STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Care Center	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. 32096 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 2's) safety when, the resident's bed locks were not completely secured in place. This failure had the potential to contribute to Resident 2's fall and placed the resident at a greater risk for avoidable accidents. Findings: Review of the clinical record for Resident 2, the Admission Record indicated Resident 2 was a short-term resident in the facility for aftercare of surgery with diagnoses that included spine and thoracic (upper and middle part of the back) region fusion, thoracic vertebra (bones) fracture and morbid obesity. In a concurrent observation and interview on 4/16/24 at 10:38 a.m., Resident 2 was in a wheelchair in his room and stated he had two back surgeries and had come to the facility from the hospital for rehabilitation. Resident 2 reported he fell on his back the previous night because the bed was not secured. The resident recounted the fall incident; he stated he decided to get out of the bed to grab a blanket for himself that was placed at the end of his bed. The resident indicated he could not reach the blanket from his lying or sitting position, so he had to get out of the bed. The resident explained that first he got up, out of the bed and held the bedframe for his balance and security as he took steps sideways to the foot of the bed to reach the blanket; however, he lost his balance, and the bed was rolling towards him as he was falling on his back because the bed was not locked. The resident rehearsed pulling the bed from his wheelchair and the upper half of the bed swung towards the resident. The resident voiced that he was scared when he fell on his back because he just had surgery and was angry that his bed was not securely locked and said his fall could have been prevented. The resident indicated he was sent to the hospital emergency room after the fall, and the doctor re-stapled his incision site as a few surgical staples were lost when he fell . It was observed there were two red bed lock pedals at the foot of the bed on the wheels that were placed downward which indicated they were in a locked position; however, the two metal prong shape locks at the head of the bed were in an upward position and the wheels moved freely. (continued on next page)

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	Review of Resident 2's clinical record, eINTERACT SBAR, dated 4/15/24, indicated, Resident was on the floor. Unable to stand and transferred back to bed .Call [Name of Ambulance company] and 4 paramedics came in. Sent resident to [Name of Hospital]. In an observation and concurrent interview on 4/16/24 at 10:42 a.m., at Resident 2's room, Licensed Nurse (LN 1), verified Resident 2 had a fall the previous day and checked the locks on resident's bed and acknowledged the locks for the wheels at the head of the bed were not secured as she was able to swing the bed easily. LN 1 attempted to lock the head of the bed locks but was unable to lock the bed. LN 1 stated she did not know how to lock the head of the bed because they were different from the foot lock pedals. LN 1 indicated she did not recall if she had been in-serviced for securing locks on the bed and stated it was unsafe when the bed was unlocked as it rolled easily and posed a great risk for resident safety. In an observation and concurrent interview on 4/16/24 at 10:55 a.m., in Resident 2's room, Maintenance Staff (MS 1) and MS 2 acknowledged the head of the bed wheel locks of the resident's bed were not in a locked position. MS 1 explained the metal prong locks should be lowered and aligned the wheels with the middle prong. In an interview on 4/16/24 at 10:57 a.m., Resident 2's roommate stated he heard a thud and witnessed the resident fell on his back on the floor the previous day. In a concurrent observation and interview on 4/16/24 at 11 a.m., in Resident 2's room, Certified Nurse Assistant (CNA 1) attempted to lock the resident's bed in the presence of MS 1 and MS 2. CNA 1 checked the head and foot of the bed a couple of times and stated there was no red pedal lock at the head of the bed. After attempting several times, CNA 1 was able to lock one of the two head of the bed wheel locks and stated the bed was locked then and left the room. MS 1 pulled the resident's bed and placed the remaining lock on the left wheel and stated all four locks needed to be put on to secure the bed. Review of the facility's policy and procedure, Bed Safety and Bed Rails, revised August 2022, stipulated, The facility's education and training activities will include instructions about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury . In an interview on 4/16/24 at 1:50 p.m., in the Director of Nursing's office, the Director of Staff Development (DSD), with the Assistant Director of Nursing (ADON) present, acknowledged the facility had not provided staff in-services on how to lock the resident's bed. The ADON indicated it was the facility practice that all bed