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	06/03/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on interview and record review the Licensed Nurse 1 (LN 1) failed to immediately notify the Nurse Practitioner (NP) and Responsible Parties (RP) for two residents (Resident 1 and Resident 2) of two sampled residents when LN 1 witnessed Resident 1 slap Resident 2 in the face. These failures resulted in delayed assessments and diagnostic testing for injury, and distress to Resident 1's RP when he discovered Resident 1's injuries without having been notified by facility staff. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE] with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and dementia with psychotic disturbance (the mental state where someone is not sure what is real or not). A review of a Minimum Data Set (MDS, an assessment tool), dated 3/4/24, indicated Resident 1 had a severe memory problem. A review of Resident 2's admission record indicated admission to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbance (such as agitation, depression, and psychosis or impaired contact with reality). A review of an MDS, dated [DATE], indicated Resident 2 had a moderate memory problem. A review of Resident 1's progress note written by LN 2, dated 5/3/24 at 7:01 a.m., indicated, During my morning rounds, I noticed a blue-purplish bruise on the right jawline, upper lip and lower lip. NP was notified of the bruises found. Cold compress and x-ray order [sic]. Orders noted and carried out. A review of Resident 1's progress note written by LN 3, dated 5/3/24 at 12:27 p.m., indicated, At 11:00 am on 5/3/24. Head to toe skin assessment completed .Resident lying in bed alert and awake with no overt s/sx [signs and symptoms] of pain, no episode of restlessness or aggressive behavior, she is calm, pleasant and cooperative. Right lower jaw reddish skin discoloration (4.5 cm [centimeters, a unit of measure] x 3.5 cm) right side of face down to right jaw greenish to reddish discoloration 4.5 x 4.0 cm redness to right jaw measures 2.0 x 3.0 cm left upper lip scratched with dry blood right lower lip reddish discoloration 92.0 x 1.0) right breast dark discoloration 91.0 x 1.0 cm) .left cheek scratch (2.0 x 0.5 cm) . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's NP progress note, dated 5/3/24 at 1:26 p.m. indicated, .According to nursing staff, patient had altercation with other resident .This morning I came to evaluate patient; I noted large bruise on the right jaw, bruises on the upper and lower lip, and bruise on inner thigh. There is no documentation how patient got those bruises .I evaluated the patient's condition today and found it to be stable .Changes: stat x-ray of jaw; monitor the bruises for worsening; patient is moved, monitor closely. A review of Resident 1's Interdisciplinary Team (IDT, a team of healthcare workers from different aspects of resident care) progress note, dated 5/3/24 at 6:36 p.m. indicated, [Resident] to [Resident] Altercation .Date of Incident: 5/2/24 .Allegation was witnessed by [LN 1], resident 1 slapping resident 2 on the face .According to [LN 1] documentation, resident 1 got up and went to resident 2's area and slapped her on the face. [LN 1] approached the event by getting in the middle to separate both and redirect. Based on interview of the [LN 1], she stated she received the last remaining punches on her abdomen. [LN 1] was successful in redirecting resident 1 and resident 2 to their appropriate beds. A review of Resident 1's progress note, dated 5/4/24 at 2:55 p.m. indicated, .Spoke to resident's [RP] this [morning] shift regarding bruises to resident's face [RP] also verbalized concern about not getting notified prior to today. Shift supervisor made aware. In an interview on 5/7/24 at 11:47 a.m., the RP 1 stated he had a video conference call with Resident 1 on 5/4/24 when he noticed bruising on Resident 1's right jaw and cut lip. The RP 1 stated he asked to speak to staff to find out what happened to Resident 1. The RP 1 stated the staff he spoke with did not know and they had noticed the bruising on 5/3/24. On 5/7/24 at 1:15 p.m., a review of Resident 1's progress note, dated 5/2/24 at 1:30 a.m. indicated, Resident sleeping well tonight without any distress or discomfort. Call light within reach. Will continue to monitor behavior. There was no additional documentation dated 5/2/24 in Resident 1's medical chart. On 5/7/24 at 1:16 p.m., a review of Resident 2's progress note, dated 5/2/24 at 1:51 a.m. indicated, Resident sleeping without anxiety or agitation at this time. Will continue to monitor behavior. Call light in reach. There was no additional documentation dated 5/2/24 in Resident 2's medical chart. On 5/17/24, a review of Resident 1's progress note written by LN 1, dated 5/2/24 at 5:41 p.m. indicated, . [Resident 1] got up, entered roommate bed .and slapped [Resident 2] in the face. This has occurred twice now. Management was notified along with [the NP]. This patient's behavior escalates during evenings and nighttime. [Resident 1] has become more aggressive and combative. I informed the .(RP) about [Resident 1's] behaviors, including constantly hitting and spitting on staff and other residents. The RP was uncooperative and rude in tone, stating, 'Deal with it, sedate her, and keep her medicated. Tell your MDs [physicians] to learn to do their jobs. I'm not wasting my money on her care, and she will be staying at [the facility] . ' The RP was reminded that this is not a memory care center, and we cannot keep patients sedated or apply restraints. