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	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Point Health & Wellness Center	600 Sunrise Avenue Roseville, CA 95661

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45770 Based on observation, interview, and record review, the facility failed to obtain an informed consent for one of 24 sampled residents (Resident 34), when Resident 34's representative did not sign a consent for the use of bilateral mittens. This failure had the potential to deprive the representative from making decisions regarding Resident 34's care. Findings: A review of Resident 34's Admission Record, indicated he was admitted in July 2024 with diagnoses including chronic respiratory failure and anxiety disorder. During a concurrent observation and interview on 10/8/24 at 9 a.m. with Licensed Nurse 9 (LN 9), Resident 34 was wearing soft mittens on both hands while in bed. LN 9 stated staff put the mittens daily to prevent Resident 34 from pulling out his tracheostomy (a tube inserted into the windpipe from outside the neck to help air and oxygen reach the lungs) tube. A review of Resident 34's Order Summary Report, dated 9/27/24, indicated an order for the daily application of bilateral soft mittens and removal when family was present. During a concurrent interview and record review on 10/9/24 at 1 p.m. with LN 2, Resident 34's clinical records were reviewed. LN 2 stated the informed consent for Resident 34's use of mittens was not completed, did not have the name of the prescriber, the name of the representative was not indicated, and was not signed. During a concurrent interview and record review on 10/10/24 at 11 a.m. with the Director of Nursing (DON), Resident 34's informed consent was reviewed. DON confirmed Resident 34's informed consent for use of hand mittens was not signed. DON stated it should have been signed by his representative before its implementation to make sure Resident 34's representative was well informed and could actively participate in Resident 34's care. A review of the facility's policy and procedure titled, Restraints, revised 2012, indicated, Before any type of restraint is used, the Licensed Nurse will verify that informed consent was obtained . If the resident lacks medical decision-making capacity . informed consent was obtained from the resident's surrogate.

