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	05/21/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure appropriate Gradual Dose Reduction (GDR) practices for a psychotropic medication (a drug prescribed to affect the mind, emotions or behavior) for one of 5 sampled residents (Resident 5) when Resident 5's dose of quetiapine (a psychotropic medication) was increased, and the GDR was documented as unsuccessful without any supporting clinical documentation to justify the dose increase.This failure resulted in the potential for unnecessary medication use and avoidable adverse effects for Resident 5.Clinical record review indicated that Resident 5 was admitted to the facility in December 2021 with diagnoses including dementia (memory loss condition), major depressive disorder (longˆterm depression), and anxiety disorder (ongoing excessive worry or nervousness).A review of Resident 5's Physician Orders, dated 9/25/25, indicated a dose increase for quetiapine 50 mg (milligram-unit of measure) to give 1.5 tablets (75 mg) by mouth at bedtime for BPSD (Behavioral and Psychological Symptoms of Dementia, the changes in behavior, emotions, or mental state that residents with dementia experience) MB (Manifested By, shown by) physical aggression. Resident 5's quetiapine dose was increased from 50 mg to 75 mg at bedtime.A review of Resident 5's monthly Medication Administration Records (MAR) indicated that Resident 5 received 75 mg of quetiapine every night at bedtime.During a concurrent record review and interview on 5/21/26 at 11:47 a.m. with Licensed Nurse (LN) 2, the facility's former interim director of nursing, LN 2 stated that according to Resident 5's monthly behavioral monitoring records for June, July, August, and September 2025, the resident did not exhibit any behaviors around the time the quetiapine dose was increased. LN 2 also stated that he created a progress note dated 9/1/25 after the maintenance staff reported that the resident appeared agitated and nearly grabbed another resident's wheelchair after he was touched. Upon follow-up, the resident was already in his room with a Certified Nursing Assistant (CNA), who reported that the resident had been combative when she attempted to assist him. LN 2 stated he was able to calm the resident, and the CNA assisted the resident back to bed.During another interview on 5/21/26 at 12:46 p.m. with LN 2, LN 2 stated there were no psychiatry chart notes completed or scanned to resident 5's chart related to the quetiapine dose increase in September of 2025.During an interview on 5/21/26 at 2:06 p.m. with the facility's Nurse Practitioner (NP) 2, NP 2 stated that she increased the resident's quetiapine dose on 9/25/25 based on a progress note. NP 2 noted that the resident did not like being touched, was not a threat to others, and did well when approached appropriately. She stated she felt safe and comfortable providing care for him. NP 2 added that if the resident had been hitting staff or was combative, she would have transferred him to a memory unit. She also noted that the September 2025 dose increase was the reason the GDR attempt was documented as failed in Resident 5's psychiatry chart notes dated 12/23/25 and 2/4/26.A Review of Resident 5's psychiatry chart notes, dated 12/23/25, stated, no behaviors; failed GDR: Seroquel [brand name for quetiapine], described any failed GDR: Seroquel, but did not provide any description of the failed GDR. A Review of Resident 5's psychiatry chart notes, dated 2/4/26, stated, no behaviors; failed GDR: Seroquel, described any failed GDR: Seroquel, but again provided no description of the failed GDR. During an interview on 5/20/26 at 2:03 p.m. with the facility's Regional Consultant (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RC), the RC stated that Resident 5 did not have notable behaviors over the last 12 months. The psychotropic medication evaluations were required to be conducted monthly to address Gradual Dose Reduction (GDR). The RC further acknowledged that the GDR Interdisciplinary Team (IDT) meetings were not being held consistently and that the facility was required to implement a Quality Assurance Performance Improvement (QAPI) plan to ensure appropriate GDR assessments.A review of quetiapine's Prescribing Information (PI), dated 1/2022, indicated that elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine was not approved for the treatment of patients with dementia-related psychosis. In addition, the PI also stated, somnolence (a state of drowsiness or heightened sleepiness) was a commonly reported adverse event reported in patients treated with quetiapine.A review of the facility Policy and Procedures (P&P) titled, Psychotropic Medication