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/24, a review of Resident 2's progress note written by LN 1, dated 5/2/24 at 7:13 p.m. indicated, [Resident 2] had confrontation with roommate who suffers from dementia. Staff intervened and redirected both residents to their beds. Advised patient not to touch other residents. WCTM [Will continue to monitor]. On 5/17/24, a review of Resident 1's progress note written by LN 1, dated 5/2/24 at 8:13 p.m. indicated, Patient was scratching face and left side of lip, noted dried blood. Management notified and cleared the remaining fluid of [sic] the face. Redirected to not scratch face .WCTM. On 5/17/24, a review of Resident 2's progress notes, dated 5/2/24, showed no documented evidence Resident 2's RP was notified of the altercation in which Resident 2 was the victim. In a telephone interview on 5/24/24 at 9:55 a.m., the NP denied being notified of the altercation between Resident 1 and Resident 2 on 5/2/24. The NP stated she was notified the following morning of Resident 1's bruises. The NP stated she was physically in the facility from 7 a.m. to 5 p.m. Monday through Friday. The NP further stated she remembered the LN 1 notified her Resident 1's behaviors had been increasing, but the information was not new as Resident 1's behaviors had been increasing for the past month. The NP added had the LN 1 stated she witnessed Resident 1 slap Resident 2 in the face, then the NP would have evaluated both residents prior to leaving the facility on 5/2/24, since the LN 1 had reported the altercation occurred in the late afternoon. The NP stated even if the altercation had occurred after she had left the facility, the LN 1 was expected to notify the on-call physician, conduct, and document an assessment, and move Resident 1 to a different room to ensure another altercation did not occur. In a telephone interview on 5/24/24 at 10:27 a.m., the LN 1 stated on 5/2/24, during the PM shift she heard screaming. The LN 1 stated she and CNA 2 went to Resident 1's room and when they arrived Resident 1 was naked and hitting Resident 2. The LN 1 reported Resident 2 yelled, That woman is trying to hit me as she was pointing to Resident 1. The LN 1 stated she reported the incident to the NS, DON, and NP as soon as it occurred and documented everything, at the time they occur or within 15 minutes. When asked what the LN 1 specifically reported to the DON, the LN 1 stated she told the DON, [Resident 1] was having behaviors again and that [Resident 1] had a 'slapfest' with [Resident 2]. When asked what the NP ordered LN 1 to do after she notified her of the incident, the LN 1 stated the NP stated Resident 1 needed a psychiatric consult. The LN 1 stated she had not called Resident 1's psychiatrist to make an appointment. In an interview on 6/3/24 at 2:51 p.m., the DON stated she expected the licensed nurse to notify the NP or on-call physician and notify the RP for all residents involved in an allegation of abuse. The DON also stated she expected licensed nurses to document a witnessed altercation between residents no later than two hours after the incident. The DON verified the LN 1 did not provide professional standards of nursing care for Resident 1 and Resident 2 when she did not notify the NP or on-call physician and RPs of both residents as soon as the residents' safety was ensured. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Change of Condition, revised on 4/1/15, indicated, Purpose to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner .It is the responsibility of the person who observes the change to report the change .The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate .the Licensed Nurse must observe and assess the overall condition utilizing a physician assessment and chart review .A Licensed Nurse will notify the resident's .Physician and legal representative .when there is an .incident .involving the resident .A Licensed Nurse will document the following .date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the .Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. The time the .responsible person was contact.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on interview and record review, the facility failed to report an incident of abuse within the regulatory timeframe for two residents (Resident 1 and Resident 2) when Resident 1 slapped Resident 2 on the face. This failure resulted in Licensed Nurse 1 (LN 1) not reporting a known issue. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE], with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and dementia with psychotic disturbance (the mental state where someone is not sure what is real or not). A review of a Minimum Data Set (MDS, an assessment tool) dated 3/4/24 indicated Resident 1 had a severe memory problem. A review of a facility training regarding Abuse Prevention; Resident to Resident Altercations and Abuse Reporting; Mandated Reporter, dated 1/19/24 and 2/26/24, indicated LN 1 was in attendance. A review of Resident 2's admission record indicated admission to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbance (such as agitation, depression, and psychosis or loss of contact with reality). A review of an MDS, dated [DATE], indicated Resident 2 had a moderate memory problem. A review of Resident 1's progress note written by LN 1, dated 5/2/24 at 5:41 p.m. indicated, .