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45770 Based on interview and record review, the facility failed to provide a written bed hold agreement for one of 24 sampled residents (Resident 40) or his representative before and upon transfer to hospital. This failure had the potential for Resident 40 or his representative to be unaware of their right to return to the facility after hospitalization . Findings: A review of Resident 40's Admission Record, indicated he was admitted in August 2021 with diagnoses including traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). A review of Resident 40's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/7/24, indicated Resident 40 was admitted back to the hospital on the same date for further evaluation. During a concurrent interview and record review on 10/9/24 at 1 p.m. with Licensed Nurse 2 (LN 2), Resident 40's clinical records were reviewed. LN 2 confirmed Resident 40 was sent to the hospital on 8/7/24 due to low oxygen saturation. LN 2 stated he could not find a copy of the completed bed hold policy agreement signed by Resident 40 or his representative. During an interview on 10/10/24 at 11 a.m. with the Director of Nursing (DON), DON stated if a copy of Resident 40's bed hold policy agreement was not available then Resident 40 or his representative did not receive a notice and were not notified of the transfer. DON stated Resident 40, or the representative should have been given the notice of bed hold policy so they became aware of their rights while out on therapeutic leave. A review of the facility's policy and procedure titled, Bed Hold, revised 7/2017, indicated, The facility notifies the resident and/or representative in writing of the bed hold option, any time the resident is transferred to an acute care hospital .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45770 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS - a federally mandated resident assessment tool) for one of 24 sampled residents (Resident 27), when Resident 27's prior level of function (PLOF) on admission was inaccurately coded. This failure increased Resident 27's risk for inadequate care planning. Findings: A review of Resident 27's Admission Record, indicated she was admitted in August 2024 with diagnoses including lung cancer which required dependence to a ventilator (a medical device to help support or replace breathing). A review of Resident 27's comprehensive MDS assessment, dated 8/26/24, indicated Resident 27's PLOF was independent with indoor/outdoor mobility and transfers but used a mechanical lift. During a concurrent interview and record review on 10/9/24 at 2:45 p.m. with the MDS Coordinator (MDSC), Resident 27's comprehensive MDS assessment was reviewed. MDSC confirmed Resident 27 was independent with mobility and transfers and did not use any device to aid her during transfers. MDSC verified the comprehensive assessment was coded inaccurately and would need modification. During an interview on 10/10/24 at 11 a.m. with the Director of Nursing (DON), DON stated the facility had no specific MDS policy and stated she expected her staff to accurately complete MDS assessments to assist them in providing appropriate care to residents.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36624 Based on observation, interview and record review, the facility failed to revise and review a person-centered comprehensive care plan for two of 24 sampled residents (Resident 2 and Resident 44), when: 1. Resident 2 had recurrent falls; and, 2. Resident 44's tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and facilitate breathing) was removed. This failure decreased the facility's potential to maintain the residents' psychosocial, physical, and mental well-being. Findings: 1. A review of Resident 2's Admission Record, indicated Resident 2 had diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and repeated falls. A review of Resident 2's History and Physical, dated 9/22/24, indicated Resident 2 was hospitalized from 6/6/24 to 6/9/24 for recurrent falls. A review of Resident 2's fall care plan, dated 6/9/24, indicated it was not revised or modified to indicate new interventions to prevent recurrent falls. During a concurrent interview and record review on 10/9/24 at 3:26 p.m. with the Minimum Data Set (MDS - a federally mandated resident assessment tool) Coordinator (MDSC), Resident 2's record was reviewed. MDSC validated Resident 2's fall care plan was not reviewed and revised to include new safety interventions to address recurrent falls. MDSC stated the fall care plan should have been reviewed and revised. 2. A review of Resident 44's Admission Record, indicated he had diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). A review of Resident 44's MDS, dated [DATE], indicated Resident 44 had mental capacity. During an observation on 10/7/24 at 9:16 a.m., Resident 44 had no tracheostomy in place. During a concurrent interview and record review on 10/7/24 at 3:38 p.m. with Licensed Nurse 5 (LN 5), Resident 44's record was reviewed. LN 5 stated the most recent care plan dated 8/24 showed tracheostomy care plan with interventions. LN 5 stated Resident 44's care plan was not current and should have been revised with the new change of condition so Resident 44 could receive appropriate care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 9:10 a.m. with Resident 44, Resident 44 stated he felt frustrated because he kept reminding staff to update his record regarding tracheostomy removal (removed in May 2024). Resident 44 stated new staff had no idea what was going on with him because the care plan was never updated as things changed. During an interview on 10/8/24 at 9:26 a.m. with the Director of Nursing (DON), DON stated the care plan had to be referenced daily and updated periodically to provide proper care for resident's needs even if conditions had improved. DON acknowledged Resident 44's care plan, dated 8/24, should have been reviewed and revised as necessary. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, revised 8/24/23, indicated, The comprehensive care plan will be periodically reviewed and revised at the following times . change of condition . onset of new problems .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on observation, interview, and record review, the facility failed to provide services which meet professional standards of quality for two of 24 sampled residents (Resident 9 and Resident 45) when: 1.The tube feeding (TF, a tube inserted to the stomach to provide nutrition, fluid and medicine to people who are unable to eat or drink safely by mouth) was left connected to Resident 9 after its completion and the residual volume was not properly documented in the Medication Administration Record (MAR) to show it had been monitored as ordered; and, 2. An empty container of a TF was left hanging for more than 24 hours for Resident 45. These failures decreased the facility's potential to safely follow the physician's order to meet residents' needs. Findings: 1. A review of Resident 9's Admission Record, indicated she was admitted in May 2022 with diagnoses including dysphagia (difficulty swallowing). A review of Resident 9's Order Summary Report, dated 8/20/24, indicated an order for a continuous tube feeding 70 milliliters per hour (ml/hr.; a unit of measurement) for a total of 1400 ml to run for 20 hours a day, patency and residual volume should be checked, feeding should be held if residual was more than 60 ml. During a concurrent observation and interview on 10/7/24 at 9:14 a.m. with Licensed Nurse 8 (LN 8), LN 8 verified the tube feeding was still connected to Resident 9 after the feeding was completed at 8 a.m. LN 8 stated the practice was nurses would leave the tubing connected to the resident until it was time to turn it on again. LN 8 also stated the only time nurses would disconnect the tube was when the resident got out of bed. During a concurrent interview and record review on 10/8/24 at 12:25 p.m. with LN 9, Resident 9's MAR was reviewed. LN 9 confirmed Resident 9's MAR did not show the amount of residual volume assessed, because nurses only signed the order without documenting the amount in ml as ordered. During a concurrent interview and record review on 10/10/24 at 11 a.m. with the Director of Nursing (DON), Resident 9's MAR was reviewed. DON acknowledged the order was incomplete and written incorrectly and stated the residual volume should have been checked and documented to prove the doctor's order was followed. DON also stated the tubing should have been disconnected promptly from Resident 9 once the feeding was completed to minimize intolerance. A review of the facility's policy and procedure titled, Physician Orders, revised 11/2022, indicated, The licensed nurses will confirm that physician orders are clear, complete, and accurate . 47465 (continued on next page)