Use, dated 10/2017, the P&P indicated, .before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and monitored objectively and qualitatively, in order to ensure the behavioral symptoms are. persistent or likely to reoccur without continued treatment. not due to environmental stressors.that can be addressed to improve the psychotic symptoms or maintain safety.not due to psychological stressors, anxiety or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed.After initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms much be reevaluated periodically to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview, and facility document review, the facility failed to implement pharmaceutical policies and procedures for a census of 87 when the refrigerator E-Kits (Emergency kits containing emergency medications for immediate use) had not been replaced within 72 hours after being used. This failure had the potential to result in emergency medications not being available when needed for the residents.During an inspection of the facility's medication room on 5/18/26 at 11:33 a.m., two emergency kits in the medication refrigerator were found to be previously opened and not replaced. A 3 ml (milliliter, unit of measure) glargine insulin pen (medication used to treat high blood sugar level) had been taken out of E-kit box #3116 on 4/3/26. A 3 ml glargine insulin pen had been taken out of E-kit box #2550 on 4/8/26. Both the E-kit boxes were still stored in the medication refrigerator without any glargine insulin. During an interview on 5/18/26 at 11:35 with Licensed Nurse (LN) 1, LN 1 acknowledged both refrigerator e-kit boxes had been previously opened on 4/3/26 and 4/8/26 and were not replaced with new sealed boxes to ensure all emergency medications were available for the residents.During an interview on 5/19/26 at 9:46 a.m. with the facility's Regional Consultant (RC), the RC stated that open E-kits needed to be replaced by the pharmacy within 24-72 hours to ensure emergency medications were available for resident use. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy, dated 8/2014, the P&P indicated, .the used sealed kits are replaced with the new sealed kits within 72 hours of opening.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the Consultant Pharmacist (CP)'s recommendation for one of 5 sampled residents (Resident 5) when the facility did not address the need for a Gradual Dose Reduction (GDR) of quetiapine (a type of psychotropic medication).This failure resulted in the potential for unnecessary medication use and avoidable adverse effects for Resident 5.Clinical record review indicated that Resident 5 was admitted to the facility in December 2021 with diagnoses including dementia (memory loss condition), major depressive disorder (longˆterm depression), and anxiety disorder (ongoing excessive worry or nervousness).A review of Resident 5's Physician Orders, dated 9/25/25, indicated an order for quetiapine 50 mg (milligram-unit of measure) to give 1.5 tablets (75 mg) by mouth at bedtime for BPSD (Behavioral and Psychological Symptoms of Dementia, the changes in behavior, emotions, or mental state that residents with dementia experience) MB (Manifested By, shown by) physical aggression.A review of Resident 5's monthly Medication Administration Records (MAR) indicated that Resident 5 received 75 mg of quetiapine every night at bedtime.During an interview on 5/20/26 at 2:03 p.m. with the facility's Regional Consultant (RC), the RC stated that Resident 5 did not have notable behaviors over the last 12 months. The psychotropic medication evaluations were required to be conducted monthly to address Gradual Dose Reduction (GDR). The RC further acknowledged that the GDR Interdisciplinary Team (IDT) meetings were not being held consistently and that the facility was required to implement a Quality Assurance Performance Improvement (QAPI) plan to ensure appropriate GDR assessments. A review of the facility's CP recommendation report regarding the GDR for Resident 5's quetiapine 75 mg, dated 12/23/25, showed that the recommendation was not reviewed and the record reflected no physician-documented consideration of risks, benefits, or clinical factors unique to the resident.During an interview on 5/21/26 at 2:21p.m. with the CP, the CP stated that a GDR request for Resident 5 was submitted to the facility on [DATE], but it was declined without providing any clinical rational. The CP stated that the plan was to resubmit the GDR recommendation.A Review of Resident 5's psychiatry chart notes, dated 12/23/25, stated, no behaviors; failed GDR: Seroquel [brand name for quetiapine], described any failed GDR: Seroquel, but did not provide any description of the