[Resident 1] got up, entered roommate's bed .and slapped [Resident 2] in the face. This has occurred twice now. Management was notified along with [the physician]. A review of Resident 2's progress note written by LN 1, dated 5/2/24 at 7:13 p.m. indicated, [Resident 2] had confrontation with roommate who suffers from dementia. Staff intervened and redirected both residents to their beds. Advised patient not to touch other residents. WCTM [Will continue to monitor]. A review of Resident 1's progress note written by LN 2, dated 5/3/24 at 7:01 a.m., indicated, During my morning rounds, I noticed a blue-purplish bruise on the right jawline, upper lip and lower lip. NP [Nurse Practitioner] was notified of the bruises found. Cold compress and x-ray order [sic]. Orders noted and carried out. A review of Resident 1's social service note, dated 5/3/24 at 12:03 p.m. indicated the California Department of Public Health (CDPH), the Ombudsman (a public advocate who investigates and tries to resolve complaints, usually through recommendations or mediation), and the police department were notified of the alleged resident to resident incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress note written by LN 3, dated 5/3/24 at 12:27 p.m., indicated, At 11:00 am on 5/3/24. Head to toe skin assessment completed by two LNs and 2 CNAs [Certified Nursing Assistant] assisted with repositioning resident .informed [Resident 1] that will conduct skin assessment. Resident lying in bed alert and awake with no overt s/sx [signs and symptoms] of pain, no episode of restlessness or aggressive behavior, she is calm, pleasant and cooperative. Right lower jaw reddish skin discoloration (4.5 cm [centimeters, a unit of measure] x 3.5 cm) right side of face down to right jaw greenish to reddish discoloration 4.5 x 4.0 cm redness to right jaw measures 2.0 x 3.0 cm left upper lip scratched with dry blood right lower lip reddish discoloration 92.0 x 1.0) right breast dark discoloration 91.0 x 1.0 cm) .left cheek scratch (2.0 x 0.5 cm) . A review of Resident 1's physician/ NP note, dated 5/3/24 at 1:28 p.m. indicated, Chief Complaint .[Patient] altercation .According to nursing staff, patient had altercation with other resident. [Resident 1] had increased [sic] in behaviors including hitting other residents. The nurse reported that son wants [Resident 1] 'sedated ' and [LN 1] was asking for morphine for [Resident 1]. However, [Resident 1] is very directable and non-pharmacedical [sic] interventions such as redirection, music, and change of environment was recommended. This morning I came to evaluate [Resident 1]; I noted large bruise on the right jaw, bruises on the upper and lower lip, and bruise on inner thigh. There is no documentation how patient got those bruises . Patient is once again pleasant today and tells me she does not remember anything from yesterday. A review of Resident 1's Interdisciplinary Team (IDT) progress note, dated 5/3/24 at 6:36 p.m. indicated, [Resident] to [Resident] Altercation .Date of Incident: 5/2/24 .Allegation was witnessed by Charge Nurse, resident 1 slapping resident 2 on the face .According to LN documentation, resident 1 got up and went to resident 2 area and slapped her on the face. LN approached the event by getting in the middle to separate both and redirect. Based on interview of the LN, she stated she received the last remaining punches on her abdomen. LN was successful in redirecting resident 1 and resident 2 to their appropriate beds. In an interview on 5/7/24 at 1 p.m., the Director of Nursing (DON) confirmed the incident between Resident 1 and Resident 2 occurred on 5/2/24 but was not reported to CDPH until 5/6/24. The DON stated the LN 1 should have reported the incident earlier as the LN 1 was the only witness to the incident. A review of the facility ' s policy and procedure titled Reporting Abuse revised 1/8/14 indicated, The Facility will report known .instances of physical abuse to the proper authorities by telephone or through a confidential internet reporting tool as required by state and federal regulations. If the reportable even results in serious bodily injury, a telephone report shall be made to the local enforcement agency immediately and no later than two (2) hours of observation, knowledge .of the physical abuse. In addition, a written report shall be made to the local Ombudsman, the [CDPH], and the local law enforcement agency within two (2) hours of the observation, knowledge .of the physical abuse. A review of the facility ' s undated document titled Steps for Reporting [Abuse] indicated, .Fill out SOC 341 [Report of Suspected Dependent Adult/ Elder Abuse] .Fax SOC 341 and call the following within 2 Hours- CDPH .Ombudsman .Law Enforcement .Utilize the Front Fax/Printer: The following contact agencies are pre-programmed onto contact lists .After sending SOC 341 via fax, keep copies of receipt of fax and attach to SOC 341. Save all contents and put into SOC 341 binder.