wheels are to be locked at all times unless the bed needed to be moved and stated Resident 2's bed should have been locked to ensure safety. The ADON stated the resident's fall could have been prevented had the bed been locked securely. Both ADON and DSD agreed that unlocked bed wheels posed a safety concern for residents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 32096 Based on interview and record review, the facility failed to manage one of three sampled residents (Resident 1's) pain timely when staff had incongruent (inconsistent) communication regarding the resident's complaint of pain. This failure resulted in Resident 1 having uncontrolled pain and a hospital transfer. Findings: Review of Resident 1's clinical record, the Admission Record indicated the resident was admitted to the facility for aftercare of hip replacement surgery in March 2024. Review of Resident 1's clinical record, Nurse's Notes, dated 3/26/24, documented by Licensed Nurse (LN 2) indicated the resident complained of uncontrolled pain that occurred during physical therapy (PT) that morning. The Nurse's Note documented, [Resident 2] stated he heard a crack and has been hurting since then [PT in the morning]. Called [Name of Doctor] but call failed twice around 1700 [5 p.m.] .Resident and wife wanted him to go to [Name of hospital] .Resident was transferred to [Name of hospital] at 1725 [5:25 p. m.]. Review of Resident 1's clinical record, Medication Administration Record (MAR) for March 2024 indicated the resident had his routine pain medications, morphine (narcotic) 15 milligram (mg, medication dose) 1 tablet and pregabalin (a nerve/muscle pain medication) 75 mg 1 tablet, at 8 a.m. prior to PT at 9:30 a.m. The MAR indicated the resident had Tylenol 500 mg 2 tablets at noon on 3/26/24. Resident 1 did not have an order for any breakthrough pain medication. In a concurrent interview and record review on 4/16/24 at 12:40 p.m. in the physical therapy room, the Physical Therapy Assistant (PTA) stated, on 3/26/24, he and a Certified Occupational Therapy Assistant (COTA) provided therapy concurrently for Resident 1 in the resident's room at around 9:30 a.m. The PTA stated the therapy goal for Resident 1 that morning was supine (lying face upward) to stand but the resident was unable to get out of the bed due to a severe pain. The PTA stated Resident 1 said, I heard a pop on my back .I heard, I heard. When the PTA assisted the resident with sit to stand, the resident complained of pain to his right leg. During the interview, the PTA initially stated the therapy session that morning was about for 5 to 10 minutes because of the resident's pain and after reviewing his notes, the PTA then restated the therapy was provided about 25 to 30 minutes that morning during which the resident was sitting at the edge of the bed. The PTA stated the therapy was discontinued because the resident requested to get back to bed due to the pain and indicated he and the COTA stopped the therapy and put the resident back to bed. The PTA stated he personally notified the resident's morning nurse that Resident 1 was in pain. In an interview on 4/16/24 at 1:13 p.m., the COTA, in the presence of the PTA, in the physical therapy room, stated on 3/26/24 Resident 1 said, I heard a little pop when the resident was changing the position from lying to sitting. The COTA stated the resident did not complain of pain other than having said he heard a pop. The COTA stated the therapy session ended after 25-30 minutes because the resident was not able to sit to stand due to pain, otherwise, the COTA stated that the therapy should have been provided for 45 minutes to one hour, had the resident had no pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure, Pain Assessment and Management, revised October 2022, stipulated, Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Review of Resident 1's clinical record included no documented evidence that LNs addressed Resident 1's new acute pain identified during the PT on 3/26/24 prior to the hospital transfer at 5:25 p.m. There was no documented evidence the physician was contacted, or any new orders obtained from the doctor to relieve the resident's pain. In a telephone interview on 4/17/24 at 10:43 a.m., LN 1 stated she was the morning nurse for Resident 1 on 3/26/24 but did not recall the PTA reporting to her that Resident 1 was in pain, or the pop crack that occurred during the PT that morning, otherwise she would have contacted the doctor who was on the premise. LN 1 stated she did not contact the doctor because there was no complaint of pain from the resident during her shift. In a telephone interview on 4/17/24 at 3:02 p.m., LN 2 recounted that around 5 p.m. on 3/26/24, when she entered Resident 1's room for his blood glucose check before dinner, Resident 1 yelled that he was in pain since that morning when he heard a pop during the PT session. LN 2 stated that Resident 1 said that he reported to PT and his nurses that his leg popped, and he was in pain, but nothing had happened. LN 2 stated Resident 1 was moaning in