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	07/02/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of six sampled residents' (Resident 2 and Resident 4) were free from physical abuse and neglect when:1. Resident 1 physically grabbed Resident 2's arm and refused to release it; and,2. Resident 3 pushed Resident 4's arm, and Resident 4 was not assessed, monitored or that the physician was notified following the incident. These failures resulted in Resident 2 becoming agitated and placed Resident 4 at risk for an undetected injury or change in condition due to the facility's failure to assess, monitor, and notify the physician after a witnessed incident of resident to resident physical abuse.Findings:1. Resident 1 was admitted to the facility in late 2025 with diagnoses that included a stroke with right sided weakness, and difficulty speaking.Resident 2 was admitted to the facility in late 2024 with diagnoses that included end stage kidney failure, muscle weakness and difficulty walking.During a review of Resident 2's Minimum Data Set (MDS, an assessment tool), dated 2/12/25, the MDS showed a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 15/15 which indicated Resident 2 had intact cognition.During a review of Resident 1's progress note (PN), dated 5/19/26 at 9:31 p.m. ,the PN indicated, .This writer noted a commotion and two agitated residents in a verbal altercation screaming and cursing at each other.Staff members were trying to de-escalate the situation. However, [Resident 2] was noted cursing and yelling, and kept trying to walk towards [Resident 1] who this writer was holding close to station 2. [Resident 2] kept insultingand (sic) using unpleasant gestures, He was visibly agitated and not listening to any nursing staff members.[Resident 1].was also very agitated trying to turn his w/c [wheelchair] towards [Resident 2].After about 10 minutes of redirecting residents and de-escalating the situation, [Resident 2] stated he wanted to call the police and press charges against [Resident 1] for assault for grabbing him by his arm.During a review of Resident 2's PN dated 5/19/26 at 10:28 p.m. the PN indicated, .[Resident 2] became involved in a verbal altercation with another resident while ambulating around the facility hallway when the other resident held on his hand firmly and got agitated later leading to verbal altercation.During a review of Resident 2's Care Plan Report [CP], dated 5/19/26, the CP indicated, Resident involved in resident-to-resident altercation related to resident agitation m/b [manifested by] verbal abuse.During an interview on 7/1/26 at 12:39 p.m. with Resident 2, Resident 2 stated he was wheeling down the hallway when Resident 1 grabbed his forearm and would not let go. Resident 2 stated when he pulled his arm away Resident 1 swung his arm toward him and they began yelling at each other, using profanity.During an interview on 7/1/26 at 3:29 p.m. with Licensed Nurse (LN 1), LN 1 stated he observed Resident 1 grab Resident 2's arm as Resident 2 wheeled past him down the hallway. LN 1 stated Resident 2 became angry and there was an argument between the two residents.During an interview on 7/2/26 at 12:40 p.m. with the Director of Nursing (DON), the DON confirmed the progress notes indicated a physical and verbal altercation occurred between Resident 1 and Resident 2. The DON stated residents have the right to be free from abuse and be safe in their environment.2. Resident 3 was admitted to the facility in early 2025 with diagnoses that included left hip joint infection, and muscle weakness.During a review of Resident 3's MDS, dated [DATE], the MDS showed a BIMS score of (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15/15 which indicated intact cognition.Resident 4 was admitted to the facility in early 2019 with diagnoses that included dementia, and a mental condition that causes extreme shifts in mood, energy and activity levels.During a review of Resident 4's MDS, dated [DATE], the MDS showed a BIMS score of 5/15 which indicated severe cognitive impairment.During a review of a witness statement from Certified Occupational Therapy Assistant (COTA) dated 5/26/26, the statement indicated, [COTA] witnessed [Resident 4] reach w/L [with left] hand for [Resident 3] soda. [Resident 3] hit [Resident 4] L forearm with moderate force using R [right] hand to prevent [Resident 4] from drinking his soda. [Resident 4] pulled his arm back after being struck and held his arm.Notified cart nurse, administrator, and supervising nurse.During an interview on 7/1/26 at 1:32 p.m. with Resident 3, Resident 3 stated Resident 4 is always grabbing for stuff, and when Resident 4 grabbed for his can of soda Resident 3 pushed Resident 4's hand away.During a review of Resident 4's electronic health record, there was no documented evidence that the resident was assessed, monitored or his physician was notified following the incident. There was no care plan for the witnessed abuse incident, either. During an interview on 7/2/26 at 1:15 p.m. with the DON the DON confirmed the witness statement from the COTA in regard to the incident between Resident 3 and Resident 4. The DON confirmed there was no nursing assessment, physical assessment, care plan or physician notification for the witnessed abuse incident. The DON stated she expected the nurse to assess the resident and make phone calls to the physician and responsible party. The DON stated there should be a care plan to document the change of condition, as abuse was a change in condition and the resident should be monitored for any injury or psychosocial distress.During a review of the facility's policy and procedures (P&P) titled, Abuse Prevention and Management, dated 6/12/24, the P&P indicated, The Facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment.PURPOSE: To address the health, safety, welfare, dignity and respect of residents.During a review of the facility's P&P titled, Change in Condition, dated 8/25/22, the P&P indicated, .The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate.A Licensed Nurse will notify the resident's Physician.and legal representative or an appropriate family member when there is an.Incident /accident involving the resident.Licensed Nurse will document the following.date, time, and pertinent details of the event and the subsequent assessment in the medical record.Update the Care Plan to reflect the resident's current status.A Licensed Nurse will communicate any changes in required interventions to the care team.A Licensed nurse will document each shift for at least seventy-two [72] hours when there is a change in the resident's condition.Documentation pertaining to a change is the resident's condition will be maintained in the resident's medical record.