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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 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on interview and record review the facility failed to ensure the safety for two residents (Resident 1 and Resident 2) after Licensed Nurse 1 witnessed Resident 1 slap Resident 2 on the face and did not separate Resident 1 and Resident 2 into different rooms. This failure resulted in Resident 1 obtaining a 4.5 centimeter (cm, a unit of measure) by 3.5 cm bruise along the right cheek and jaw due to continued exposure to the perpetrator. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE], with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and dementia with psychotic disturbance (the mental state where someone is not sure what is real or not). A review of a Minimum Data Set (MDS, an assessment tool), dated 3/4/24, indicated Resident 1 had a severe memory problem. A review of Resident 2's admission record indicated admission to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbance (such as agitation, depression, and psychosis or loss of contact with reality). A review of an MDS, dated [DATE], indicated Resident 2 had a moderate memory problem. A review of Resident 1's progress note written by LN 1, dated 5/2/24 at 5:41 p.m. indicated, .[Resident 1] got up, entered roommate bed .and slapped [Resident 2] in the face .This patient's behavior escalates during evenings and nighttime. [Resident 1] has become more aggressive and combative . A review of Resident 2's progress note written by LN 1, dated 5/2/24 at 7:13 p.m. indicated, [Resident 2] had confrontation with roommate who suffers from dementia. Staff intervened and redirected both residents to their beds. Advised patient not to touch other residents. WCTM [Will continue to monitor]. A review of Resident 1's progress note written by LN 2, dated 5/3/24 at 7:01 a.m., indicated, During my morning rounds, I noticed a blue-purplish bruise on the right jawline, upper lip and lower lip. NP [Nurse Practitioner] was notified of the bruises found. Cold compress and x-ray order [sic]. Orders noted and carried out. A review of Resident 1's progress note written by LN 3, dated 5/3/24 at 12:27 p.m., indicated, At 11:00 am on 5/3/24. Head to toe skin assessment completed by two LNs and 2 CNAs [Certified Nursing Assistant] assisted with repositioning resident .informed [Resident 1] that will conduct skin assessment. Resident lying in bed alert and awake with no over s/sx [signs and symptoms] of pain, no episode of restlessness or aggressive behavior, she is calm, pleasant and cooperative. Right lower jaw reddish skin discoloration (4.5 cm [centimeters, a unit of measure] x 3.5 cm) right side of face down to right jaw greenish to reddish discoloration 4.5 x 4.0 cm redness to right jaw measures 2.0 x 3.0 cm left upper lip scratched with dry blood right lower lip reddish discoloration 92.0 x 1.0) right breast dark discoloration 91.0 x 1.0 cm) .left cheek scratch (2.0 x 0.5 cm) . (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's social service progress note, dated 5/3/24 at 12:52 p.m. indicated, [Resident 1] to be moved .as a plan of care after alleged Resident to Resident altercation filed on 5/3/24 .Will monitor for 72 hours post room change. A review of Resident 1's NP progress note, dated 5/3/24 at 1:26 p.m. indicated, .According to nursing staff, patient had altercation with other resident .I noted large bruise on the right jaw, bruises on the upper and lower lip, and bruise on inner thigh. There is no documentation how patient got those bruises .Changes: stat x-ray of jaw; monitor the bruises for worsening; patient is moved, monitor closely. A review of Resident 1's Interdisciplinary Team (IDT, a team of healthcare workers from different aspects of resident care) progress note, dated 5/3/24 at 6:36 p.m. indicated, [Resident] to [Resident] Altercation .Date of Incident: 5/2/24 .Allegation was witnessed by [LN 1], resident 1 slapping resident 2 on the face .According to [LN 1] documentation, resident 1 got up and went to resident 2's area and slapped her on the face. [LN 1] approached the event by getting in the middle to separate both and redirect. Based on interview of the [LN 1], she stated she received the last remaining punches on her abdomen. [LN 1] was successful in redirecting resident 1 and resident 2 to their appropriate beds. In a telephone interview on 5/24/24 at 9:55 a.m., the NP stated she was notified of Resident 1 and Resident 2's altercation the morning of 5/3/24. The NP stated the LN 1 was expected to move Resident 1 to a different room to ensure another altercation did not occur. In a telephone interview on 5/22/24 at 4:53 p.m., the Nurse Supervisor (NS) confirmed she worked the evening (PM) shift on 5/2/24 was not made aware of the altercation between Resident 1 and Resident 2 by LN 1. The NS stated nurses were expected to notify nurse supervisors of abuse so staff could find a room to move one of the residents to ensure their safety. The NS stated, I would have made sure they were both separated, and both monitored. In a telephone interview on 5/22/24 at 5:20 p.m., the LN 2 stated LN 1 had mentioned an incident between Resident 1 and Resident 2 had occurred on the evening of 5/2/24 but had not been specific as to what happened. The LN 2 stated when she rounded on Resident 1 and Resident 2, they were in the same room. The LN 2 stated she was shocked to see bruises on Resident 1's face. The LN 2 referred to Resident 1's chart, there was no documentation of what occurred to explain the bruises on Resident 1's face. The LN 2 also stated both Resident 1 and Resident 2 were confused but capable of getting out of bed by themselves and added both were not weak and could potentially cause damage to each other. In a telephone interview on 5/24/24 at 10:16 a.m., the Certified Nurse Assistant 1 (CNA 1) confirmed she was assigned to care for Resident 1. The CNA 1 denied moving either Resident 1 or Resident 2 to a different room during her shift on 5/2/24. The CNA 2 stated if a licensed nurse notified her of an altercation between resident roommates, the protocol was for the residents to be separated into different rooms to make sure they were safe while the nurses conduct the investigation. In a telephone interview on 5/24/24 at 10:27 a.m., the LN 1 stated on 5/2/24 during the PM shift she heard screaming. The LN 1 stated she and CNA 2 went to Resident 1's room and when they arrived Resident 1 was naked and hitting Resident 2. The LN 1 reported Resident 2 yelled, That woman is trying to hit me as she was pointing to Resident 1. The LN 1 also reported she had been kicked in the back by Resident 1 and stated CNA 2 was a witness to it. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 5/24/24 at 11:04 a.m., the CNA 2 stated during his shift on 5/2/24. The CNA 2 stated he did not see any hitting or kicking from Resident 1 or Resident 2 that night. The CNA 2 verified Resident 1 nor Resident 2 were moved to another room during his shift on 5/2/24. In an interview on 6/3/24 at 2:51 p.m., the DON confirmed she was not informed by LN 1 she witnessed Resident 1 slap Resident 2 in the face. The DON stated had she been notified; she would have instructed LN 1 to collaborate with the NS to move either Resident 1 or Resident 2 to a different room. The DON stated if she had been unavailable, the LN 1 could have also notified the admissions department, the NS, and the Infection Preventionist (IP). The DON stated she expected the licensed nurse to separate residents to ensure safety and to monitor all residents involved in the abuse. The DON verified the LN 1 did not follow the facility ' s policy and procedure regarding abuse. A review of the facility's policy and procedure titled Reporting Abuse revised 1/8/14, indicated, .The facility will ensure that the resident has the right to be free from verbal, sexual, physical, and mental abuse .Facility Staff as Mandated Reporters .If the allegation [of abuse] is regarding a resident-resident altercation, the residents will be separated immediately, pending the investigation .Responding to an Allegation . If the allegation [of abuse] is regarding a resident-resident altercation, the residents will be separated immediately, pending the investigation.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on interview and record review, the Licensed Nurse 1 (LN 1) failed to provide care per professional standards for two residents (Resident 1 and Resident 2) of two sampled residents when LN 1 witnessed Resident 1 slap Resident 2 in the face and: 1. Did not assess both of the residents after the witnessed altercation; and, 2. Did not initiate a care plan for each of the residents after the witnessed altercation. These failures decreased the facility's potential to provide nursing care which encompassed the nursing practice. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE], with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and dementia with psychotic disturbance (the mental state where someone is not sure what is real or not). A review of an Minimum Data Set (MDS, an assessment tool), dated 3/4/24, indicated Resident 1 had a severe memory problem. A review of a facility training regarding Abuse Prevention; Resident to Resident Altercations and Abuse Reporting; Mandated Reporter, dated 1/19/24 and 2/26/24, indicated LN 1 was in attendance. A review of Resident 2's admission record indicated admission to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbance (such as agitation, depression, and psychosis or loss of contact with reality). A review of an MDS, dated [DATE], indicated Resident 2 had a moderate memory problem. A review of Resident 1's progress note written by LN 2, dated 5/3/24 at 7:01 a.m., indicated, During my morning rounds, I noticed a blue-purplish bruise on the right jawline, upper lip and lower lip. NP [Nurse Practitioner] was notified of the bruises found. Cold compress and x-ray order [sic]. Orders noted and carried out. A review of Resident 1's progress note written by LN 3, dated 5/3/24 at 12:27 p.m., indicated, At 11:00 am on 5/3/24. Head to toe skin assessment completed by two LN and 2 CNA [Certified Nursing Assistant] assisted with repositioning resident .informed [Resident 1] that will conduct skin assessment. Resident lying in bed alert and awake with no over s/sx [signs and symptoms] of pain, no episode of restlessness or aggressive behavior, she is calm, pleasant and cooperative. Right lower jaw reddish skin discoloration (4.5 cm [centimeters, a unit of measure] x 3.5 cm) right side of face down to right jaw greenish to reddish discoloration 4.5 x 4.0 cm redness to right jaw measures 2.0 x 3.0 cm left upper lip scratched with dry blood right lower lip reddish discoloration 92.0 x 1.0) right breast dark discoloration 91.0 x 1.0 cm) .left cheek scratch (2.0 x 0.5 cm) . (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's NP progress note dated 5/3/24 at 1:26 p.m. indicated, .According to nursing staff, patient had altercation with other