failed GDR. A Review of Resident 5's psychiatry chart notes, dated 2/4/26, stated, no behaviors; failed GDR: Seroquel, described any failed GDR: Seroquel, but again provided no description of the failed GDR. A review of quetiapine's Prescribing Information (PI), dated 1/2022, indicated that elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine was not approved for the treatment of patients with dementia-related psychosis. In addition, the PI also stated that somnolence (a state of drowsiness or heightened sleepiness) was a commonly reported adverse event reported in patients treated with quetiapine.A review of the facility Policy and Procedures (P&P) titled, P-NP106 Behavior/Psychoactive Medication Management, dated 2022, the P&P indicated, Evaluation: The Behavior Management/Psychoactive Review Committee will review the following and make recommendations based on the resident's need.A review of the facility's Quality Assurance Performance Improvement (QAPI) form, date initiated 4/28/26, showed that under improvement plan, it indicated, during this meeting the team shall review: a. pharmacy recommendations.The facility's Pharmacist Medication Review policy was not provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, the facility failed to ensure accurate and consistent medical record documentation for two of 27 sampled residents (Resident 26 and Resident 11) when: 1. A physicianˆordered wound care treatment for Resident 26 were not entered or documented on the Treatment Administration Records (TAR) and,2. Resident 11's Advance Health Care Directive (AHCD, a legal document that outlines your medical preferences) was incomplete; and, These failures increased the potential for miscommunication among staff that could lead to unmet needs for Resident 26 and Resident 11. Findings: 1. Resident 26 was admitted to the facility on February of 2026 with a diagnoses which included Acute Hypoxic Respiratory Failure (a sudden, life-threatening condition where the lungs cannot adequately transfer oxygen into the bloodstream, Quadriplegia (a partial or total loss of sensory and motor function in all four limbs and the torso, typically caused by a spinal cord injury in the neck) and Pressure Ulcer of Sacral Region (a skin and tissue damage over the tailbone or lower spine). A review of Resident 26's Order Summary Report (ORS) indicated, Resident (Resident 26) is capable of making healthcare decisions. A review of Resident 26' Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 04/22/26, the MDS indicated, Resident [Resident 26] has a pressure ulcer/injury.Is the resident at risk for developing pressure ulcers/injuries? 1. Yes. Skin and Ulcer/Injury Treatments, Pressure ulcer/injury care. A review of Resident's 26 Care Plan (CP) indicated, Documented Pressure Ulcer.Evaluate skin.Evaluate ulcer.Provide skin care per facility guidelines.Resident at risk for uti [urinary tract infection] and pressure ulcers.Resident will be monitored. A review of Resident 26's Treatment Administration Record (TAR) for January, February, March, April, and May 2026 revealed several instances of missing documentation for the following treatment orders. For the order, 'Tx Nurse: Right Heel. Clean with NS.for unstageable pressure ulcer injury,' documentation was missing on 1/21/26, 1/29/26, 2/5/26, 2/9/26, 2/14/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, and 2/19/26. For the order, 'Tx Nurse: Left Heel.every day shift,' documentation was missing on 1/29/26, 2/19/26, 2/6/26, 02/9/26, 02/14/26, 02/15/26, 02/16/26, 02/17/26, and 02/18/26. For the order, 'Tx Nurse: Right inner knee.Stage 2 pressure injury,' documentation was missing on 1/19/26. For the order, 'Tx Nurse: Sacrum.Stage 2 pressure injury,' documentation was missing on 1/25/26, 1/28/26, 2/6/26, 2/9/26, 2/13/26, and 2/19/26. For the order, 'Tx Nurse: Coccyx.Stage 2 pressure injury,' documentation was missing on 3/26/17, 3/22/17, 3/3/26, 3/7/26, 3/10/26, and 3/13/26. For the order, 'Tx Nurse: Right Foot.Stage 2 pressure injury,' documentation was missing on 3/3/26, 3/7/26, and 3/17/26. During an interview with Resident 26 on 05/20/26 at 1:27 p.m., Resident 26 confirmed that he had wounds that required treatment in the facility and stated that he expected the nurses to perform his wound treatments. During a concurrent interview and record review with the Treatment Nurse (TN) on 5/20/26 at 1:52 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., the TN stated that treatments performed on residents should be documented as soon as possible after completion. The TN confirmed that Resident 26 had an active woundˆcare order and acknowledged that she failed to document the treatments on the following dates: March 3, 4, 10, 