motor vehicle accident. The ADM stated he was not aware of Resident 1's complaint of bed malfunction until several months after discharge when she contacted the facility. The ADM stated if a piece of equipment malfunctions the staff notifies the maintenance department. The staff can input into the maintenance log kept at the nurse's station or can notify maintenance staff in person. The ADM stated that the reporting documentation in the maintenance log of equipment malfunction is not retained. During an interview on 4/10/24 at 12:43 p.m. and a subsequent interview at 1:10 p.m. with the Maintenance Director (MD), the MD stated he is notified of equipment malfunction by staff writing in the maintenance log or by notifying him verbally. When an item is repaired it is signed and dated as repaired in the maintenance log. When asked if he recalled Resident 1's bed malfunctioning, the MD stated he did not recall the specific incident, but the bed would have been switched out. Reviewed the maintenance log for March 2023 with the MD. The maintenance log did not reflect any report of bed malfunction. The MD stated if it was verbally reported to him, it would not have been recorded in the maintenance log and there would not be a record of it. During a telephone interview on 4/10/24 at 1:03 p.m. with Resident 1, Resident stated that her bed had malfunctioned when the head rest crashed down. Resident 1 stated she had left neck pain due to this. She stated a Certified Nursing Assistant (CNA) and Licensed Nurse (LN) were aware of the incident. Resident stated she requested an x ray and requested to be sent to the ER. During an interview on 4/10/24 at 2:51 p.m. with the Physician Assistant (PA), the PA stated that Resident 1 was sent to theER on [DATE] when she complained of neck pain. The PA stated Resident 1 told her the bed malfunctioned, dropped so quickly, neck hurts. The PA stated the MRI done only showed chronic changes. During an interview on 4/10/24 at 3:42 p.m. with LN 2, LN 2 stated that if equipment malfunctions it is put in the maintenance log at the nursing station or maintenance is called. LN 2 stated if a bed malfunctions, maintenance is called and the bed is replaced. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 3:46 p.m. with CNA 2, the CNA stated if a bed is not working, she will unplug it and plug it back in to see if it will start working. CNA 2 stated also puts it in the maintenance log and notifies maintenance right away. During a telephone interview on 4/12/24 at 10:24 a.m. with LN 3, LN 3 stated she recalled that Resident 1's head of bed fell and Resident 1 complained of neck pain. LN 3 stated this happened about 9:00 p.m. while the CNA was assisting Resident 1 in bed. The CNA reported to LN 3 that the head of the bed fell down. LN 3 stated she tried to raise the head of the bed up, but it would not stay up. LN 3 requested a new bed and it was replaced. Resident 1 complained of neck and upper back pain. LN 3 stated she contacted the physician and obtained an order for an x ray. LN 3 stated she does not recall if she put it in the maintenance log. LN 3 stated, Should have been a progress note. May not have been because I was new and not sure if I did everything correctly. LN 3 stated Resident 1 still complained of neck pain after that night and had lingering pain for two weeks. When asked if Resident 1 had harm from the bed malfunction, LN 3 stated, I'm sure she did. Hurt her neck. Complained about it for a while. Equipment Maintenance and Accident Prevention Policies were requested but not provided. A review of the facility's Policy and Procedure (P&P) titled Accidents and Incidents-Investigating and Reporting, revised 7/17, indicated All accidents or incidents involving residents, employees, visitors, vendors, etc, occurring on our premises shall be investigated and reported to the Administrator .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident Form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident .Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility . A review of the facility's P&P titled Bed Safety and Bed Rails, revised 8/22, indicated .Maintenance staff routinely inspects all beds and related equipment to identify risks and problems .Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications .