

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER River City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 Carmichael Way Carmichael, CA 95608	
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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview, and record review, the facility failed to exercise the resident representative's right for one out of five sampled residents (Resident 5) when Resident 5 signed the facility's admission agreement, consent for treatment and release of information, and consents for facility services while Resident 5 was not oriented to person, place, date and time and did not have the capacity to make medical decisions. This failure has the potential to result in Resident 5 and Resident 5's representative to not fully understand the facility's admission agreement, treatment options, and other services that would be provided to Resident 5. Findings: A review of Resident 5's clinical record indicated Resident 5 was admitted May of 2025 and had diagnoses that included dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 5's progress note, dated 5/5/25, indicated, .Is the resident [Resident 5] oriented to person, place and time: No .A review of Resident 5's physician's orders did not indicate that Resident 5 has the capacity to make medical decisions on 5/5/25. A review of Resident 5's CONSENT FOR TREATMENT AND RELEASE OF INFORMATION document indicated it was signed by Resident 5 on 5/5/25 and by a facility representative with no sign date. A review of Resident 5's CALIFORNIA STANDARD admission AGREEMENT FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES document indicated it was signed by Resident 5 with no sign date and by a facility representative on 6/20/25. A review of Resident 5's informed consents for bed hold, influenza vaccine, and pneumococcal vaccine documents indicated the documents were signed by Resident 5 on 5/5/25 and by a facility representative on 5/5/25. During a concurrent interview and record review on 11/20/25 at 3:09 p.m. with the Assistant Director of Nursing (ADON), Resident 5's clinical records were reviewed. The ADON confirmed that Resident 5 signed the facility's admission agreement, consent for treatment and release of information, and consents for facility services while Resident 5 was not oriented to person, place, date and time and did not have the capacity to make medical decisions. The ADON also confirmed that the referral documents from the hospital did not indicate that Resident 5 had the capacity to make medical decisions. The ADON stated that signing of the admission agreement and consents should be done upon admission, before starting the care of the resident. The ADON also stated the resident must have the capacity to make medical decisions so he can sign the admission agreement and consents, or they must reach out to a family member who can sign the admission agreement and consents. The ADON further stated the protocol for admissions should always be followed for resident safety and for the residents and their families to understand the agreements and services in the facility. During an interview on 11/20/25 at 4:26 p.m. with the Director of Nursing (DON), the DON stated, I would check the policy on that, when asked about her expectations if a resident is signing his admission agreement and consents. A review of the facility's policies and procedures (P&P) titled, Resident Rights, revised 12/2021, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .m. exercise rights not delegated to a legal representative; . o. be notified of his or her medical (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition and of any changes in his or her condition; p. be informed of, and participate in, his or her care planning and treatment; .A review of the facility's P&P titled, Health Care Decision Making, dated 2/1/23, indicated, Centers must: .Inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law.A review of the facility's P&P titled, admission Agreement, revised 2/2025, indicated, 1. At the time of admission, the resident (or his/her representative) must sign an admission agreement (contract).		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 1) was free from significant medication error when Resident 1 did not receive his prescribed antiseizure medications (used to treat epilepsy and other seizure disorders by altering electrical activity in the brain) in accordance with the physician's order and standards of practice. This failure had the potential for Resident 1 to experience seizure activity (a sudden, uncontrolled electrical disturbance in the brain that can cause a range of symptoms, such as muscle stiffening, shaking, or altered sensations) and other seizure related complications which could negatively affect the resident's health. Findings: A review of Resident 1's clinical record indicated Resident 1 was admitted January of 2025 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), cerebrovascular disease (a group of conditions that affects the blood flow and the blood vessels in the brain), hemiplegia (complete loss of the ability to move one side of the body) affecting right dominant side, and aphasia (a language disorder that affects a person's ability to understand and express written and spoken language). A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 10/3/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 1 had an intact cognition (mental process of acquiring