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	056139	A. Building B. Wing	10/10/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of an admission record indicated Resident 45 was admitted to the facility on ,d+[DATE] with diagnoses including traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) , persistent vegetative state (when a person is awake but showing no signs of awareness), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During an observation on 10/7/24 at 11:32 a.m., in Resident 45's room, a container of Jevity 1.5 CAL (a calorically dense, fiber-fortified therapeutic nutrition) tube feeding, dated 10/3, was attached to an undated tubing and was hanging on a pole connected to a feeding pump. During an interview on 10/7/24 at 11:39 a.m. with LN 3, LN 3 confirmed the date on the bottle indicated 10/3 and stated the container needed to be changed every 24 hours because it can put Resident 45 at risk for getting sick and increased risk of infection. During an interview on 10/9/24 at 11:57 a.m. with the Director of Staff Development (DSD), DSD stated her expectations were if the tube feeding and tubing were hung for 24 hours then it should have been discarded. During an interview on 10/9/24 at 2:13 p.m. with DON, DON stated her expectations were the tube feeding containers and tubing should have been changed every 24 hours. A review of the manufacturer's guidelines for the use of Jevity 1.5 CAL, dated 7/22/24, indicated, . hang for no more than 24 hours. A review of the facility's policy and procedure titled, Enteral Feeding - Closed, dated 1/1/12, indicated, Change feeding formula and tubing every 24-48 hours or as required by manufacturer guidelines.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on observation, interview, and record review, the facility failed to provide restorative nursing assistance to two of 24 sampled residents (Resident 9 and Resident 40) when: 1. Resident 9's left hand carrot and right hand foam roll splints were not placed as ordered; and 2. Resident 40's bilateral resting hand splints were not applied consistently as per plan of care. These failures decreased the facility's potential to help maintain range of motion (ROM) and prevent further contracture (a stiffening/shortening at any joint, that reduces the joint's ROM) for residents. Findings: 1. A review of Resident 9's Admission Record, indicated she was admitted in May 2022 with diagnoses including cerebral infarction (loss of blood flow to a part of the brain) and bilateral hand contractures. A review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/13/24, indicated Resident 9 was dependent with activities of daily living. A review of Resident 9's Order Summary Report, dated 6/23/24, indicated Resident 9 should receive daily restorative nursing services by applying a carrot splint to her left hand and a rolled foam splint to the right hand to minimize the risk of worsening her contractures. During an observation on 10/7/24 at 8:20 a.m., Resident 9 was lying on her left side with both arms bent and hands in tightly closed fist. During an observation on 10/7/24 at 11 a.m., Resident 9 was lying on her left side without using hand splints. During an interview on 10/7/24 at 1:50 p.m. with the Restorative Nurse Assistant (RNA), RNA confirmed Resident 9 was not wearing any hand splints. During an interview on 10/8/24 at 1:15 p.m. with Licensed Nurse 8 (LN 8), LN 8 stated Resident 9 was not wearing any of the ordered hand splints and acknowledged that Resident 9 should have been wearing hand splints to maintain ROM. 2. A review of Resident 40's Admission Record, indicated he was admitted in August 2021 with diagnoses including traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). A review of Resident 40's MDS, dated [DATE], indicated Resident 40 had limited ROM to bilateral upper limbs. (continued on next page)

