

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 06/24/2024
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45770</p> <p>Based on interview and record review the facility failed to report allegations of abuse to the Department on a timely manner for one of four sampled residents (Resident 1) when the Department received the report of alleged abuse the day after the incident occurred.</p> <p>This failure resulted in a delay in the abuse investigation and decreased the facility's potential to protect the resident from harm.</p> <p>Findings:</p> <p>A review of an Admission Record for Resident 1 indicated she was admitted in March 2024 with diagnoses including post-traumatic stress disorder (PTSD) and unspecified psychosis.</p> <p>A review of Resident 1's Minimum Data Set (MDS, an assessment tool used for care), dated 6/11/24, indicated a Brief Interview of Mental Status (BIMS, an assessment tool) score of 12 out of 15 with memory problems.</p> <p>During a concurrent interview and record review on 6/24/24 at 12 p.m. with the Social Services Director (SSD) Resident 1's Progress Notes were reviewed, SSD confirmed a nurses' note that indicated an alleged abuse incident involving Resident 1 occurred on 6/18/24 but was reported to the Department, Ombudsman and Law Enforcement on 6/19/24, a day after it happened.</p> <p>In an interview on 6/24/24 at 3:03 p.m. with Licensed Nurse 2 (LN 2), LN 2 verified Resident 1 reported the alleged abuse incident to her on 6/18/24. LN 2 then notified the Assistant Director of Nursing (ADON) that day, and LN 2 confirmed she did not make a nurses' note or file a report notifying the proper agencies of the alleged incident.</p> <p>In an interview on 6/24/24 at 3:30 p.m. with the Director of Nursing (DON) the DON acknowledged that an alleged incident of abuse was reported to her on 6/18/24 at around 5:30 p.m. and the Department was only notified the next day on 6/19/24 because according to what they know the required reporting time for an allegation of an abuse was within 24 hours depending on its nature.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised 9/2022 the P&P stipulated The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The local/state ombudsman; Law Enforcement officials .Immediately is defined as: within two hours of an allegation involving abuse .</p>		