

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Roseville Point Health & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a grievance was resolved for one of four sampled residents (Resident 4), when Resident 4's reported missing clothes were not replaced since May 2026. This failure decreased the facility's potential to settle grievances in a timely manner. Findings: A review of Resident 4's Face Sheet, indicated he was admitted to the facility in April 2026 with a diagnosis of sepsis (a life-threatening blood infection) and was discharged to an assisted living facility 12 days after. A review of Resident 4's Order Summary Report, dated 4/16/26, indicated Resident 4 was incapable of making health care decisions, and Resident 4's daughter was appointed as the Responsible Party (RP). During a concurrent interview and record review on 7/28/26 at 3:10 p.m. with Licensed Nurse (LN) 1, Resident 29's Inventory Sheet (IS) dated 4/16/26 was reviewed. LN 1 stated she met with Resident 29's RP on 4/28/26 and confirmed that a pair of pajamas, two shirts and a pair of joggers were found to be missing according to the IS. LN 1 further stated she formally reported the grievance concerning the missing items to the social services department for further action. During a concurrent interview and record review on 7/28/26 at 2 p.m. with the Assistant Social Services Director (ASSD), Resident 29's IS dated 4/16/26, Theft /Loss Report (TLR) dated 4/27/26, and the Social Services progress notes were reviewed. ASSD confirmed a grievance had been reported by a nursing staff member concerning Resident 29's missing clothing items and stated she communicated to the RP that the missing clothing items could not be located, and the facility would proceed with replacing them. ASSD added she notified the Social Services Director (SSD) the investigation's outcome more than five weeks ago in order to be resolved. ASSD further stated she did not follow up on the actions taken by SSD after the initial report and there were no available SSD progress notes documented in Resident 4's chart to tell if a resolution was completed. During a concurrent interview and record review on 7/28/26 at 3:15 p.m. with the Administrator (ADM), Resident 4's IS dated 4/16/26 and the TLR dated 4/27/26 were reviewed. ADM confirmed an IS had been completed for Resident 4 from his admission on [DATE] and discharge on [DATE] which indicated LN 1 signed with the RP that three items were missing from the IS list. ADM stated after the staff investigation has been completed, the TLR was signed on 5/4/26 and a resolution was decided that only the lost clothing items that were listed in the IS will be replaced. ADM acknowledged that Resident 4's missing clothing items were not found and have not been replaced by the facility. A review of the facility's policy titled, Grievances and Complaint, revised in October 2025, indicated, The Facility Administrator is the Grievance Official responsible for overseeing grievance process . through to their conclusion . If follow up is required, the Grievance Official is responsible for ensuring that the follow up action is taken in a timely manner.		

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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