STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056139	A. Building B. Wing	03/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Point Health & Wellness Center	600 Sunrise Avenue 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for a resident with a deep tissue injury pressure ulcer (DTI-PU, a purple or maroon area of discolored intact skin due to pressure) for one of five sampled residents, Resident 4. This failure prevented Resident 4 from receiving the care she needed to prevent the development of a pressure ulcer. Findings: During a review of the clinical record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) following a nontraumatic intracerebral hemorrhage (stroke) affecting the left non dominant side, and compression of the brain (brain gets compressed due to increase pressure caused by bleeding or swelling). During a review of Resident 4's Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive Patterns, dated 12/14/23, indicated Resident 4 had a Brief Interview for Mental Status (a tool to assess cognition) score of 6 out of 15 which indicated Resident 4 had severe cognitive impairment. A further review of Resident 4's MDS, under the functional abilities and goals section, indicated Resident 4 was dependent with the staff to roll left and right; sit to lying; and lying to sitting on the side of bed. A review of Resident 4's Braden Scale's total score (a tool used for predicting pressure ulcer risk) dated 12/9/23, indicated, Resident 4's total score was 12 which indicated the resident was at a high risk for the development of a PU. A review of Resident 4's Wound Progress Note, dated 12/15/23, indicated, .Wounded [sic] area found on residents coccyx onto left and right buttock. A review of Resident 4's Surgical Consult note, dated 12/18/23, indicated, .ETIOLOGY: Pressure injury/ulcer - deep tissue pressure injury The measurement was 4.0 cm (centimeter, unit of measurement) in length, 7.5 cm width, 30.00 cm wound area, and depth of UTD (unstageable full thickness skin or tissue loss, depth unknown), with 100 % necrotic tissue (death of body tissue). (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

Printed: 06/27/2024
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	056139	A. Building B. Wing	03/10/2024

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Roseville Point Health & Wellness Center	600 Sunrise Avenue Roseville, CA 95661

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/24 at 9:30 a.m., with the ADON (Assistant Director of Nursing), the ADON confirmed, Resident 4 was admitted to the facility on [DATE], and did not have skin breakdown upon admission. The ADON stated, Licensed Nurse 4 (LN 4), found the wound on Resident 4's coccyx area on 12/15/23, which meant her pressure sore developed during her stay in the facility. The ADON further stated her expectation from the staff was to monitor the resident for skin breakdown, turn the resident every two hours and create a care plan. The ADON stated she did not see documentation that Resident 4 was being turned every 2 hours and further confirmed that there was no care plan created for Resident 4's DTI-PU. During a concurrent interview and record review on 3/13/24 at 12:03 p.m., with LN 4, LN 4 acknowledged she found the wound area on Resident 4's left and right buttocks as she documented it under the wound progress notes. LN 4 stated, Resident 4 was considered at high risk to develop a pressure sore as indicated in her Braden Scale score. LN 4 further stated, staff should have turned Resident 4 every 2 hours to prevent Resident 4 from developing pressure sores. When asked, LN 4 confirmed she did not find documentation that the staff turned and performed incontinent care every 2 hours for Resident 4. LN 4 acknowledged, that there was no care plan created for Resident 4's DTI-PU. LN 4 also stated, the care plan should be initiated as soon as the wound was identified. During a review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, revised November 2018, indicated, .It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, psychosocial well-being . It should address resident-specific health and safety concerns to prevent decline of injury, and would identify needs for supervision .