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	056139	A. Building B. Wing	10/10/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 40's Order Summary Report, dated 6/23/24, indicated Resident 40 should wear bilateral resting hand splints with finger separators daily to decrease the risk of contracture progression. During an observation on 10/7/24 at 10:28 a.m., Resident 40 was in bed without hand splints. During a concurrent interview and record review on 10/8/24 at 1 p.m. with LN 9, Resident 40's Order Summary Report was reviewed. LN 9 confirmed Resident 9 had an order to use hand splints daily but was not wearing it consistently. During an interview on 10/10/24 at 11 a.m. with the Director of Nursing (DON), DON stated Resident 9 and Resident 40 should have been assisted and monitored in the application of their hand splints so that the plan of care would be followed as ordered to prevent further hand contractures. A review of the facility's policy and procedure titled, Contracture-Prevention, revised 5/15, indicated, The facility implements interventions . to prevent the worsening of contractures for residents admitted with contractures.

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	056139	A. Building B. Wing	10/10/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 36624 Based on observation, interview and record review, the facility failed to ensure a tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and facilitate breathing) care risk and benefit assessment, care plan and physician's order were placed for one of 24 sampled residents (Resident 15), when Resident 15 was allowed to perform his own tracheostomy gauze change, suction, and inner cannula insertion. This failure decreased the facility's ability to provide proper tracheostomy care to maintain a patent airway and to prevent infection for Resident 15. Findings: A review of Resident 15's Admission Record, indicated he had diagnoses which included acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own) with hypoxia (a condition that occurs when the body doesn't have enough oxygen at the tissue level) and tracheostomy dependent. During an observation on 10/7/24 at 9:20 a.m., Resident 15 had a tracheostomy covered with white colored cloth dressing on his neck. During a concurrent observation and interview on 10/9/24 at 9:36 a.m. with Resident 15, Resident 15 stated he had at his bedside drawer all the supplies for his tracheostomy care. Resident 15 confirmed he was performing his own tracheostomy suctioning, inner cannula insertion and gauze dressing change. During a concurrent interview and record review on 10/9/24 at 3:48 p.m. with the Minimum Data Set (MDS - a federally mandated resident assessment tool) Coordinator (MDSC), Resident 15's record was reviewed. MDSC validated Resident 15's clinical record indicated a risk and benefit assessment was not conducted, a care plan was not developed, and a physician's order was not obtained to ensure Resident 15 could safely perform his own tracheostomy care. During an interview on 10/9/24 at 4 p.m. with the Respiratory Therapy (RT) Director, the RT Director stated she was not aware of any risk and benefit assessment done, a care plan developed, and a physician's order obtained to ensure Resident 15 was fully capable to safely do his own tracheostomy care. The RT Director stated the assessment, care plan, and order should have been placed but there was none. A review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/23, indicated, the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. A review of the facility's P&P titled, Physician's Order, revised 11/16/21, indicated, Orders will include a clear and complete description to provide clarity on the physician's plan of care . documentation pertaining to physician's orders will be maintained in the resident's medical record.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48694 Based on observation, interview and record review, the facility failed to ensure staffing information was posted on a daily basis at the beginning of each shift for a census of 80, when staffing information was not posted for five consecutive days including weekend and at the beginning of weekdays' morning shifts. This failure decreased the facility's potential to post staffing information on a daily basis for residents and visitors. Findings: During an observation on 10/7/24 at 8:05 a.m., the daily nurse staffing information was posted for 10/2/24 at the front desk in the entrance lobby. During a concurrent observation and interview on 10/8/24 at 7:07 a.m. with Licensed Nurse 2 (LN 2) at the front desk in the entrance lobby, the daily nurse staffing information was observed. LN 2 confirmed the posted staffing information was for 10/7/24. LN 2 stated morning shifts start at 6 a.m. for subacute hall and 6:30 a.m. for skilled nursing halls. During an interview on 10/8/24 at 8:25 a.m. with Staffing Coordinator (SC), SC stated morning shift started between 6 and 6:30 a.m. everyday. SC confirmed the nurse staffing information was posted daily after 8 a.m. for residents and visitors. During an interview on 10/10/24 at 10:07 a.m. with Director of Nursing (DON), DON stated nurse staffing information for residents and visitors should be posted before the beginning of morning shift on daily basis. A review of the facility's policy and procedure titled, Nursing Department-Staffing, Scheduling & Postings, dated 2018, indicated, . The facility will post the nurse staffing data . on a daily basis at the beginning of each shift .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47465 Based on observation, interview, and record review, the facility had a 9.09 % error rate when three medication errors out of 33 opportunities were observed during a medication pass for one of seven residents (Resident 2). This failure decreased the facility's potential to administer residents' medications according to prescriber's orders and manufacturer's specifications. Findings A review of an admission record indicated, Resident 2 was admitted to the facility in June 2024 with diagnoses including depression and hypertension (HTN-high blood pressure). During an observation on 10/7/24 at 8:23 a.m., Licensed Nurse 4 (LN 4) was observed preparing medications for Resident 2. LN 4 crushed all medications, mixed it with apple sauce and spoon fed it to Resident 2. During an interview on 10/7/24 at 08:26 a.m. with LN 4, LN 4 stated there was no order to crush Resident 2's medications. A review of Resident 2's Order Summary Report, dated 10/9/24, indicated physician orders for: 1. Carvedilol (blood pressure medication) oral tablet 3.125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). Give one tablet by mouth two times a day for HTN. 2. Lisinopril (blood pressure medication) oral tablet 20 mg. Give one tablet by mouth one time a day for HTN. 3. Duloxetine (antidepressant medication) oral capsule delayed release particles 60 mg. Give one capsule by mouth one time a day for depression. During an interview on 10/9/24 at 11:01 a.m. with Nurse Practitioner (NP), NP stated an order was needed for nurses to crush medications and it would be indicated in the pharmacy review. During an interview on 10/9/24 at 2:13 p.m. with the Director of Nursing (DON), DON stated her expectations were nurses should make sure that medications could be crushed. DON further stated doctor's orders were needed for medications to be crushed. A review of the facility's pharmacist monthly medication regimen review, dated June 2024, indicated, To ensure proper dosing, please add (do not crush) to the following medication order - duloxetine. A review of the manufacturer's specifications for the use of duloxetine, dated 10/10, indicated, duloxetine should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened, and its contents be sprinkled on food or mixed with liquids. (continued on next page)

