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	07/09/2025

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 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. Based on observation, interview, and record review the facility failed to provide supervision to protect two residents (Resident 1 and Resident 2) from abuse when Resident 1 and Resident 2 had a physical altercation. This failure had the potential to result in physical injury or emotional distress for both Resident 1 and Resident 2. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in April 2024 with multiple diagnoses including dementia (a condition characterized by impairment of brain functions, including memory loss and judgment), diabetes (too much glucose in the blood), osteoarthritis (the flexible tissue at the end of the bones, cartilage, wears down causing pain and decreased mobility). A review of Resident 1's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 4/29/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS-tool to assess cognition) score of 3 out of 15 that indicated Resident 1 had severe cognitive impairment. A review of Resident 1's MDS, Functional Abilities, dated 4/29/25, indicated Resident 1 used a wheelchair for mobility and had no impairment to upper and lower extremities. A review of Resident 1's Order Summary Report, indicated .Resident does not have the capacity to make her decisions . A review of Resident 1's Progress Notes, dated 7/8/25 at 12:59 p.m., indicated .At approx. [approximately] 1250 [12:50 p.m.] resident was on her wc [wheelchair] at the hallway by A-1 nurses station. This nurse observed resident and another resident hitting each other . [Resident 1] bump into [Resident 2] wc. [Resident 1] hit [Resident 2] by R [right] forearm, [Resident 2] hit her back hitting her to her L [left] forearm. This writer removed immediately [Resident 1] from the situation d/t [due to] resident confusion and orientation only to herself, apparently doesn't comprehend what is going on .This writer asked some questions regarding incident, but resident is unable to recall incident . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Progress Notes, dated 7/8/25 at 1:54 p.m., indicated .On 07/08/2025 at around 12:30 [p.m.], SS [Social Services] was notified by the DON [Director of Nursing] and nurse in charge that [Resident 1] and [Resident 2] were fighting in the A-1 hallway, both patient's were in a w/c. [Resident 1] hit the R arm of the victim first, victim hit back, they were both hitting each other's arms .Nurse in charge separated them, making sure they are both away from each other, both patient's refuse room change . A review of Resident 1's Progress Notes, dated 7/8/25 at 9:57 p.m., indicated .Per CNA [Certified Nursing Assistant], the resident around 1900 [7:00 p.m.] tried to hit resident [resident in a different room] but couldn't reach him, CNA moved this resident immediately away . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in September 2012 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (condition that impacts the blood flow to the brain), depressive disorder (mental health disorder characterized by depressed mood or loss of interest in activities), and epilepsy (seizure disorder). A review of Resident 2's MDS, Cognitive Patterns, dated 6/4/25, indicated Resident 2 had a BIMS score of 12 out of 15 that indicated Resident 2 had moderate cognitive impairment. A review of Resident 2's MDS, Functional Abilities, dated 6/4/25, indicated Resident 2 used a wheelchair for mobility and had no impairment to upper and lower extremities. A review of Resident 2's Order Summary Report indicated .Resident has capacity to make his/her decisions . A review of Resident 2's Progress Notes, dated 7/8/25 at 1:23 p.m., indicated .At approx. 1250 [12:50 p.m.] resident was on his wc at the hallway by A-! nurses station. This nurse observed resident and another resident hitting each other . [Resident 1] bump into [Resident 2] wc. [Resident 1] hit [Resident 2] first hitting him to R forearm, [Resident 2] hit her back, hitting to her left forearm . This writer asked resident what happened, resident stated I wanted to go outside to smoke, and she was on the way, blocking the hallway, she hit me first . During a joint interview on 7/9/25 at 1:19 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the DON stated she was present during the incident between Resident 1 and Resident 2 on 7/8/25 in hallway A. The DON stated both residents were in their wheelchairs near the