17, 11, and 25, and May 7 and 13. During a concurrent interview and record review with Licensed Nurse (LN) 2 on 5/21/26 at 8:34 a.m., LN 2 confirmed the findings and explained that documentation verified completion of a treatment order and that the absence of documentation indicated the treatment was not performed. LN 2 further stated that signing the resident's TAR represented best practice. During a concurrent interview and record review with the Regional Consultant (RC) on 5/20/26 at 2:16 p.m., the RC confirmed the findings and stated that staff should document services provided to residents immediately. This included medication administration and wound treatments. The RC expected staff to follow the facility's policy and added that documentation ensured care was provided according to each resident's specific needs. A review of the facility's policy and procedures (P&P) titled Skin Integrity Management, revised 6/27/24 indicated, Treatments administered will be documented in the resident medical records. A review of the facility's P&P titled Completion and Correction, effective date 3/25/26 indicated, The Facility will work to complete and correct medical records.to provide the highest quality and accuracy in documentation. 2. Resident 11 was admitted to the facility in late 2025 with diagnoses that included dementia and cognitive communication deficit. During a review of Resident 11's OSR, order date 12/1/25, the OSR indicated, Resident is incapable of making healthcare decisions.r/t dementia. During a review of Resident 11's AHCD, the AHCD was undated, unwitnessed, and signed by Resident 11. During a concurrent interview and record review on 5/20/26 at 11:07 with the Social Work Consultant (SWC), the SWC confirmed the document was undated and signed by Resident 11, who was incapable of making healthcare decisions. The SWC stated the AHCD was not an accurate or valid part of the medical record. The SWC stated it was important to have an accurate AHCD to ensure the resident's wishes were followed and to identify who was responsible for making healthcare decisions. During a concurrent interview and record review on 5/21/26 at 11:58 a.m. with the RC, the RC stated the AHCD for Resident 11 was invalid. The RC he expected the AHCD to be completed and accurate before it was placed into Resident 11's medical record. During a review of the facility P&P titled, MR04 Completion & Correction, dated 3/26, the P&P indicated, The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. Purpose: To ensure that medical records are complete and accurate.

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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. Based on interviews and record review, the facility failed to follow professional standards of quality for four of the 27 sampled residents (Resident 26, Resident 52, Resident 32 and Resident 6 when:1. Staff did not accurately enter a physician's order for tracheal/oral suctioning into Resident 26's medical record;2. Resident 52's oxygen tubing was not changed as ordered by the physician; and3. Staff did not change the enteral feeding tubing for Residents 6 and 32 as ordered by the physician.These failures placed Resident 6, Resident 26, Resident 32, and Resident 52 at risk for infection and placed Resident 26 at additional risk for respiratory complications. Findings: 1. Resident 26 was admitted to the facility on February of 2026 with a diagnoses which included Acute Hypoxic Respiratory Failure (a sudden, life-threatening condition where the lungs cannot adequately transfer oxygen into the bloodstream, Quadriplegia (a partial or total loss of sensory and motor function in all four limbs and the torso, typically caused by a spinal cord injury in the neck) and Pressure Ulcer of Sacral Region (a skin and tissue damage over the tailbone or lower spine). A review of Resident 26's Order Summary Report (OSR) indicated, Resident (Resident 26) is capable of making healthcare decisions. A review of Resident 26' Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 04/22/26, the MDS indicated that Resident 26 had a BIMS (Brief Interview for Mental Status) score of 10 out of 15 which indicated a moderate cognitive impairment. A review of Resident's 26 Care Plan (CP) indicated, Risk for Ineffective Airway Clearance.Resident Will Maintain Airway Patency.Ineffective Airway Clearance.Resident Will be Free of Respiratory Distress. A review of Resident 26's Order Summary Report (OSR) indicated the following physician's order: Assess resident for the need to suction trach [trachea]/oral secretions Q2H [every 2 hours] and PRN [as needed] and may suction the resident for excessive trach/oral secretions. The order had a start date of 