knowledge and understanding). During an interview on 11/20/25 at 12:09 p.m. with Resident 1, in Resident 1's room, Resident 1 gestured he was not receiving his antiseizure medication regularly. During a phone interview on 11/20/25 at 12:16 p.m. with Resident 1's sister, in Resident 1's room, Resident 1's sister stated a facility staff called her yesterday and told her that Resident 1 had not received his antiseizure medication since November 13th. A review of Resident 1's active physician's order, dated 7/2/25, indicated, levetiracetam (a medication used to prevent and control seizures in individuals with epilepsy) Oral Tablet 1000 MG (milligrams- unit of measurement) .Give 1 tablet by mouth three times a day for Seizures. A review of Resident 1's medication administration record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of November 2025 indicated Resident 1 did not receive levetiracetam on the following times: 11/13/25 at 10 p.m. 11/14/25 at 9 a.m. 11/14/25 at 1 p.m. 11/15/25 at 9 a.m. 11/15/25 at 1 p.m. 11/15/25 at 10 p.m. 11/16/25 at 9 a.m. 11/16/25 at 1 p.m. 11/18/25 at 9 a.m. 11/18/25 at 1 p.m. During an interview on 11/20/25 at 12:42 p.m. with Licensed Nurse (LN) 2, LN 2 stated nurses should make sure that residents with antiseizure medication should be given their medications properly and timely. LN 2 also stated staff should always re-order the antiseizure medication seven days ahead before it ran out. LN 2 further stated there would be a risk for the resident to have a seizure if he was not getting his medications regularly. A review of Resident 1's Physician Progress Note, dated 11/13/25, indicated, .Plan .3. Seizure Disorder*** Continue **levetiracetam 1000 mg TID [three times a day** A review of a facility documented titled, PROVIDER COMMUNICATION LOG, NON-URGENT MATTERES ONLY, dated 11/13/25, indicated, . [Name of Resident 1] .Levetiracetam oral tablet 1000 MG give 1 tab [tablet] by mouth three times a day for seizures. Patient is fine and stable. Called pharmacy to order medication, awaiting delivery. The column indicating that the doctor noted the issue was blank. A review of a facility document titled, URGENT: NOTICE OF NON-COVERED/HIGH-COST DRUG, for Resident 1's levetiracetam indicated the Director of Nursing (DON) signed the notice on 11/14/25. A review of Resident 1's Progress Note, dated 11/18/25, indicated, Resident has not received his levetiracetam for > [more than] 3 days. Resident has not had any seizures [on] AM shift. Continuing to monitor for any seizures. A review of the delivery Manifest [receipt] for Resident 1's levetiracetam indicated the facility received the medication on 11/18/25 at 5:29 p.m. During a concurrent interview and record review on 11/20/25 at 3:09 p.m. with the Assistant Director of Nursing (ADON), Resident 1's clinical records were reviewed. The ADON confirmed that Resident 1 did not receive his (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed antiseizure medications in accordance with the physician's order for 10 occasions. The ADON also confirmed that there was no documented evidence in Resident 1's clinical records that his doctor was notified with the issue and the medication re-order was followed up to the pharmacy between 11/13/25 to 11/18/25. The ADON stated Resident 1 should have received his antiseizure medications on those 10 occasions because there would be a risk for Resident 1 to have a seizure if he was not getting his medications regularly. During a concurrent phone interview and record review on 11/20/25 at 3:41 p.m. with the Pharmacist from the Facility's Pharmacy (PP), Resident 1's medication orders were reviewed. The PP stated they only received Resident 1's medication order for levetiracetam on 11/18/25 through a phone call and had filled and sent it on the next scheduled delivery time. The facility then received a 30-day supply of levetiracetam on for Resident 1 on 11/18/25 at 5:29 p.m. During an interview on 11/20/25 at 4:26 p.m. with the Director of Nursing (DON), the DON stated she would expect staff to re-order medications before it ran out. The DON further stated that the doctors' order should always be followed and that the doctor should always be notified if they don't have the medication. A review of the facility's policies and procedures (P&P) titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated 10/2017, indicated, B. Administration .2) Medications are administered in accordance with written orders of the attending physician. A review of the facility's P&P titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, dated 4/2008, indicated, A. Ordering Medications from the Dispensing Pharmacy .2) If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: a. Reorder medication five days in advance of need to assure an adequate supply is on hand .A review of the facility's P&P titled, Pharmacy Services - Role of the Provider Pharmacy, revised 4/2019, indicated, 3. The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including (but not limited to), the following: a. Supply the facility with approved medications, biologicals, and supplies, as well as any compounded medications or investigational drugs that are needed; .e. Provide routine pharmacy service seven days a week and emergency pharmacy service 24 hours per day, seven days a week; .h. Establish a reliable way to notify the facility in a timely fashion of issues and concerns related to medications and prescriptions; .		