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	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Point Health & Wellness Center	600 Sunrise Avenue Roseville, CA 95661

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication-Administration, revised 1/1/12, indicated, . If the medication is to be crushed, a physician order is required.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47465 Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly for a census of 80. This failure increased the residents' risk of infection and receiving expired medications. Findings: During a concurrent observation and interview on 10/8/24 at 8:12 a.m. with Licensed Nurse 2 (LN 2) in the medication storage room, 10 bottles of 16 ounces (oz; a unit of measure) sorbitol solution (a laxative) were found with an expiration date of 9/24. LN 2 stated the expired medication should be discarded and not stored in the medication room. During a concurrent observation and interview on 10/8/24 at 10:47 a.m. with LN 4 in the skilled nursing medication cart three, the following medications were stored: 1. A used insulin pen (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was stored without a plastic bag, 2. A medication card of benzonatate (a cough suppressant) 100 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) pills was found with an expiration date of 9/19/24; and 3. Six loose pills were found in the bottom of the medication drawer. LN 4 stated the insulin pen should have been in a bag to prevent cross contamination, confirmed that benzonatate was expired and should have been placed in the expired bin in the medication room, and the loose pills should not be in the cart. During a concurrent observation and interview on 10/8/24 at 3:45 p.m. with LN 6 in the skilled nursing medication cart two, the following medications were stored: 1. An opened bottle of simethicone (treats the symptoms of gas) 80 mg tablets, was found without an open date, 2. An unwrapped fluticasone propionate/salmeterol inhaler (medication to treat difficulty breathing) 500 micrograms/50 micrograms (mcg- metric unit of measurement, used for medication dosage and/or amount), was found without an open date, 3. A bottle of atropine sulfate eye drops (used to decrease secretions) was found with no open date and label indicating the medication to be discarded 28 days after opening, (continued on next page)