4/21/26. In contrast, the facility's written order in OSR directed staff to perform the suctioning assessment every 4 hours, rather than every 2 hours as ordered by the physician. During a concurrent interview and record review with the Regional Consultant (RC) on 5/19/26 at 11:00 a.m., the RC confirmed the findings and stated that physician orders, including Nurse Practitioner orders, must be accurately entered into PointClickCare (PCC, electronic health record) by the licensed nurses (LN). The RC added that if an order was entered incorrectly, such as the suctioning order in this case, it may result in respiratory concerns for the residents. During a concurrent interview and record review with Licensed Nurse (LN) 2 on 5/21/26 at 8:34 a.m., LN 2 stated the facility verified the orders after the initial nurse entered them into PCC for confirmation. LN 2 emphasized that entering orders correctly and accurately in the health record was important for resident safety. LN 2 confirmed that the breathing orders indicated above were entered incorrectly. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Nurse Practitioner (NP) on 5/21/25 at 10:11 a.m., the NP confirmed the findings and stated that the breathing treatment orders were based on each resident's condition. She stated that nurses entered the orders and reviewed them. The NP further stated that no one could change the orders without her consent or the consent of a medical doctor. She stated that she had not been informed that some breathing treatment schedules were being entered differently from how they were ordered. She denied the existence of any facility policy requiring suctioning every 4 hours and stated that suctioning frequency depended on the resident's condition. A review of the facility policy and procedures (P&P) titled, Physician Orders, revised 11/16/22 indicated, The licensed nurse will confirm that the physician orders are clear, complete and accurate.verify all physicians orders are complete and accurate. A review of the facility P&P titled, Telephone Orders, revised 6/26/25 indicated, Only a licensed nurse (RN or LVN) may accept telephone order from a provider.The documentation must include.full order details. A request was made for the facility's P&P for breathing treatments, assessments and related cares. The facility was unable to provide the requested document. 2. Resident 52 was admitted to the facility in early 2026 with diagnoses that included acute respiratory failure, lifeˆthreatening infection, and two progressive chronic lung diseases. During a review of Resident 52's OSR order date 3/24/26, the OSR indicated, Change 02 [oxygen] tubing [tube that connects the oxygen to the resident] every night shift every Sunday. During a review of Resident 52's Treatment Administration Record [TAR] dated 5/1/26–5/31/26, the TAR indicated the oxygen tubing was changed on 5/3/26, 5/10/26, and 5/17/26. During concurrent observation and interview on 5/18/26 at 10:01 a.m. with the Director of Respiratory Therapy (DRT), of Resident 52's oxygen tubing, the oxygen tubing had a paper tab with Resident 52's name and was dated 4/27/26. The DRT confirmed the tubing had been dated three weeks earlier. The DRT stated the policy was to change oxygen tubing once a week on Sunday night, noted tubing was changed to prevent infection, and stated she expected it to be changed per policy. During a concurrent interview and record review on 5/21/26 at 8:20 a.m. with the DRT Resident 52's TAR (Treatment Administration Record) and a photo of the oxygen tubing (dated 4/27/26), the DRT confirmed the order to change the oxygen tubing was marked as completed on 5/3/26, 5/10/26 and 5/17/26. The DRT confirmed staff had not changed the oxygen tubing according to physician orders. During a concurrent interview and record review on 5/21/26 at 11:58 a.m. with the RC, of Resident 52's TAR and a picture of the oxygen tubing dated 4/27/26, the RC confirmed physician orders were not followed. The RC stated he expected that when staff signed the TAR, it meant the task was completed. During a review of the P&P titled PˆNP94 Oxygen Therapy, dated 10/25, the P&P indicated, .Oxygen equipment shall be maintained as follows: The tubing and mask should be changed at least every 7 days and labeled with the date of change. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review of Resident 6's admission record indicated that Resident 6 was admitted with diagnoses that included a gastrostomy (a feeding tube in the stomach) and dysphagia (difficulty swallowing). A review of Resident 6's Order OSR, dated 5/4/26, the OSR indicated, Enteral Feed Order every night shift. Change tubing syringe daily. During a concurrent observation and interview on 5/18/26 at 10:18 a.m. with LN 2, LN 2 confirmed that Resident 6's enteral tubing attached to the flush bag was labeled 5/17/26 0500. LN 2 stated that night shift should have changed the tubing during their shift as ordered to prevent infection. During a concurrent observation and interview on 5/19/26 at 1:30 p.m. with LN 5, LN 5 confirmed that Resident 6's enteral tubing was still labeled 5/17/26 0500. LN 5 stated she did not check the label before spiking a new enteral formula and should have changed the entire tubing system. A review of Resident 32's admission record indicated that Resident 32 was admitted with diagnoses that included gastrostomy and dysphagia. A review of Resident 32's OSR, dated 4/28/26, the OSR indicated, Enteral Feed Order every night shift. Change tubing syringe daily. During a concurrent observation and interview on 5/18/26 at 11:42 a.m. with LN 7, LN 7 confirmed that Resident 32's enteral tubing attached to the flush bag was labeled 5/17/26 0430 LN 7 stated night shift nurses should change the tubing as ordered. LN 7 also stated the tubing was only good for 24 hours and not changing it could cause gastrointestinal symptoms, such as diarrhea. During an interview on 5/21/26 at 8:35 a.m. with the Infection Prevention Nurse (IPN), the IPN stated that they expected night shift nurses to follow the doctor's orders for changing the enteral feeding tubing. The IPN also stated that if night shift did not change it, then day shift should complete it. A review of the facility's P&P titled Enteral Feedings, effective 9/7/23, the P&P indicated, Changed feeding bag and tubing every 24 hours.

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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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure medications were stored properly for a census of 87 when Resident 55's opened inhaler (used to administer medication by breathing in) stored in the medication cart 1 was not dated when opened,This failure placed Resident 55 at risk of receiving ineffective, expired or outdated medication.During an inspection of medication cart 1 on 5/18/26 at 11:20 a.m., a box of budesonide and formoterol (a multidose inhaler containing two medications used to treat breathing issues) 80/4.5 mcg (microgram, unit of measure) was observed to be stored without an open date label. During an interview on 5/18/26 at 11:23 a.m. with Licensed Nurse (LN) 1, LN 1 stated there was no open date on the label to determine the product's expiration date. Furthermore, LN 1 stated that expired medications may lose efficacy and may not be beneficial to the residents. During an interview on 5/19/26 at 9:48 a.m. with the facility's Regional Consultant (RC), the RC stated that the open date needed to be documented on the multidose inhaler to know the product's expiration date and to minimize the risk of using expired medications.During a review of the budesonide and formoterol inhalation manufacturer box and label, the box and label indicated, discard within 3 months after removing from foil pouch [opening].During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 4/2008, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations.outdated, contaminated, or deteriorated medications.are immediately removed from stock, disposed of according to procedures for medication disposal.

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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. Based on observations, interviews, and record review, the facility failed to keep an effective infection prevention and control program for a census of 87 residents when: Licensed Nurse (LN) 5 entered a contactˆprecaution room (Resident 6) without wearing the required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments); and Respiratory Therapist (RT) did not change PPE after providing care between residents (Resident 6 and Resident 71).These failures increased the risk of infections and cross contamination for the residents. Findings:1. A review of Resident 6's medical record showed the resident was first admitted in October 2025. The record also showed that on 2/28/26, Resident 6 tested positive for Candida auris (C. auris, a fungus that spreads easily in healthcare settings and can cause outbreaks), and on 5/10/26, the resident was diagnosed with Pseudomonas aeruginosa (P. aeruginosa, a bacteria can cause infection in the blood, lungs, urinary tract, or other parts of the body after surgery).During an observation on 5/18/26 at 10:15 a.m., Resident 6's room is a three resident room and on the door has a contact precaution signage posted.During a concurrent observation and interview on 5/19/26 at 1:30 p.m., LN 5 entered Resident 6's room without