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NAME OF PROVIDER OR SUPPLIER Roseville Point Health & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Sunrise Avenue Roseville, CA 95661	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on interview and record review, the facility failed to follow their policy and procedures to prevent a pressure sore from developing for one of five sampled residents (Resident 4) when, the resident developed a deep tissue injury pressure sore (DTI-PU- a purple or maroon area of discolored intact skin with underlying tissue damage due to pressure or shearing). This deficient practice caused the development of a deep tissue injury pressure sore to Resident 4's left and right buttocks, coccyx area. Findings: A review of the clinical record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses that included Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) following nontraumatic intracerebral hemorrhage (stroke) affecting the left non dominant side, and compression of the brain (brain gets compressed due to increase pressure caused by bleeding or swelling). During a review of Resident 4's Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive Patterns, dated 12/14/23, indicated Resident 4 had a Brief Interview for Mental Status (a tool to assess cognition) score of 6 out of 15 which indicated Resident 4 had severe cognitive impairment. Section Functional Abilities and Goals indicated Resident 4 was dependent on the staff to roll left and right; sit to lying; and lying to sitting on side of bed. The section for Bladder and Bowel, dated 12/14/23, indicated, Resident 4 was always incontinent of stool and urine and under Skin Conditions, .Skin and Ulcer/Injury Treatments .None of the above were provided ., 0 [zero] Number of unstageable pressure injuries presenting as deep tissue injury . A review of Resident 4's discharge instructions from the hospital [name of the hospital] dated 12/8/23, indicated, Resident 4 was discharged to the skilled nursing home [name of the facility] with the ability to perform less than half the effort to transfer from chair/bed to chair; to roll left and right and return to back; and sitting on side of bed to lying flat on bed. A review of Resident 4's Braden Scale (a tool used for predicting pressure ulcer risk) dated 12/9/23, indicated, Resident 4's total score was 12 which indicated the resident was at a high risk for the development of a PU. A review of Resident 4's Weekly Skin/Wound Assessment, dated 12/9/23, indicated, Resident 4 had Skin Intact with no identified skin impairment . No skin issues noted during admission . A review of Resident 4's Wound Progress Note, effective date 12/15/23, indicated, .Wounded [sic] area found on residents coccyx onto left and right buttock. A review of Resident 4's Surgical Consult note, dated 12/18/23, indicated, .ETIOLOGY: Pressure injury/ulcer - deep tissue pressure injury .Recommend low air loss mattress. The measurement was 4.0 cm (centimeter, unit of measurement) in length, 7.5 cm width, 30.00 cm wound area, and depth of UTD (unstageable full thickness skin or tissue loss, depth unknown), with 100 % necrotic tissue (death of body tissue). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's ADL sheet, dated January 2024, indicated, Resident 4 was incontinent of bowel and bladder function. During a concurrent interview and record review on 3/13/24 at 9:30 a.m., with the ADON (Assistant Director of Nursing), the ADON confirmed, Resident 4 was admitted to the facility on [DATE], and did not have skin breakdown upon admission. The ADON stated, Licensed Nurse 4 (LN 4), found the wound on Resident 4's coccyx area on 12/15/23, which meant her pressure sore developed during her stay in the facility. The ADON further stated her expectation from the staff was to monitor the resident for skin breakdown, turn the resident every two hours and create a care plan. The ADON stated she did not see documentation that Resident 4 was being turned every 2 hours and further confirmed that there was no care plan created for Resident 4's DTI-PU. During a concurrent interview and record review on 3/13/24 at 12:03 p.m., with LN 4, LN 4 acknowledged she found the wound area on Resident 4's left and right buttocks and she documented it under the wound progress notes. LN 4 stated, Resident 4 was considered at high risk to develop a pressure sore as indicated in her Braden Scale score. LN 4 further stated, staff should have turned Resident 4 every 2 hours to prevent Resident 4 from developing pressure sores. When asked, LN 4 confirmed she did not find documentation that the staff turned and performed incontinent care every 2 hours for Resident 4. LN 4 acknowledged, that there was no care plan created for Resident 4's DTI-PU. LN 4 also stated, the care plan should be initiated as soon as the wound was identified. During a review of the facility's policy and procedure titled, SK04 Skin Integrity Management, effective date 11/14/23, indicated, .The facility will identify, evaluate, and intervene to prevent and/or heal pressure ulcers and other skin integrity conditions .