STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055402	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Post Acute	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews and record review, the facility failed to protect one of five sampled residents (Resident 3's) right to be free from verbal abuse when Licensed Nurse 2 (LN 2) cursed and yelled at him.This failure caused Resident 3 to feel humiliated, fearful and intimidated.During a review of Resident 3's admission Record (AR), the AR indicated that Resident 3 was admitted to the facility in December 2025 with diagnoses that included Hemiplegia (severe loss of strength), Hemiparesis (weakness), and Depression (serious mental health condition).During a review of Resident 3's Progress Notes (PR), dated 1/12/26, The PR indicated that Resident 3's Brief Interview for Mental Status (BIMS, tool to assess cognition) score was 13 out of 15 which suggested Resident 3 was cognitively intact.During an interview on 2/2/26 at 9:32 a.m., with the Administrator, the Administrator stated that LN 2 verbally abused Resident 3. The Administrator further stated that Resident 3 was mentally and emotionally affected, as evidenced by Resident 3 deciding to stay in his room and refused to participate in any activities in the facility. The Administrator stated that LN 2 disrespected and verbally abused Resident 3.During a concurrent observation and interview on 2/2/26 at 12:45pm, with Resident 3 inside his room, Resident 3 was observed lying on his bed in a curled-up position, and his room had no lights on. Resident 3 stated that he went to the smoking area as scheduled, to smoke with his friends, but when LN 2 saw him coming towards the group of smokers, LN 2 curse and yelled at him and said, get the fuck out of here. Resident 3 further stated, he felt intimidated, humiliated and scared. Resident 3 left the smoking area, went back and stayed in his room for fear of seeing LN 2 in the hallway. Resident 3 described when LN 2 saw Resident 3 walking in Hall 5, LN 2 immediately instructed Resident 3 to leave. Resident 3 felt discriminated against and picked on by LN 2. Resident 3 was agitated, got up from his bed, and paced the room while he recalled the incident and in garbled speech, Resident 3 stated, this is my home, as he pointed out his bed. During an interview on 2/10/26 at 9:05 a.m., with the Social Services Director (SSD), the SSD confirmed that LN 2 verbally abused Resident 3. The SSD stated, LN 2 did not allow Resident 3 to smoke in the designated smoking area as witnessed by one of the residents, who came forward and told the staff that LN 2 cursed, yelled and prevented Resident 3 from smoking. The SSD continued, Resident 3 went back to his room and refused to go out of his room to socialize. The SSD said, as a daily routine Resident 3 would walk around the building as he liked to exercise every day but after the verbal abuse, Resident 3 stopped walking outside of his room. The SSD additionally stated that Resident 3 enjoyed socializing with his friends in Hall 6 but Resident 3 needed to go past Hall 5 to get to Hall 6 to meet with his friends, and out of fear of a possible confrontation with LN 2, Resident 3 decided to stay in his room instead. SSD stated Resident 3 felt he was being singled-out. The SSD stated that Resident 3 decided to stay in his room as he felt distant from LN 2.During a review of Resident 3's Care Plan (CP), date initiated 12/9/25, the CP indicated, Patient may smoke with supervision per smoking assessment and facility policy. While in the facility, resident states that it (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. During a review of Resident 3's Order Summary Report (OSR), dated 1/13/26, the OSR indicated, For Psych Consult /Eval and Treatment as Recommended and appropriate. During a review of Resident 3's Progress Notes (PN) dated 1/13/26, the PN indicated, The resident reported an alleged verbal abuse from a staff member during the evening smoke break on 01/10/2026. According to him, after that incident, he avoided the evening smoke break so he wouldn't have to deal with the same staff. During a review of the facility's concluded Alleged Incident/Investigation, (AII), dated 1/16/26, the AII indicated, The information gathered from the investigation substantiated the alleged incident.During a review of Facility's Policy and Procedures, titled Abuse Prohibition (AP), revision dates 10/25/24, the AP indicated, Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Purpose: To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment.

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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** Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for one of five sampled residents, Resident 4's change of condition when: 1.There was no signed documentation of a physician telephone order (TO, verbal orders given by physician over the phone) of naloxone on file for Resident 4 that was given on [DATE], 2. There was no documentation of naloxone administration on Resident 4's Medication Administration Record (MAR), used to document medications taken by patient); and3. The Assistant Director of Nursing (ADON) did not follow the facility's policy and procedures for the administration of Naloxone which included giving repeated doses and calling 911. These failures had the potential to have resulted in a lack of continuity of care and the delay of critical interventions.Findings:During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility in [DATE] with diagnoses that included Hypertension (high blood pressure), and Heart Failure (weak heart to efficiently pump oxygen-rich blood to meet the body's needs). During a review of Resident 4's Order Summary Report (OSR), dated [DATE], the OSR indicated that Resident 4 was admitted to [name of agency] Hospice (life expectancy of 6 months or less. Care focuses on quality of life, rather than curative treatment) on [DATE] with diagnosis of Cerebrovascular Disease (restricting oxygen supply and potentially causing brain damage or strokes). During an interview on [DATE] at 12:35 p.m., with Licensed Nurse 1 (LN 1), LN 1 stated, the TO should indicate resident's name, nurse's signature, name of ordering physician, date and time the order was taken, dose, frequency and name of medications. LN 1 continued, nurses should give medications as ordered by the physician, and TO are taken by the nurse and then transcribed to the resident's physician order form at the time the order was taken, Yes, we have to follow our policy and procedure for telephone orders. During an interview on [DATE] at 11:18 a.m., with the ADON, the ADON stated, the copy of the physician's [name of the physician] TO of naloxone was in her office, on her desk together with other files. ADON acknowledged that as of [DATE], the copy of Resident 4's TO of naloxone given on [DATE] was not recorded to Resident 4's medical chart. During a record review of Resident 4's Progress Notes (PN), the progress note dated [DATE], indicated, naloxone was ordered and showed the ordering physician's name was inscribed under Physician on the order. There was no signature from the physician, and the order was not documented on the Physician's OSR. During a review of Resident 4's OSR with order range of [DATE] to [DATE], the OSR did not indicate a TO of naloxone given to Resident 4 on [DATE]. 2. During an interview on [DATE] at 11:18 a.m., with the ADON, the ADON acknowledged she did not record in Resident 4's MAR the naloxone she gave to Resident 4 on [DATE]. During a review of Resident 4's MAR, dated [DATE] to [DATE], the naloxone was not recorded as given by the ADON to Resident 4 on [DATE]. During a record review of the facility's policy and procedures titled, Physician Orders (PO), effective date, [DATE], the PO indicated, Telephone Orders . B. The Medical Record Department staff mails an original cop to the physician promptly for signature C. The order is transcribed onto the Physician's Order Form at the time the order is taken D. A copy of the Physician order form that was sent to the Attending Physician is maintained in the medical record until the form signed by the physician is returned. VIII the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. X Documentation pertaining to physician orders will be maintained in the resident's medical record . 3. During an interview on [DATE] at 11:18 a.m., with the ADON, the ADON stated she entered Resident 4's room with Resident 4's relative and Resident 4 was unresponsive. The ADON stated per request of the relative who said she thought the unresponsiveness (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was due to an opioid overdose, she gave naloxone 4mg nasal spray to Resident 4 at 8:32 a.m., then gave Resident 4 a second dose of naloxone 4mg nasal spray at 8:34 a.m., however, Resident 4 was still unresponsive. The ADON confirmed she did not call 911 per Resident 4's relative request or per the policy. ADON further stated she gave the naloxone to show the relative that Resident 4's condition was not opioid related. During a review of Resident 4's PN, dated [DATE] at 5:16 p.m., the PN indicated, This writer administered the first dose at 0832 and repeated the dose at 0834. No change in status., agonal breathing [gasping breath] at this time. [NAME] stoking, [alternating between deep/fast breaths and periods of no breathing] rr shallow [respiration rate shallow] . During a record review of the facility's policy and procedures titled, Opioid Overdose Response (Naloxone), (OORN), dated [DATE], OORN indicated, .3. If there is no response, check for a pulse, clear the airway, and begin rescue breathing if respirations are absent or very shallow, and CPR if there is no pulse 4. Direct someone to call 911. Indicate that the individual is not responsive and not breathing, or that breathing is shallow. 5. Administer naloxone. 7. Intranasal naloxone administration: . d. Administer an additional dose every two (2) to three (3) minutes and continue rescue breathing or CPR, as needed until emergency personnel arrive.