resident .I noted large bruise on the right jaw, bruises on the upper and lower lip, and bruise on inner thigh. There is no documentation how patient got those bruises .I evaluated the patient ' s condition today and found it to be stable .Changes: stat x-ray of jaw; monitor the bruises for worsening; patient is moved, monitor closely. A review of Resident 1's Interdisciplinary Team (IDT, a team of healthcare workers from different aspects of resident care) progress note dated 5/3/24 at 6:36 p.m. indicated, [Resident] to [Resident] Altercation .Date of Incident: 5/2/24 .Allegation was witnessed by [LN 1], resident 1 slapping resident 2 on the face .According to [LN 1] documentation, resident 1 got up and went to resident 2 area and slapped her on the face. [LN 1] approached the event by getting in the middle to separate both and redirect. Based on interview of the [LN 1], she stated she received the last remaining punches on her abdomen. [LN 1] was successful in redirecting resident 1 and resident 2 to their appropriate beds. On 5/7/24 at 1:15 p.m., a review of Resident 1's progress note, dated 5/2/24 at 1:30 a.m. indicated, Resident sleeping well tonight without any distress or discomfort. Call light within reach. Will continue to monitor behavior. There was no additional documentation dated 5/2/24 in Resident 1's medical chart. On 5/7/24 at 1:16 p.m., a review of Resident 2's progress note, dated 5/2/24 at 1:51 a.m. indicated, Resident sleeping without anxiety or agitation at this time. Will continue to monitor behavior. Call light in reach. There was no additional documentation dated 5/2/24 in Resident 2's medical chart. On 5/17/24, a review of Resident 1's progress note written by LN 1, dated 5/2/24 at 5:41 p.m. indicated, . [Resident 1] got up, entered roommate bed .and slapped [Resident 2] in the face. This has occurred twice now. Management was notified along with [the NP]. This patient's behavior escalates during evenings and nighttime. [Resident 1] has become more aggressive and combative. I informed the .(RP) about [Resident 1's] behaviors, including constantly hitting and spitting on staff and other residents. The RP was uncooperative and rude in tone, stating, ' Deal with it, sedate her, and keep her medicated. Tell your MDs [physicians] to learn to do their jobs. I'm not wasting my money on her care, and she will be staying at [the facility] .' The RP was reminded that this is not a memory care center, and we cannot keep patients sedated or apply restraints. On 5/17/24, a review of Resident 2's progress note written by LN 1, dated 5/2/24 at 7:13 p.m. indicated, [Resident 2] had confrontation with roommate who suffers from dementia. Staff intervened and redirected both residents to their beds. Advised patient not to touch other residents. WCTM [Will continue to monitor]. A review of all of Resident 1's care plans conducted on 5/17/24 indicated a care plan was initiated on 5/3/24 by LN 2 regarding Resident 1's new bruises n the right jawline, upper lip, and bottom lip. A review of all of Resident 2's care plans conducted on 5/17/24 indicated a care plan was initiated on 5/3/24 by the Social Worker (SW) regarding Resident 2's, Resident to Resident: potential altercation- bruising involved, not to [Resident 2] . (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 5/22/24 at 4:53 p.m., the Nurse Supervisor (NS) confirmed there was no documentation of the altercation in neither Resident 1 nor Resident 2's charts when she reviewed the charts the following day on 5/3/24 when the Director of Nursing (DON) notified her of the altercation. In a telephone interview on 5/22/24 at 5:20 p.m., the LN 2 stated when she checked on Resident 1, she was shocked to see the bruises on Resident 1's face. The LN 2 referred to Resident 1's chart, there was no documentation of what occurred to explain the bruises on Resident 1's face. The LN 2 stated, .I started to look at the notes to see if anything was documented and what was reported. I didn't see anything. The LN 2 further stated, When something happens, you're [the LN] supposed to document it and document what you did for the resident. In a telephone interview on 5/24/24 at 9:55 a.m., the NP stated she expected the LN 1 to have conducted and documented an assessment for each resident after the LN 1 witnessed Resident 1 slap Resident 2 and to have notified the NP or on-call physician of the altercation. In a telephone interview on 5/24/24 at 10:27 a.m., the LN 1 stated on 5/2/24 during the PM shift she heard screaming. The LN 1 stated she and CNA 2 went to Resident 1's room and when they arrived Resident 1 was naked and hitting Resident 2. The LN 1 reported Resident 2 yelled, That woman is trying to hit me as she was pointing to Resident 1. The LN 1 stated she documented everything, at the time they occur or within 15 minutes. When asked what LN 1 documented in Resident 1's chart, the LN 1 stated, I'm obligated to document what I see. In an interview on 6/3/24 at 2:51 p.m., the DON stated she expected the licensed nurse to conduct and document an assessment in the progress notes, complete a Change of Condition document, and initiate a care plan of the incident of abuse. The DON also stated she expected licensed nurses to document a witnessed altercation between residents no later than two hours after the incident. The DON verified the LN 1 did not provide professional standards