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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056139 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/17/2024 |
| NAME OF PROVIDER OR SUPPLIER Roseville Point Health & Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>45770</p> <p>Based on interview and record review the facility failed to implement its own policy and procedure for one of 4 sampled residents (Resident 4) when Resident 4's Responsible Party (RP) was not informed of a new medication order due to a change in condition.</p> <p>This failure had the potential to result in disregarding Resident 4 and her RP's right to be informed of her treatment.</p> <p>Findings:</p> <p>A review of an Admission Record for Resident 4 indicated she was admitted in August 2020 with diagnoses including neurocognitive disorder with Lewy bodies (abnormal deposits of a protein in the brain that can lead to problems with movement, thinking, behavior, and mood).</p> <p>A review of Resident 4's Order Summary Report (OSR) dated 8/25/20 indicated she did not have the capacity to make own healthcare decisions, family or RP shall be informed of condition.</p> <p>A review of the same OSR for Resident 4 dated 6/10/24 indicated an order for ivermectin tablet 3 milligrams (mg, unit measurement) give four tablets one time for scabies (a contagious, intensely itchy skin condition caused by a tiny, burrowing mite) prophylaxis.</p> <p>A review of Resident 4's Medication Administration Report (MAR) dated 6/11/24 indicated four tablets of the ivermectin 3mg tablet were administered to Resident 4.</p> <p>In a concurrent interview and record review on 6/17/24 at 1:30 p.m. with Licensed Nurse 1 (LN 1) the Nurses' Progress Notes for Resident 4 were reviewed. LN 1 stated she did not write a note notifying Resident 4's RP of the ivermectin order because she forgot to inform the RP.</p> <p>In a concurrent interview and record review on 6/17/24 at 3 p.m. with the Director of Nursing (DON) Resident 4's 6/24 MAR and Nurses' Progress Notes were reviewed. The DON confirmed four tablets of ivermectin 3 mg tablets were administered to Resident 4 on 6/11/24 but documentation that the RP was informed of the new order was missing. The DON acknowledged that there was no evidence that the RP was notified of the new medication order which should have been done before the medication was given to the resident.</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 0552</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 titled, Change of Condition Notification revised 4/2015, indicated, The Licensed Nurse will notify the family/surrogate decision-makers of any changes in the resident's condition as soon as possible .A Licensed Nurse will document the following .the time the family/responsible person was contacted.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45770</p> <p>Based on interview and record review the facility failed to provide services which meet professional standards of quality for one of 4 sampled residents (Resident 3) when Resident 3's Blood Pressure (BP, the force of blood pushing against the walls of the arteries as the heart pumps blood in the body) was not checked against physician orders before administering his BP medication.</p> <p>This failure had the potential to affect Resident 3's health by receiving BP medication that is not in accordance with the physician's order.</p> <p>Findings:</p> <p>A review of an Admission Record for Resident 3 indicated he was admitted in November 2023 with diagnoses including hypertension (high blood pressure) and end stage renal disease on dialysis.</p> <p>In an interview on 6/17/24 at 12: 45 p.m. with Resident 3, Resident 3 stated he filed a grievance regarding his concern for the nurses not checking his BP before giving his BP medications and that the incident had happened five times already. Resident 3 expressed his concern for his BP to go critically low, especially after receiving dialysis.</p> <p>A review of Resident 3's Order Summary Report (OSR) dated 5/23/24 indicated Resident 3 had three different kinds of BP medications ordered: Nifedipine 30 milligrams (mg, unit of measurement) 1 tablet at bedtime; hydralazine 25 mg 1/2 tablet three times a day; and, carvedilol 25 mg two times a day. All three BP medications had parameters to hold the medication if Resident 3's systolic BP (larger number in a BP reading, pressure in the arteries when the heart beats and pumps blood) was less than 130, per doctor's order.</p> <p>A review of Resident 3's Medication Administration Record (MAR) indicated on 6/3/24 and 6/4/24 at 9 p.m., Resident 3's BP readings were 118/78 and 118/82. Resident 3 received the BP medication nifedipine 30 mg on both nights.</p> <p>In a concurrent interview and record review on 6/17/24 at 3 p.m. with the DON, the same MAR from 6/3/24 and 6/4/24 for Resident 3 was reviewed. The DON verified that the BP medication nifedipine 30 mg was administered to Resident 3 on 6/3/2024 and 6/4/2024 as evidenced by the nurses signature in the MAR on both dates. The DON stated the nurses should have checked Resident 3's BP before giving the medication, and should have read the doctor's order properly to prevent making medication errors. She further stated the BP medication should have been held because the resident's systolic BP was less than 130.</p> <p>A review of the facility's Policy and Procedure (P&P) titled, Telephone Orders for Medication, revised 1/2012, the P&P indicated the facility would ensure accurate administration and delivery of medications and treatments ordered by the Attending Physician and/or a Nurse Practitioner or Physician Assistant.</p> | | |