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	05/28/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interviews and record review, the facility failed to exercise reasonable care to protect residents' personal property from loss for two of six sampled residents (Resident 1 and Resident 3) when staff did not properly inventory and safeguard Resident 1's hearing aids and Resident 3's clothing and toiletries.These failures contributed to the loss of Resident 1's hearing aids and the loss of Resident 3's clothing and toiletries and placed the residents' other property at risk for loss or theft.Findings:Resident 1 was admitted to the facility in February of 2026 with diagnoses that included cellulitis (infection of the skin).Resident 3 was admitted to the facility in December of 2025 with diagnoses that included acute kidney failure.A review of Resident 1's Personal Effects Inventory Form [a facility document that lists residents' belongings and anything of value they brought in], undated, indicated that Resident 1's hearing aids were not inventoried on admission and at any point during his stay.During Resident 3's record review, Resident 3 did not have a Personal Effects Inventory Form in her medical record.A review of Resident 1's, admission Summary, dated 2/26/26, indicated, He has hearing aids (L&R) [left and right].A review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used in skilled nursing facilities), dated 3/4/26, indicated Resident 1 was using his hearing aids during the assessment.During an interview on 5/26/26 at 1:14 p.m. with Resident 3, Resident 3 indicated that, since she was admitted , she has had some pants and toiletries such as shampoo go missing. Resident 3 further indicated that her items were never inventoried on her inventory sheet (Personal Effects Inventory Form) and the facility never reimbursed her for these lost items.During an interview on 5/26/26 at 2:56 p.m. with the Social Services Assistant (SSA), the SSA indicated that residents' inventory sheet should have been filled out on admission but could also have been updated at any time by staff.During an interview on 5/26/26 at 4:24 p.m. with Charge Nurse 1 (CN 1), CN 1 indicated that on admission, she would have handed the inventory sheet to a CNA to fill out and, if she had received a blank inventory sheet, she would have questioned why it was not filled out.During an interview on 5/27/26 at 10:03 a.m. with the Case Manager (CM), the CM confirmed that Resident 1's inventory sheet on discharge was blank. The CM further explained that facility staff were responsible for ensuring residents' belongings were properly inventoried and tracked.During an interview on 5/27/26 at 11:10 a.m. with the Administrator (ADM), the ADM indicated that if a resident had lost an item listed on their inventory sheet, the facility would have tried to reimburse the resident for the fair market value of the item.During an interview on 5/28/26 at 9:59 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 indicated that she had noticed that Resident 3 had about three of her pants go missing. CNA 3 further indicated that Resident 3 had complained to her about her missing clothing and searched for the pants in Resident 3's room and in the laundry room, but she was unable to find Resident 3's pants.During an interview on 5/28/26 at 10:43 a.m. with the Medical Records Staff (MRS), the MRS indicated that staff never filled out an inventory sheet for Resident 3.During a review of the facility's policy and procedures (P&P) titled, Personal Property, revised 10/25, the PNP indicated, Upon admission, the Certified Nursing Assistant (CNA)/designee will conduct a personal property inventory of the resident's property.The personal property inventory will be signed and placed in the medical record.A copy of the written inventory (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall be provided to the resident/resident representative.Subsequent items brought into or removed from the Facility shall be added to or deleted from the personal property inventory by the facility at the request of the resident/resident representative.The IDT [interdisciplinary team] will review the resident's personal property inventory, as applicable.

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to protect one of seven sampled residents (Resident 2's) right to be free from physical and verbal abuse when Certified Nursing Assistant 1 (CNA 1) threw Resident 2 face down on her bed and called her a derogatory name. This failure had the potential to cause physical and mental harm to Resident 2.Findings:Resident 2 was admitted to the facility in December of 2025 with diagnoses that included spinal stenosis in the lumber region (the narrowing of the spaces within the spine, which puts pressure on the spinal cord and nerves).A review of Resident 2's medical record titled, IDT [Interdisciplinary team] Note, dated 5/6/26, indicated, IDT met to discuss allegation of physical abuse from a pm cna [Certified Nursing Assistant] to the Resident. It was reported by the witness cna [CNA 2] that Resident was found lying face down on the fall mattress @ [at] 1910 inside her room, another cna [CNA 1] came (Perpetrator) to assist but instead grabbed Resident's arm and stated ?Come here you old Chinese lady' then threw the Resident face-first sideways on the bed, then proceeded to pick her up by the back of the collar and pants then threw her onto the bed again but positioning her on the bed.During an interview on 5/27/26 at 9:30 a.m. with Charge Nurse 2 (CN 2), CN 2 indicated that if a staff member threw a resident face down onto their bed and made derogatory comments, she would have considered that to be abuse.During an interview on 5/27/26 at 10:14 a.m. with CNA 2, CNA 2 indicated that on 5/5/26, during her evening shift at approximately 7 p.m., she walked into Resident 2's room and found Resident 2 on the floor mat beside her bed. CNA 2 indicated that, she then asked CNA 1 for assistance in getting Resident 2 back into bed during which CNA 1 grabbed Resident 2 by her arm and threw her onto the bed. CNA 2 further indicated that CNA 1 then grabbed Resident 2 by her pants and collar and threw her face down onto her bed again causing Resident 2's feet to strike the bed's footboard. CNA 2 further reported that during this incident, CNA 1 said, Come here, you old Chinese lady.During an interview on 5/27/26 at 11:10 a.m. with the Administrator (ADM), the ADM confirmed that residents in the facility have the right to be free from abuse.During a review of the facility's policy and procedures (P&P) titled, Abuse Prevention and Management, revised 5/24, the PNP indicated, The facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment.