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 02/24/2026

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 observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from mental and emotional abuse when Resident 1's visitor/caregiver displayed anger by physical aggression in Resident 1's room and was verbally aggressive to Resident 1. This failure had the potential for Resident 1 to experience mental anguish and psychosocial distress. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in March 2025 with multiple diagnoses including neuromuscular dysfunction of the bladder (loss of bladder control due to nerve damage), protein calorie malnutrition (decreased protein and calorie intake causing weight loss and nutritional deficiencies), dysphagia (difficulty swallowing), and congestive heart failure (heart does not pump blood as efficiently as it should). The admission Record indicated Resident 1's visitor/caregiver was his Responsible Party (RP) and healthcare decision maker. A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 12/22/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 that indicated Resident 1 had moderate cognitive impairment.A review of Resident 1's orders, indicated order dated 3/26/25, .Resident does not have capacity to make decisions . A review of Resident 1's Nurses Progress Note, dated 1/31/26 at 10:09 a.m., indicated .Resident room mate reported to the cna [Certified Nursing Assistant] that RP is physically abusing resident but when LN [Licensed Nurse] spoke with resident he just laughed over it and said we were just fooling around Another cna also said RP is violent because she witnessed the RP kicking the wall and resident bedside drawer when he discovered that resident drawer was cleaned and a pair of scissors he left in the drawer has been removed . A review of Resident 1's Nurses Progress Note, dated 2/2/26 at 3:32 p.m., indicated the name of the form . [Report of Suspected Dependent Adult/Elder Abuse-information by reporting party regarding suspected incident of abuse to notify regulatory agencies including The Department, the ombudsman, law enforcement] FILLED [sic] FOR ALLEGED VERBAL ABUSE ON 01/31/2026. IT HAS BEEN REPORTED [RP] IS ABUSIVE. UPON INTERVIEWING THE RESIDENT, [RESIDENT 1] STATED THAT HE HAS NEVER BEEN PHYSICAL, BUT HE DOES YELL AND HE CONSIDERS [RP] TO BE AN ANGRY PERSON .A review of Resident 1's Social Service Progress Note, dated 2/2/26 at 10 p.m., indicated .SW [Social Worker] placed a call to the resident 's RP/Caregiver to speak with him regarding the reported allegations of abuse towards the resident .He denied physical abuse but admitted to verbal abuse towards his friend for over 25 years .They argue often and exchange profanity toward each other. Cursing at each other has been normal to them . A review of Resident 1's Social Service Progress Note, dated 2/3/26 at 6:14 p.m., .The resident was visited earlier this afternoon to check how he was doing .The resident was consistent in verbally expressing that what is happening between him and his friend and his caregiver is far from abuse as they have been communicating like that for many years. The social worker explained to him in this type of setting .when friends, even families, co-residents, or staff members are heard or witnessed being verbally abusive or physically (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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(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	abusive towards a resident, it is considered abuse. It is our responsibility to make sure that it is stopped and reported to other agencies/authorities to do their own investigation. It is our responsibility to protect the residents to the best of our abilities . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in July 2025 with multiple diagnoses including cerebrovascular accident (stroke- occurs when blood flow to the brain is blocked causing brain cell death), diabetes (high blood sugar due to insufficient or ineffective insulin), and congestive heart failure.A review of Resident 2's MDS, Cognitive Patterns, dated 1/12/26, indicated Resident 2 had a BIMS score of 10 out of 15 that indicated Resident 2 had moderate cognitive impairment.During an interview on 2/24/26 at 10:35 a.m. with Resident 1, Resident 1 stated his RP is his paid caregiver and comes into facility usually every other day and assists with correspondence, grooming, and transportation to appointments. Resident 1 stated his RP came in to give him a shave and the shaving cream was missing which made the RP angry. Resident 1 stated the RP began yelling