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	09/02/2025

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 six sampled residents (Resident 2) was free from abuse, when Resident 3 touched Resident 2's groin area. This failure decreased the facility's potential to maintain Resident 2's highest practicable physical, mental, and psychosocial well-being.Findings:A review of an admission record indicated Resident 2 was admitted to the facility in July 2024 with diagnoses including cognitive communication deficit (difficulty communicating) and dementia (a progressive decline in memory, thinking, reasoning, executive function). A review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/21/25, indicated a Brief Interview of Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of five out of 15 with memory problems and severe cognitive impairment. A review of an admission record indicated Resident 3 was admitted to the facility in October 2024 with diagnoses including aphasia (a disorder that makes it difficult to speak) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).A review of Resident 3's MDS, dated [DATE], indicated a BIMS score of 14 out of 15 with intact cognition.During an interview on 9/2/25 at 2:20 p.m. with Activity Assistant (AA), AA stated while she was conducting facility activities in the activity room on 9/1/25 around 10 a.m., she observed Resident 3 touching with his left hand Resident 2's lap near the groin area. AA immediately gestured Resident 3 to stop and separated him from Resident 2. During an interview on 9/2/25 at 3:30 p.m. with the Administrator (ADM), ADM confirmed Resident 3 touched Resident 2's lap near the groin area and stated the incident was witnessed by AA. A review of the facility's policy titled, Abuse Prevention and Management, dated 6/12/24, indicated, The Facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment.

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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(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. Based on interview and record review, the facility failed to report immediately to the Department an alleged incident of sexual abuse for one of six sampled residents (Resident 2), when the Department received the facility's report of alleged sexual abuse after two hours of occurrence. This failure had the potential to cause a delayed response by enforcement agencies to ensure Resident 2's safety.Findings:A review of an admission record indicated Resident 2 was admitted to the facility in July 2024 with diagnoses including cognitive communication deficit (difficulty communicating) and dementia (a progressive decline in memory, thinking, reasoning, executive function). A review of an admission record indicated Resident 3 was admitted to the facility in October 2024 with diagnoses including aphasia (a disorder that makes it difficult to speak) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During an interview on 9/2/25 at 2:20 p.m. with Activity Assistant (AA), AA stated while she was conducting facility activities in the activity room on 9/1/25 around 10 a.m., she observed Resident 3 touching with his left hand Resident 2's lap near the groin area. AA immediately gestured Resident 3 to stop and separated him from Resident 2. AA further stated she did not report the incident to proper agencies or notify her supervisor. A review of a document titled, Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 9/2/25, indicated on 9/1/25 around 10 a.m. Resident 3 was seen sitting next to Resident 2 and moving his hand up and down touching Resident 2's private area. The report further indicated staff told Resident 3 to stop and escorted him out of the room. A review of a document titled, Fax Log, dated 9/2/25, indicated the facility faxed the SOC 341 to the Department on 9/2/25 at 9:59 a.m. During an interview on 9/2/25 at 3:30 p.m. with the Administrator (ADM), ADM stated the expectation was to report the alleged sexual abuse incident immediately within two hours. A review of the facility's policy titled, Abuse Prevention and Management, dated 6/12/24, indicated, The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies . Reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices for one of six sampled residents (Resident 6), when the Housekeeper did not apply the required Personal Protective Equipment (PPE, gloves, gown, and/or goggles/face shield if risk of splash and spray) while cleaning Resident 6's room. This failure had the potential to spread infection among vulnerable residents. Findings: A review of an admission record indicated Resident 6 was admitted to the facility in June 2022 with a diagnosis of stage 4 pressure ulcer (a severe deep open wound that extends through the skin and into the muscle, bone or tendons) to the sacrum (triangular shaped bone located at the base of the spine). During an observation on 9/2/25 at 10:31 a.m. inside Resident 6's room, the Housekeeper was observed not wearing the proper PPE while cleaning the room. Housekeeper stated he was aware that Resident 6 was on Enhanced Barrier Precaution (EBP, infection control intervention to reduce transmission of resistant organisms). During a concurrent observation and interview on 9/2/25 at 10:40 a.m. with Licensed Nurse 1 (LN 1) inside Resident 6's room, LN 1 confirmed there was a sign outside Resident 6's room indicating he was placed on EBP and the Housekeeper was not wearing a gown while cleaning Resident 6's room. LN 1 stated staff should follow the EBP when providing care to Resident 6. During a concurrent interview and record review on 9/2/25 at 12:35 p.m. with the Director of Staff Development (DSD), Resident 6's Physician Order was reviewed. DSD confirmed Resident 6 was placed on EBP due to his pressure ulcer. DSD stated the Housekeeper should have followed infection prevention and control practices by donning gloves and gown while cleaning Resident 6's room to prevent the spread of infection and decrease putting other residents at risk. A review of the facility's policy titled, Enhanced Barrier Precautions, revised in October 2024, indicated, . Enhanced Barrier Precautions . will be used in the facility . EBP is employed for resident care . at risk of transmission . include residents with chronic wound . Use of EBP by Environmental Services . EVS personnel should use gown and gloves while cleaning and disinfecting the environment around residents on EBP . cleaning and disinfecting high touch surfaces such as bed rails . bed side tables or stands on or near the resident's space.