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	056139	A. Building B. Wing	10/10/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A bottle of lansoprazole powder (medication to reduce stomach acid) 10 milliliters (ml-metric unit of measurement, used for medication dosage and/or amount) was found with an expiration date of 9/13/24, 5. One vial of ipratropium bromide (medication to treat runny nose) nasal spray was found with torn prescription label; and 6. Six loose pills were found at the bottom of the cart. LN 6 confirmed there were no open dates for the simethicone bottle, the fluticasone propionate/salmeterol inhaler, and the atropine sulfate eye drops. LN 6 stated open dates were needed to know when to stop using the medication. LN 6 further stated expired medications and loose pills should not be in the cart. LN 6 also added because of the torn label, he could not identify to which resident the ipratropium bromide vial belonged. During an interview on 10/9/24 at 2:13 p.m. with the Director of Nursing (DON), DON stated her expectations were that expired medications should not be stored in the medication storage room or medication carts and medications needed to have open dates. A review of the manufacturer's labelling for use of fluticasone propionate and salmeterol indicated to discard fluticasone propionate and salmeterol inhalation powder one month after opening the foil pouch or when the counter reads zero. A review of the facility's policy and procedure titled, Medication storage in the facility, dated 2/23/20, indicated, Outdated, contaminated, or deteriorated medications . are immediately removed from stock, and medication storage areas are kept clean, and free of clutter .

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	056139	A. Building B. Wing	10/10/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 36624 Based on observation, interview, and record review, the facility failed to ensure dietary staff demonstrated sufficient skills during red bucket and low temperature dishwasher test strip testing for a census of 80. This failure decreased the facility's ability to carry out the functions of the food and nutrition services safely and effectively. Findings: During an observation on 10/9/24 at 2:06 p.m. in the kitchen, one dietary aide (DA) demonstrated how to use the chemical sanitization test strip on low temperature dishwasher and on the red bucket. The DA ran the dishwasher at wash and final rinse. Using the test strip, the DA dipped the test strip, then immediately compared the test strip color against the test strip kit. The DA did not blot the test strip on a tissue paper lightly prior to comparing it against the test strip kit. During an interview on 10/9/24 at 2:09 p.m. with the DA, the DA confirmed she did not follow the manufacturer's specifications in using the chlorine test strips for the low temperature dishwasher. During a concurrent observation and interview on 10/9/24 at 2:12 p.m. with the DA, the DA prepared the red bucket, tore two inches of test strip, dipped it on the solution and compared. The DA was unable to identify what to do next when the sanitizing solution did not meet the target concentration and/or when the chemical concentration exceeded or was below the target solution concentration. During an interview on 10/9/24 at 2:13 p.m. with the Dietary Supervisor (DS), DS stated he expected the DA to follow the manufacturer's specification when using the chlorine test strip on the low temperature dishwasher. A review of the manufacturer's specification on the Chlorine Test Strip, indicated, dip and remove quickly, blot immediately with paper towel, compare to color chart at once. A review of the United States Food Code 2022 Section 3-304.14: Wiping Cloths Use Limitations, indicated, Soiled wiping cloths, especially when moist, can become breeding grounds for those pathogens that could be transferred to food. Any wiping cloths that are not dry must be stored in a sanitizer solution of adequate concentration between uses. The sanitizing solution must be changed as needed to minimize the accumulation of organic materials and sustain proper concentration. Proper sanitize concentration should be ensured by checking the solution periodically with an appropriate chemical test strip. A sanitizing solution of adequate temperature with the correct chemical concentration should then be applied to the surface. A review of the facility's policy and procedure titled, Staff Competency Validation, revised 3/28/24, indicated, to protect the health, safety, and well-being of resident, re-education will be provided to the employee who is unable to satisfactorily perform the skills, followed by re-evaluation of the competency.

