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	06/11/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was protected from verbal abuse and neglect when the resident was told, You will stay on the floor until the end of the f*cking shift and Certified Nursing Assistant (CNA) 1 placed a pillow under his head and placed a blanket on him and then left. This failure had the potential to negatively impact the resident's psychosocial well-being. Findings: Review of Resident 1's admission record indicated his original admission date was 3/6/25 with diagnoses that included aphasia (difficulty speaking) following cerebral infarction, cognitive communication deficit, and acute and chronic respiratory failure with hypoxia (low levels of oxygen). Review of Resident 1's admission Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/26/25, indicated Resident 1 had short and long-term memory problems, severely impaired cognitive skills for daily decision making, and no delirium or behavioral symptoms. The MDS indicated Resident 1 was dependent upon staff for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing and personal hygiene. During a review of Resident 1's Progress Note dated 5/24/2025 at 7:50 a.m., Resident was found on the floor in supine position on top of the floor mat, yelling out, Get me off the floor. Resident unable to verbalize why he's on the floor. CNA went to get the assigned CNA for the resident. The CNA that she did not ask for help, went to the room and started yelling, He just needs to stay on the floor. She then told him, You will stay on the floor until the end of the f*cking shift. The resident's roommate said, Hey, you don't need to talk to him like that, he doesn't know what he's doing. She then replied, Yes he does. He knows what he is doing. She placed a pillow under his head and placed a blanket on him and left. During a review of the facility's Summary of Investigation, dated 5/28/25 indicated on 5/24/25, it was reported by the Charge Nurse ([NAME], RN) that CNA 1 allegedly abused Resident 1 by responding to him who was on the floor stating he should remain on the floor until the end of the shift. When the resident's roommate, Resident 2, objected to her tone, she responded inappropriately and dismissed the concern. She then placed a pillow and blanket on the resident and left the room. (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
	056139	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Summary of Investigation, dated 5/28/25 indicated CNA 1 was interviewed on 05/26/2025 at around 11:40AM. CNA 1 stated that on 05/24/2025, during the early morning hours, RN 1 used the intercom multiple times to call for a CNA to assist. She approached the room and suggested making resident comfortable until assistance was available, as she was in the middle of rounds and could not leave her assigned side unattended. CNA 1 admitted to using profanity aloud in the presence of residents and staff. She speci?cally stated, in reference to the resident, We are about to make his f*cking ass comfortable. This was said in front of the resident's roommate. The facility investigation report indicated on 05/27/25, Social Services Director (SSD) visited Resident 1. Resident 1 stated that he had a fall that early morning of 05/24/2025 and that a CNA not assigned to him, entered the room yelling and called him mother****r and threw and pillow and a blanket and said, You will sleep on the ?oor. A review of the facility investigation report dated 5/28/25 indicated, Resident 2, Resident 1's roommate, was interviewed on 5/27/25. Resident 2 stated that Resident 1 fell out of bed and began calling for help. A CNA who was not assigned entered the room and began yelling using inappropriate language, calling the Resident 1 stupid mother****r and telling him to sleep on the floor, put a pillow and a blanket and left. During a review of the facility's Summary of Investigation, dated 5/28/25 indicated, Based on the information gathered from staff and resident interviews, there is credible evidence to support that [CNA 1] engaged in inappropriate, unprofessional, and verbally abusive behavior toward [Resident 1] on the morning of 05/24/2025. Both the resident and his roommate independently corroborated the use of profane and demeaning language, as well as the neglectful response to the resident's fall. [CNA 1] herself admitted to the use of profanity in the presence of residents, citing frustration, though this does not excuse the behavior observed. Resident 1 was unable to be interviewed because he was discharged from the facility on 6/3/25. During an interview on 6/1/25 at 10:10 a.m., with Resident 2, Resident 2 stated he heard Resident 1 fall out of bed and was calling out. He overheard a CNA (CNA 1) state something like, I'm tired of this shit and He (Resident 1) can stay on the f*ing floor. Resident 2 stated he was unable to see anything due to the privacy curtain was closed but was able to recognize the CNA's voice and stated it was CNA 1. During an interview on 6/1/25 at 10:28 a.m. with the Assistant Director of Nursing (ADON), she confirmed CNA 1was unprofessional and used profanity. The ADON confirmed the facility substantiated the allegation and CNA 1 was terminated. During a review of the facility's policy and procedure titled, Resident Rights-Quality of Life, revised March 2017 indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being .Facility Staff speaks respectfully to residents at all times .Demeaning practices and standards of care that compromise dignity are prohibited. Facility Staff promote dignity and assist residents as needed .Facility Staff treats cognitively impaired residents with dignity and sensitivity.