wearing an isolation gown while touching the enteral flush bag. LN 5 stated that she should have put on the isolation gown before entering Resident 6's room.During an interview on 5/21/26 at 8:35 a.m., the Infection Prevention Nurse (IPN) stated that Resident 6 was on contact precautions and that staff were expected to wear the appropriate PPE before entering any contact precaution room. The IPN further stated this helped prevent staff from spreading organisms to other residents or staff, especially when many residents were immunocompromised.2. A review of Resident 71's medical record showed the Resident 71 was admitted in February 2025 with a diagnosis of ventilator dependence. On 2/8/26, the diagnosis of carrier of infectious disease was added, and on 5/10/26, the medical record indicated carrier of carbapenemˆresistant Acinetobacter baumannii (CRAB, is a species of bacteria that cause variety of different type of infections that don't respond to common antibiotics and some are resistant to all available antibiotics).A review of Resident 71's Order Summary Report (OSR) dated 5/7/26 indicated, Contact precaution d/t [due to] C. auris.During a concurrent observation and interview on 5/20/26 at 9:39 a.m., the RT put on PPE before entering a multiˆresident room. The RT provided care to Resident 6 but did not change PPE before checking Resident 71's ventilator (a machine that helps a person breathe). The RT then returned to Resident 6. The RT acknowledged they should have removed their PPE before touching Resident 71's ventilator to prevent crossˆcontamination.During an interview on 5/21/26 at 8:35 a.m., the IPN stated that in a multiˆresident room, staff were expected to change PPE before caring for another resident, even if the residents were roommates. The IPN further stated that staff should never use the same gown and gloves for more than one resident because it could spread infections or microorganisms.A review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated September 2024, indicated, Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient's room is done to contain pathogens.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure equipment was maintained in working order when the arm rests of two wheelchairs (Resident 11 and Resident 35) out of 54 wheelchairs in use in the facility were in disrepair. This failure increased the potential for discomfort and skin tears to resident forearms. Resident 11 was admitted to the facility with diagnoses which included muscle weakness and difficulty in walking.During a review of Resident 11's Minimum Data Set (MDS, an assessment tool), dated 3/18/26, the MDS indicated Resident 11 was alert and oriented, able to make her needs known.During a review of Resident 11's care plan (CP) titled [Resident 11] has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to].DIFFICULTY IN WALKING. revised 2/14/26, the CP indicated independent with.wheelchair mobility.During a concurrent observation of Resident 11's wheelchair armrests and interview with the Director of Staff Development (DSD) on 5/18/26 at 11:50 a.m. in the facility dining room, the DSD verified the observation and said, It should be reported to maintenance as soon as possible.During a concurrent observation and interview with 5/18/26 at 1:29 p.m. Maintenance standby (MS 2) verified the observation of the disrepair of Resident 11's wheelchair armrests and said, The staff should notify the maintenance department when armrests are in disrepair.During an interview on 5/18/26 at 1:37 p.m. with Certified Nurses Assistant (CNA) 1 , CNA 1 was asked about the armrests and said, I didn't notice [Resident 11's wheelchair] armrests were in disrepair.During an interview on 5/18/26 at 1:43 p.m. with CNA 2, CNA 2 was asked about Resident 11's wheelchair armrests and said, I did notice [Resident 11's wheelchair] armrests were worn but I didn't report it because I never saw maintenance.I didn't put it on the computer yet.Resident 35 was admitted to the facility in the winter of 2025 with diagnoses which included muscle weakness, low back pain and a history of falling.During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 had moderate memory impairment.During a review of Resident 35's [PT] Physical Therapy Evaluation and Plan of Treatment [PT eval], dated 5/19/26-6/14/26 , the PT eval indicated Resident uses a wheelchair and/or scooter.YesDuring an observation on 5/18/26 at 9:49 a.m. of Resident 35 in his room, Resident 35's high back wheelchair had extensive damage to both armrests. Multiple pieces of the waterproof cover was worn and missing with the padding showing through.During a concurrent observation and interview on 5/18/26 at 10:13 a.m. with Licensed