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	056139	A. Building B. Wing	10/10/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36624 Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored in a safe and sanitary manner and air vents were sanitarily maintained for a census of 80, when: 1. A big container pan of cooked brussels sprout was uncovered and left exposed to contaminants on top of the stove burner; 2. A square-shaped stainless steel container with corn and sliced bell pepper was left on a counter corner undated and unlabeled; 3. A rectangle-shaped stainless steel container with cooked carrots was left uncovered, unlabeled, and undated in the counter corner; 4. Personal cell phone and water jug were placed next to the uncovered and unlabeled food; 5.Three packs of corn tortilla wrap was found expired in the dry storage area; and 6.The air vents horizontal slats in the dry storage area had whitish substance. These failures decreased the facility's potential to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings: During a kitchen observation on [DATE] at 8:15 a.m., the following were observed uncovered, undated, unlabeled, expired, and uncleaned: 1. On top of the stove burner was a big container pan of brussels sprout; 2. A square-shaped stainless steel container with corn and sliced bell pepper; 3. A rectangle-shaped stainless steel container of cooked carrots; 4. A personal cell phone and personal water jug were placed next to the uncovered and unlabeled food; 5. Three packs of corn tortilla was expired inside the dry storage area; and 6. Air vents horizontal slats in the dry storage area had whitish substance. During a concurrent observation and interview on [DATE] at 8:05 a.m. with the Dietary [NAME] (DC), DC validated the kitchen observations and stated food should have been covered, dated, and labeled. DC also stated personal belongings should not be placed next to uncovered and unlabeled food. (continued on next page)

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	10/10/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:40 a.m. with the Dietary Supervisor (DS), DS stated he expected that food brought out of the refrigerator or from the freezer left out in the kitchen counter should be covered, dated, and labeled. DS also stated he expected the staff not to place personal belongings in the food counter area. During a concurrent observation and interview on [DATE] at 3:54 p.m. with DS inside the dry storage area, DS validated there were three packs of expired corn tortilla and the dry storage area air vents horizontal slats had whitish substance. DS stated the expired corn tortilla should have been thrown away and the air vents should have been cleaned. A review of the facility's policy and procedure (P&P) titled, Food Storage and Handling, revised ,d+[DATE], indicated, Foods should be labeled and dated . label and date all food items. A review of the facility's P&P titled, Maintenance Service, revised ,d+[DATE], indicated, . Maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. A review of the United States Food Code of 2022, Section ,d+[DATE].14-Food Preparation, indicated, Food preparation activities may expose food to an environment that may lead to the food's contamination. Just as food must be protected during storage, it must also be protected during preparation. Sources of environmental contamination may include splash from cleaning operation, drips from overhead air conditioning vents, or air from an uncontrolled atmosphere such as maybe encountered when preparing food in a building that is not constructed according to Food Code requirements.

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	056139	A. Building B. Wing	10/10/2024

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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. 47465 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for a census of 80, when: 1. Licensed Nurse 4 (LN 4) did not perform hand hygiene during medication pass; 2. Resident 44's breath activated call cord disposable mouthpiece was not changed and had a large, brown substance in the end of it; 3. One container of food sitting on shelf labeled yogurt dated 10/6/24 was found inside Resident 17's room; and, 4. Resident 17's and Resident 44's privacy curtains were dirty, stained, and in disrepair. These failures had the potential to expose residents to infectious diseases. Findings: 1. During a medication pass observation on 10/7/24 at 8:23 a.m., LN 4 entered Resident 2's room, put on disposable gloves and checked Resident 2's blood pressure. LN 4 returned to the medication cart, removed gloves, accessed the computer, and began to prepare medication for the resident without performing hand hygiene. During an interview on 10/7/24 at 8:25 a.m. with LN 4, LN 4 stated hand hygiene needed to be performed when leaving the room and before preparing medication. During an interview on 10/9/24 at 11:57 a.m. with the Director of Staff Development (DSD), DSD stated her expectations were hand hygiene was to be done upon entering and leaving the room and before and after medication preparation. During an interview on 10/9/24 at 2:13 p.m. with the Director of Nursing (DON), DON stated her expectations were staff to use hand sanitizer gel going in and out of the room and before and after giving medication. A review of the facility's Infection Prevention and Control Program, dated 10/8/22, indicated, Implementation of Control Measures and Precautions including basics such as hand hygiene, provide a safe, sanitary and comfortable environment and decrease the risk of infection to both residents/patients and staff. 36624 2. A review of Resident 44's Admission Record, indicated Resident 44 was admitted with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). (continued on next page)

