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	04/27/2026

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. Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 1) was free from abuse when Activity Assistant (AA) 1 aggressively yelled at and grabbed Resident 1's shoulder.This failure had the potential to cause psychosocial harm to Resident 1.Findings:A review of Resident 1's clinical record indicated that the resident was admitted to the facility in March 2026 with diagnoses including dementia with agitation (a condition in which a person has memory and thinking problems and also becomes easily upset, restless, angry, or difficult to calm down) and metabolic encephalopathy (a change in how the brain works that can cause confusion, memory problems, or difficulty thinking clearly).A review of Resident 1's Minimum Data Set (MDS-assessment tool) dated 3/11/26 showed a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 0/15, which indicated severe problems with thinking and memory.During an interview on 4/27/26 at 10:39 a.m. with Interim Director of Nursing (IDON) 1, IDON 1 stated that Resident 1 had been discharged from the facility and was confused. IDON 1 stated that on 4/3/26, Resident 1 was in the Activity room and repeatedly stood up and touched other residents. AA 1, using a powerful voice, told Resident 1 to stop what he was doing while grabbing Resident 1's shoulder to assist him back into his wheelchair.During an interview on 4/27/26 at 12:46 p.m. with Resident 2, Resident 2 stated that Resident 1 kept standing up and holding onto the table, causing it to shake. When Resident 1 was about to grab another resident, AA 1 yelled at Resident 1 while grabbing Resident 1's shoulder and pulled him back into his wheelchair. During an interview on 4/27/26 at 12:53 p.m. with Resident 3, Resident 3 stated that Resident 1 was being difficult, would not sit down, and kept standing up and walking around the table. AA 1 asked Resident 1 several times to sit down, and when AA 1 became frustrated, AA 1 began yelling at Resident 1 and placed Resident 1 back into his wheelchair. During an interview on 4/27/26 at 1:50 p.m. with Business Office Manager (BOM) 1, BOM 1 stated that they heard shouting coming from the Activity room. BOM 1 recalled AA 1 yelling, Stop this, and Don't do that. When BOM 1 left the office to investigate, they witnessed AA 1 aggressively wheeling Resident 1 out of the Activity room, likely taking Resident 1 back to his room. BOM 1 stated that AA 1 appeared visibly frustrated.During a phone interview on 4/27/26 at 2:29 p.m. with BOM 2, BOM 2 stated that initially they did not know which resident AA 1 had been speaking to aggressively. However, when AA 1 wheeled the resident, they realized it was Resident 1. BOM 2 added that if staff members talked or yelled aggressively at a resident, it was considered a form of abuse.A review of the facility's operational manual titled Reporting Abuse, revised 1/08/2014, indicated, The Facility will ensure that the residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

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