of nursing care for Resident 1 and Resident 2 when LN 1 did not document an assessment and initiate a care plan after the altercation. A review of the facility's policy and procedure titled Change of Condition, revised on 4/1/15, indicated, .It is the responsibility of the person who observes the change to report the change .The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate .the Licensed Nurse must observe and assess the overall condition utilizing a physician assessment and chart review . A Licensed Nurse will document the following .date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes .Update the Care Plan to reflect the resident's current status. The incident and brief details in the 24 Hour Report .Complete an incident report per Facility policy. A Licensed Nurse will communicate any changes in required interventions to the CNAs involved in the resident ' s care .Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the Twenty-Four Hour Report.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on interview and record review, the Licensed Nurse 1 (LN 1) failed to accurately document on medical charts for two residents (Resident 1 and Resident 2) of two sampled residents when LN 1 witnessed Resident 1 slap Resident 2 in the face and: 1. Did not document the details of the altercation in either of the residents' medical records; and, 2. Did not document the time at which both of the residents' Responsible Parties (RP) were notified. These failures resulted in delayed assessments and diagnostic testing for injury, and distress to Resident 1's RP when he discovered Resident 1's injuries without having been notified by facility staff. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE], with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and dementia with psychotic disturbance (the mental state where someone is not sure what is real or not). A review of an Minimum Data Set (MDS, an assessment tool), dated 3/4/24, indicated Resident 1 had a severe memory problem. A review of Resident 2's admission record indicated admission to the facility on [DATE], with diagnoses which included dementia with other behavioral disturbance (such as agitation, depression, and psychosis or loss of contact with reality). A review of an MDS, dated [DATE], indicated Resident 2 had a moderate memory problem. A review of Resident 1's progress note written by LN 2, dated 5/3/24 at 7:01 a.m., indicated, During my morning rounds, I noticed a blue-purplish bruise on the right jawline, upper lip and lower lip. NP was notified of the bruises found. Cold compress and x-ray order [sic]. Orders noted and carried out. A review of Resident 1's progress note written by LN 3, dated 5/3/24 at 12:27 p.m., indicated, At 11:00 am on 5/3/24. Head to toe skin assessment completed .Resident lying in bed alert and awake with no overt s/sx [signs and symptoms] of pain, no episode of restlessness or aggressive behavior, she is calm, pleasant and cooperative. Right lower jaw reddish skin discoloration (4.5 cm [centimeters, a unit of measure] x 3.5 cm) right side of face down to right jaw greenish to reddish discoloration 4.5 x 4.0 cm redness to right jaw measures 2.0 x 3.0 cm left upper lip scratched with dry blood right lower lip reddish discoloration 92.0 x 1.0) right breast dark discoloration 91.0 x 1.0 cm) .left cheek scratch (2.0 x 0.5 cm) . (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's NP progress note, dated 5/3/24 at 1:26 p.m. indicated, .According to nursing staff, patient had altercation with other resident .This morning I came to evaluate patient; I noted large bruise on the right jaw, bruises on the upper and lower lip, and bruise on inner thigh. There is no documentation how patient got those bruises .I evaluated the patient's condition today and found it to be stable .Changes: stat x-ray of jaw; monitor the bruises for worsening; patient is moved, monitor closely. A review of Resident 1's Interdisciplinary Team (IDT, a team of healthcare workers from different aspects of resident care) progress note, dated 5/3/24 at 6:36 p.m. indicated, [Resident] to [Resident] Altercation .Date of Incident: 5/2/24 .Allegation was witnessed by [LN 1], resident 1 slapping resident 2 on the face .According to [LN 1] documentation, resident 1 got up and went to resident 2's area and slapped her on the face. [LN 1] approached the event by getting in the middle to separate both and redirect. Based on interview of the [LN 1], she stated she received the last remaining punches on her abdomen. [LN 1] was successful in redirecting resident 1 and resident 2 to their appropriate beds. In an interview on 5/7/24 at 11:47 a.m., the RP 1 stated he had a video conference call with Resident 1 on 5/4/24 when he noticed bruising on Resident 1's right jaw and cut lip. The RP 1 stated he asked to speak to staff to find out what happened to Resident 1. The RP 1 stated the staff he spoke with did not know and they had noticed the bruising on 5/3/24. On 5/7/24 at 1:15 p.m., a review of Resident 1's progress note, dated 5/2/24 at 1:30 a.m. indicated, Resident sleeping well tonight without any distress or discomfort. Call light within reach. Will continue to monitor behavior. There was no additional documentation dated 5/2/24 in Resident 1's medical chart. On 5/7/24 at 1:16 p.m., a review of Resident 2's progress note, dated 5/2/24 at 1:51 a.m. indicated, Resident sleeping without anxiety or agitation at this time. Will continue to monitor behavior. Call light in reach. There was no additional documentation dated 5/2/24 in Resident 2's medical chart. On 5/17/24, a review of Resident 1's progress note written by LN 1 dated 5/2/24 at 5:41 p.m. indicated, . [Resident 1] got up, entered roommate bed .and slapped [Resident 2] in the face. This has occurred twice now. Management was notified along with [the NP]. This patient's behavior escalates during evenings and nighttime. [Resident 1] has become more aggressive and combative. I informed the .