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	056139	A. Building B. Wing	10/10/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 44's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 7/27/24, indicated Resident 44 had mental capacity. During a concurrent observation and interview on 10/7/24 at 9:16 a.m. with Resident 44, Resident 44's mouthpiece had a large, brown substance in the end of it. Resident 44 stated his breath activated call cord disposable mouthpiece was not changed. During a concurrent observation and interview on 10/7/24 at 3:29 p.m. with LN 5, LN 5 stated Resident 44's mouthpiece on call cord had gunky substance and had to be changed. LN 5 also stated this gunky substance could cause infection and possible pneumonia (an infection/inflammation in the lungs). During an interview on 10/8/24 at 9:26 a.m. with the DON, DON stated disposable mouthpiece on call cord had brown residue in it. DON also stated she expected the mouthpiece to be cleaned and it could put Resident 44 at risk for respiratory problems or possible pneumonia. A review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program Description, dated 10/8/22, indicated, The goals of the program are to reduce the risks and spread of infectious pathogens . decrease the risk of infection to residents . identify and correct problems related to infection prevention. A review of the facility's manufacturer's recommendations titled, Disposable . Accessory Package, indicated, It is recommended that the filter assembly be replaced regularly (every 3 to 5 days, or when it becomes unclean). 3. During an observation on 10/7/24 at 9:42 a.m. in Resident 17's room, one container of food was found on the shelf within reach of Resident 17. The food was labeled yogurt and dated 10/6/24. During a concurrent observation and interview on 10/7/24 at 9:46 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated the item on the shelf contained yogurt and was dated 10/6/24. CNA 2 stated to avoid food poisoning of patient, perishable food items should have been taken out of the room if not eaten at meal or snack. During a concurrent observation and interview on 10/7/24 at 12:15 p.m. with LN 3, LN 3 confirmed the date on the container read 10/6/24. LN 3 stated perishable food items not eaten had to be thrown away and Resident 17 could try to eat it and might get sick from bacteria growth. During an interview on 10/8/24 at 9:26 a.m. with the DON, DON stated she expected perishable food items left over from meal or snack to be thrown out within two hours. A review of the facility's P&P titled, Infection Prevention and Control Program Description, dated 10/8/22, stipulated the facility will provide a safe, sanitary and comfortable environment. 4. During an observation on 10/7/24 at 9:16 a.m. in Resident 44's room, the privacy curtain between bed A and bed B had several large dark brown spots, greyish brown areas throughout, and was torn on top of the netting. (continued on next page)

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	056139	A. Building B. Wing	10/10/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/7/24 at 12:05 p.m. with LN 4, in Resident 44's room, LN 4 confirmed the privacy curtain was dirty and had a large stains on it. LN 4 stated dirty curtains could spread germs and was not good for the residents to look at it all day. During a concurrent observation and interview on 10/7/24 at 9:46 a.m. with CNA 2, in Resident 17's room, CNA 2 confirmed the privacy curtain was very dirty. CNA 2 stated this could be an infection control issue and could spread germs. CNA 2 also stated it was not good for the resident to look at this curtain every day. During a concurrent observation and interview on 10/7/24 at 12:15 p.m. with LN 3, inside Resident 17's room, LN 3 stated there were stains on the curtain and it appeared very dirty. LN 3 stated dirty and stained privacy curtains could lead to a possible infection control issue, and it was not good for the resident to look at it all day. During an interview on 10/8/24 at 9:26 a.m. with the DON, DON stated she expected privacy curtains in residents' rooms to be clean and free from tears. DON stated this could result in an infection control issue. A review of the facility's P&P titled, Resident Rooms and Environment, revised 1/12, stipulated, The Facility provides residents with a safe, clean, comfortable, and homelike environment.