nursing station. The DON stated Resident 1 accidentally hit Resident 2's wheelchair when she was trying to pass by Resident 2. The DON stated Resident 1 hit Resident 2 on the arm and Resident 2 hit her back. The DON stated when she asked Resident 1 about the incident, Resident 1 stated she did not remember. The DON stated that Resident 2 stated, If someone is hitting me, will hit back. That's how it's done if you grew up on the streets. During an interview on 7/9/25 at 2:08 p.m. with the Social Services Director (SSD), the SSD stated Resident 1 and Resident 2 were side by side in the hallway when the incident occurred. The SSD stated Resident 2 does not like to be touched and wants his own space. The SSD stated Resident 1 hit Resident 2 on the arm and then both residents started throwing their arms at each other. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/25 at 2:45 p.m. with Licensed Nurse (LN) 1, LN 1 stated she was sitting at the nurse's station on 7/8/25 when incident occurred between Resident 1 and Resident 2. LN 1 stated Resident 1 and Resident 2 were in their wheelchairs beside each other when Resident 2 tried to pass by Resident 1 and bumped into Resident 1's wheelchair. LN 1 stated Resident 1 hit Resident 2 on the forearm and Resident 2 hit Resident 1 back and each resident hit back two to three times. LN 1 moved Resident 1 back to her room and asked her what happened. LN 1 stated Resident 1 did not know what happened. LN 1 stated she asked Resident 2 what happened, and he replied, She hit me first. She did it first, so I have to do something. LN 1 stated Resident 1 can be aggressive and tried to hit someone else that same evening. LN 1 stated Resident 1 has been physically aggressive towards staff and has hit and kicked staff. LN 1 stated Resident 2 had her Ativan (medication to treat anxiety) dose increased yesterday after second incident of trying to hit someone because the prior dose was not working. During an interview on 7/9/25 at 2:54 p.m. with CNA 1, CNA 1 stated Resident 1 can be resistive to care and will strike out at staff. CNA 1 stated Resident 2 sometimes gets angry, but CNA 1 was not aware of any physical aggression. During an interview on 7/9/25 at 3:00 p.m. with Resident 1, Resident 1 stated she did not recall any incident with Resident 2 or any other resident. When asked if anyone had hit her, Resident 1 stated she did not remember. During an interview on 7/9/25 at 3:08 p.m. with Resident 2, Resident stated he recalled incident with Resident 2 on 7/8/25. Resident 2 stated he was in his wheelchair and was trying to squeeze by Resident 1 in the hallway and Resident 1 moved her wheelchair and banged into him. Resident stated he quietly asked Resident 1, Do you understand why you shouldn't sit at the intersection where there are too many people. Resident 2 stated Resident 1 yelled No and started hitting him with both her arms. When asked if he hit back, Resident 2 stated, [Expletive] right. World I grew up in, if someone hits you, you have the perfect right to hit him back. If she is a mental case this place should not have her here. [Expletive] right I hit her back. Had no choice, then I hit her twice back. Staff finally woke up and moved her away from me which is what I was trying to do anyway. Hit back a couple of times and was done with the crazy .Wanted to go on with the rest of my day. Resident 2 stated he has not had any incidents with any other residents, only her mental case, an active menace. A review of the facility's Policy and Procedure (P&P) titled Abuse Prevention Program, revised 12/16, indicated .Our residents have the right to be free from abuse .This incudes but is not limited to freedom from . physical abuse .As part of the resident abuse prevention, the administration will: .Protect our residents from abuse by anyone including .other residents .Identify and assess all possible incidents of abuse .Protect residents during abuse investigations . A review of the facility's P&P titled Resident-to-Resident Altercations, revised 10/17, indicated .All altercations, including those that may represent resident-to-resident abuse, shall be investigated .Facility staff will monitor residents for aggressive/ inappropriate behavior towards other residents .or to the staff .If two residents are involved in an altercation, staff will .Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation .Review the events with the Nursing Supervisor and Director of Nursing and possible measures to try and prevent additional incidents .