(RP) about [Resident 1's] behaviors, including constantly hitting and spitting on staff and other residents. The RP was uncooperative and rude in tone, stating, ' Deal with it, sedate her, and keep her medicated. Tell your MDs [physicians] to learn to do their jobs. I ' m not wasting my money on her care, and she will be staying at [the facility] .' The RP was reminded that this is not a memory care center, and we cannot keep patients sedated or apply restraints. On 5/17/24, a review of Resident 2's progress note written by LN 1, dated 5/2/24 at 7:13 p.m. indicated, [Resident 2] had confrontation with roommate who suffers from dementia. Staff intervened and redirected both residents to their beds. Advised patient not to touch other residents. WCTM [Will continue to monitor]. On 5/17/24, a review of Resident 1's progress note written by LN 1 dated 5/2/24 at 8:13 p.m. indicated, Patient was scratching face and left side of lip, noted dried blood. Management notified and cleared the remaining fluid of [sic] the face. Redirected to not scratch face .WCTM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/24, a review of Resident 2's progress notes, dated 5/2/24 showed no documented evidence Resident 2's RP was notified of the altercation in which Resident 2 was the victim. In a telephone interview on 5/22/24 at 4:53 p.m., the Nurse Supervisor (NS) confirmed she worked the evening (PM) shift on 5/2/24 was not made aware of the altercation between Resident 1 and Resident 2 by LN 1. The NS confirmed there was no documentation of the altercation in neither Resident 1 or Resident 2's charts when she reviewed the charts the following day when the Director of Nursing (DON) notified her of the altercation. In a telephone interview on 5/24/24 at 9:55 a.m., the NP denied being notified of the altercation between Resident 1 and Resident 2 on 5/2/24. The NP stated she was notified the following morning of Resident 1's bruises. The NP stated she was physically in the facility from 7 a.m. to 5 p.m. Monday through Friday. The NP added had the LN 1 stated she witnessed Resident 1 slap Resident 2 in the face, then the NP would have evaluated both residents prior to leaving the facility on 5/2/24 since the LN 1 had reported the altercation occurred in the late afternoon. The NP stated even if the altercation had occurred after she had left the facility, the LN 1 was expected to notify the on-call physician, conduct, and document an assessment, and move Resident 1 to a different room to ensure another altercation did not occur. In a telephone interview on 5/24/24 at 10:27 a.m., the LN 1 stated on 5/2/24 during the PM shift she heard screaming. The LN 1 stated she and CNA 2 went to Resident 1's room and when they arrived Resident 1 was naked and hitting Resident 2. The LN 1 reported Resident 2 yelled, That woman is trying to hit me as she was pointing to Resident 1. The LN 1 stated she reported the incident to the NS, DON, and NP as soon as it occurred and documented everything, at the time they occur or within 15 minutes. When asked what the LN 1 specifically reported to the DON, the LN 1 stated she told the DON, [Resident 1] was having behaviors again and that [Resident 1] had a 'slapfest' with [Resident 2]. When asked what the NP ordered LN 1 to do after she notified her of the incident, the LN 1 stated the NP stated Resident 1 needed a psychiatric consult. The LN 1 stated she had not called Resident 1's psychiatrist to make an appointment. In an interview on 6/3/24 at 2:51 p.m., the DON stated she expected the licensed nurse to notify the NP or on-call physician and notify the RP for all residents involved in an allegation of abuse. The DON also stated she expected licensed nurses to document a witnessed altercation between residents no later than two hours after the incident. The DON verified the LN 1 did not provide professional standards of nursing care for Resident 1 and Resident 2 when she did not notify the NP or on-call physician and RPs of both residents as soon as the residents' safety was ensured. A review of the facility's policy and procedure titled Change of Condition, revised on 4/1/15, indicated, Purpose to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner .It is the responsibility of the person who observes the change to report the change .The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate .the Licensed Nurse must observe and assess the overall condition utilizing a physician assessment and chart review .A Licensed Nurse will notify the resident's .Physician and legal representative .when there is an .incident .involving the resident .A Licensed Nurse will document the following .date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the .Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. The time the .responsible person was contacted.