pain, and she immediately reached out to the doctor, but the doctor was not in the building at that time and failed to get a hold of the doctor. LN 2 stated the resident called his spouse in and when she came to the facility, she and the resident both requested to call 911 and to send the resident to a hospital because the resident was experiencing uncontrolled pain since that morning.Based on interview and record review, the facility failed to manage one of three sampled residents (Resident 1's) pain timely when staff had incongruent communication regarding the resident's complaint of pain. This failure resulted in Resident 1 having uncontrolled pain and a hospital transfer. Findings: Review of Resident 1's clinical record, Admission Record, indicated the resident was admitted to the facility aftercare for hip replacement surgery and diabetes in March 2024. Review of Resident 1's clinical record, Nurse's Notes, dated 3/26/24, documented by Licensed Nurse (LN 2) indicated the resident complained of uncontrolled pain that occurred during physical therapy (PT) that morning. The Nurse's Note documented, [Resident 2] stated he heard a crack and has been hurting since then [PT in the morning]. Called [Name of Doctor] but call failed twice around 1700 [5 p.m.] .Resident and wife wanted him to go to [Name of hospital] .Resident was transferred to .at 1725 [5:25 p.m.]. Review of Resident 1's clinical record, Medication Administration Record (MAR) for March 2024 indicated the resident had his routine pain medications, morphine (narcotic) 15 milligram (mg, medication dose) 1 tablet and pregnable (a nerve/muscle pain medication) 75 mg 1 tablet, at 8 a.m. prior to PT at 9:30 a.m. The MAR indicated the resident had Tylenol 500 mg 2 tablets at noon on 3/26/24. Resident 1 did not have any order for as needed basis breakthrough pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and record review on 4/16/24 at 12:40 p.m. at the physical therapy room, the Physical Therapy Assistant (PTA) stated, on 3/26/24, he and a Certified Occupational Therapy Assistant (COTA) provided therapy concurrently for Resident 1 in the resident room at around 9:30 a.m. The PTA stated the therapy goal for Resident 1 that morning was supine (lying face upward) to stand but the resident was unable to get out of the bed due to a severe pain. The PTA stated Resident 1 said, I heard a pop on my back .I heard, I heard when the resident was sitting up from lying position and did not complain any pain and the resident was able to sit at the edge of the bed. When the PTA assisted the resident with sit to stand, the resident complained pain to his right leg then. During the interview, the PTA initially stated the therapy session that morning was about for 5 to 10 minutes because the resident's pain and after reviewing his notes, the PTA then restated the therapy was provided about 25 to 30 minutes that morning during which the resident was sitting at the edge of the bed. The PTA stated the therapy was discontinued because the resident requested to get back to bed due to the pain and indicated he and the COTA stopped the therapy and put the resident back to bed. The PAT stated he personally notified the resident's AM LN that Resident 1 was in pain. In an interview on 4/16/24 at 1:13 p.m., the COTA, in the presence of the PTA, in the physical therapy room, stated on 3/26/24 Resident 1 said, I heard a little pop when the resident was changing the position from lying to sitting. The COTA stated the resident did not complain of pain other than having said he heard a pop. The COTA stated the therapy session ended after 25-30 minutes because the resident was not able to sit to stand due to pain, otherwise, the COTA stated that the therapy should have been provided for 45 minutes to one hour, had the resident had no pain. The COTA stated the therapy hours were inclusive the time spent in communicating with LNs regarding the resident pain or pain medication administration prior to therapy. The COTA stated Resident 1's COTA and PTA hours were 64 minutes and 55 minutes respectively on 3/25/24. Review of the facility's policy and procedure, Pain Assessment and Management, revised October 2022, stipulated, Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Review of Resident 1's clinical record included no documented evidence that LNs addressed Resident 1's new acute pain identified during the PT on 3/26/24 prior to the hospital transfer at 5:25 p.m. There was no documented evidence the physician was contacted or any new orders obtained from the doctor to relieve the resident's pain. In a telephone interview on 4/17/24 at 10:43 a.m., LN 1 stated she was the AM nurse for Resident 1 on 3/26/24 but did not recall the PTA reported her that Resident 1 was in pain or the pop crack occurred during the PT that morning, otherwise she would have contacted the doctor who was on the premise. LN 1 stated she did not contact the doctor because there was no complaint of pain from the resident during her shift. (continued on next page)

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