Nurse 4 in Resident 35's room, LN 4 verified both armrests of Resident 25's highback wheelchair were heavily damaged and in poor repair. LN 4 stated and that it probably couldn't be sanitized.During an interview on 5/20/26 at 9:25 a.m. with CNA 2, CNA 2 said, If the upholstery is broken and sticking up, the resident could get scratches on his outer arm.During an interview on 5/20/26 at 9:27 a.m. with LN 5, LN 5 was asked about damaged wheelchair armrests of Resident 11 and Resident 35 and said, .I never noticed the arm rests were worn out so I didn't report it to maintenance.During an interview with the Regional Consultant (RC) on 5/20/26 at 9:33 a.m., the RC was asked his expectations for the maintenance of equipment and said, All resident equipment should be maintained in working order, including the armrests of wheelchairs which should be clean and in good repair.During a review of the facility policy and procedure (P&P) titled Maintenance Service, revised 1/1/12, the P&P indicated The Maintenance Department is responsible for maintaining the.equipment in a safe and operable manner at all times.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to maintain a functional, accessible communication system that allowed one of 27 sampled residents (Resident 28) to easily request staff assistance from his bedside when there was no call light or bell within reach.This failure increased the risk Resident 28 would not have to ability to call for help in an emergency or when needing assistance. Findings: Resident 28 was admitted to the facility in the summer of 2024 with diagnoses which included hemiplegia (paralysis) of the left side and hemiparesis (weakness) of the right side, respiratory failure, seizures, chronic pain, dysphagia (difficulty in swallowing).During a review of Resident 28's Minimum Data Set (MDS, an assessment tool), dated 3/26/26, the MDS indicated Resident 28 had moderate memory impairment and was dependent with most activities of daily living (ADLs).During a review of Resident 28's care plan (CP) titled, [Resident 28] is at risk for fall and self injury related to medical conditions affecting strength, balance & endurance.hemiplegia.h/o [history of] of fall.seizure disorder.impaired mobility.chronic pain., revised 10/8/24, the CP indicated Be sure The (sic) resident's call light is in reach.The resident needs prompt response to all requests for assistance.During an observation on 5/18/26 at 3:46 p.m. Resident 28 was observed laying on his back in bed with no call light or bell within reach.During a concurrent observation and interview on 5/18/26 at 3:49 p.m. with Licensed Nurse (LN) 6, LN 6 was asked to find Resident 28's call light and verified there was no call light in place. LN 6 stated, I didn't even notice he did not have a call light or bell.During a concurrent observation and interview on 5/18/26 at 3:52 p.m. with Certified Nurses Assistant (CNA) 3, CNA 3 was also asked to find Resident 8's call light or bell. CNA 3 verified Resident 28 had no call light or bell & the wires meant to be connected to the call light cord were covered and sticking out of the box. CNA 3 verified there was no alternative means to call staff for assistance such as a bell and said, Maintenance has been going around replacing call lights. Staff checks him regularly or he'll call you when you're walking by.During a concurrent observation and interview on 5/18/26 at 3:57 p.m. with Maintenance Standby (MS 2), MS 2 said [Maintenance Supervisor, MS 1] . was fixing it [3 days prior]. He must not have finished. MS 2 verified the call light box had covered wires visible with no call light cord attached and no bell observed at Resident 28's bedside.During an interview 5/19/26 at 7:09 a.m. with MS 1, MS 1 said, The nurses should have given them a bell.During an interview on 5/20/26 at 7:25 a.m. with Resident 28 laying in bed, Resident 28 indicated, if he couldn't I can't reach the call light, he'd call staff that were passing. I think I was without a call light for one week. It was a problem.During an interview in a facility communal room on 5/20/26 at 9:33 a.m. with the Regional Nursing Consultant (RC), RC was asked his expectations for having a call system in place for residents and said, The call light should be in reach at all times and if it's not working, the resident should be provided with an alternate means to call staff such as a bell.During a review of the facility policy and procedure (P&P), titled .Communication - Call System, dated 2022, the P&P indicated The Call (sic) alert device will be placed within the resident's reach.If the call alert system cannot be repaired immediately, an alternative call alert process will be put in place (i.e. tap bells.etc.).