and slammed the door really hard. When asked if the RP was ever abusive to him, Resident 1 stated the RP gets mad and uses profanity, which bothers him. During an interview on 2/24/26 at 11:02 a.m. with LN 1, LN 1 stated Resident 1 has a hired caregiver who comes in to provide grooming to Resident 1 and takes him out of the facility. LN 1 stated there was a report that the caregiver was verbally abusing Resident 1. LN 1 stated Resident1's paid caregiver talked aggressively to Resident 1 and was always angry. During an interview on 2/24/26 at 11:12 a.m. with Resident 2, Resident 2 stated he is Resident 1's roommate. Resident 2 stated Resident 1 has a hired caregiver that comes in every day. Resident 2 stated that Resident 1's caregiver has anger issues and gets mad when Resident 1 does not do things right or fast enough and will yell and pound on the wall. Resident 2 stated that about two weeks ago, the caregiver threw a cup of water at Resident 1 but missed him. Resident 2 stated he had observed the caregiver slam the bedside table. Resident 2 stated Resident 1's caregiver gets angry easily and Resident 2 has told him to calm down. Resident 2 stated he was worried about Resident 1. During an interview on 2/24/26 at 11:33 a.m. with the Administrator (ADM), the ADM stated Resident 1's caregiver had come in and was upset that the staff had cleaned out the nightstand and kicked the nightstand. Resident 1 stated he and the caregiver get angry with each other. The ADM stated Resident 1's caregiver was not allowed back in the facility until the investigation was completed. The DM stated Resident 1 wanted the caregiver to come back and the caregiver was then allowed to come back. The caregiver was provided with rules and regulations for visiting and was notified if happened again would have to make other arrangements for visits.During an interview on 2/24/26 at 1:31 p.m. with CNA 3, CNA 3 stated Resident 1's caregiver comes in every day or every other day. CNA 3 stated on 1/31/26 she offered to shave Resident 1, but he stated his caregiver would do it. CNA 3 stated Resident 1's caregiver came in and became angry there was no razor in the nightstand drawer, started talking loudly, became aggressive kicking the closet door and the trash can. CNA 3 stated roommate Resident 2 was in the room at the time. CNA 3 stated she was afraid the caregiver was losing control and afraid of what he might do. CNA 3 stated Resident 1 caregiver's behavior was potential abuse. During an interview on 2/24/26 at 1:56 p.m. with CNA 4, CNA 4 stated Resident 2 reported to him on 1/31/26 that Resident 1's caregiver was becoming verbally aggressive to Resident 1. CNA 4 stated he notified LN 1 of the situation but did not go into the room himself. During a subsequent interview on 2/24/26 at 2:22 p.m. with LN 1, LN 1 stated she did not recognize the incident on 1/31/26 as abuse because Resident 1 did not indicate he was being abused and Resident 2 was not always accurate or reliable with his reporting so did not fully trust what he said. LN 1 stated she did document the incident in the chart in case it needed to be reported later. A review of the facilities Policy and Procedure (P&P), titled (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse Prohibition Policy and Procedure, dated 2/23/21, indicated .HealthCare Centers prohibit abuse, mistreatment .and exploitation for all residents .The Center will implement an abuse prohibition program through the following: .Prevention of occurrences .Identification of possible incidents or allegations which need investigation .Investigation of incidents and allegations .Abuse is defined as the willful infliction of injury .intimidation . with resulting .mental anguish .Instances of abuse of all patients, irrespective of any mental or physical condition, cause .mental anguish. It includes verbal abuse .mental abuse .Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to report suspected abuse for one of three sampled residents (Resident 1) to The Department within the regulatory timeframe, when Resident 1's visitor/ caregiver was reported as abusive and the incident was not reported until two days later. This failure resulted in a delay of an investigation of abuse which had the potential for abuse to continue causing increased emotional distress or mental anguish for Resident 1. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in March 2025 with multiple diagnoses including neuromuscular dysfunction of the bladder (loss of bladder control due to nerve damage), protein calorie malnutrition (decreased protein and calorie intake causing weight loss and nutritional deficiencies), dysphagia (difficulty swallowing), and congestive heart failure (heart does not pump blood as efficiently as it should). The admission Record indicated Resident 1's visitor/caregiver was his Responsible Party (RP) and healthcare decision maker. A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 12/22/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 that indicated Resident 1 had moderate cognitive impairment.A review of Resident 1's orders, indicated order dated 3/26/25, .Resident does not have capacity to make decisions . A review of Resident 1's Nurses Progress Note, dated 1/31/26 at 10:09 a.m., indicated .Resident room mate reported to the cna [Certified Nursing Assistant] that RP is physically abusing resident but when LN [Licensed Nurse] spoke with resident he just laughed over it and said we were just fooling around Another cna also said RP is violent because she witnessed the RP kicking the wall and resident bedside drawer when he discovered that resident drawer was cleaned and a pair of scissors he left in the drawer has been removed . A review of Resident 1's Nurses Progress Note, dated 2/2/26 at 3:32 p.m., indicated name of the form . [Report of Suspected Dependent Adult/Elder Abuse-information by reporting party regarding suspected incident of abuse to notify regulatory agencies including The Department, the ombudsman, law enforcement] FILLED [sic] FOR ALLEGED VERBAL ABUSE ON 01/31/2026. IT HAS BEEN REPORTED [RP] IS ABUSIVE. UPON INTERVIEWING THE RESIDENT, [RESIDENT 1] STATED THAT HE HAS NEVER BEEN PHYSICAL, BUT HE DOES YELL AND HE CONSIDERS [RP] TO BE AN ANGRY PERSON . REPORT SENT OVER FOR CDPH [California Department of Health], OMBUDSMAN VIA FAX. REPORT CALLED IN TO LOCAL LAW ENFORCEMENT . A review of Resident 1's Care Plan, initiated 2/2/26, .Resident with potential/risk to exhibit Psycho-Social distress related to verbal abuse allegation [name of the form] filed 02/2/2026 . indicated .Interventions/Tasks .Facility will complete all needed abuse reporting requirements [name of form completed] (. notification of Department of Health/Ombudsman/LPD [local police department]/physician/RP .), investigate thoroughly, and integrate all appropriate interventions . During an interview on 2/24/26 at 10:35 a.m. with Resident 1, Resident 1 stated his RP is his paid caregiver and comes into facility usually every other day and assists with correspondence, grooming, and transportation to appointments. Resident 1 stated his RP came in to give him a shave and the shaving cream was missing which made the RP angry. Resident 1 stated the RP began yelling and slammed the door really hard. When asked if the RP was ever abusive to him, Resident 1 stated the RP gets mad and uses profanity, which bothers him. During an interview on 2/24/26 at 11:02 a.m. with LN 1, LN 1 stated Resident 1 has a hired caregiver who comes in to provide grooming to Resident 1 and takes him out of the facility. LN 1 stated there was a report that the caregiver was verbally abusing to Resident 1. LN 1 stated Resident 1's paid caregiver talked aggressively to Resident 1 and was always angry. LN 1 stated she informed the Administrator (ADM) of the report of verbal abuse of Resident 1 by his caregiver. During an interview on 2/24/26 at 11:10 a.m. with CNA 1, CNA 1 stated if abuse was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to her, she would notify the nurse and the abuse coordinator who is the ADM and take the steps to complete the form used to report allegations of abuse. During a concurrent interview and record review on 2/24/26 at 1:22 p.m. with the ADM, the ADM acknowledged that incident with Resident 1 and his caregiver occurred on 1/31/26 as reported by his roommate and CNA. The ADM stated LN 1 did not report incident or complete the reporting form on 1/31/26 when reported to her because she did not see or hear the incident herself. The ADM stated she (ADM) was not aware of the incident until 2/2/26 and then the reporting was completed. The ADM acknowledged that the reporting document was not sent within the regulatory timeframe for abuse reporting. During an interview on 2/24/26 at 1:31 p.m. with CNA 3, CNA 3 stated Resident 1's caregiver comes in every day or every other day. CNA 3 stated on 1/31/26 she offered to shave Resident 1, but he stated his caregiver would do it. CNA 3 stated Resident 1's caregiver came in and became angry there was no razor in the nightstand drawer, started talking loudly, became aggressive kicking the closet door and the trash can. CNA 3 stated roommate was in the room at the time. CNA 3 stated she was afraid the caregiver was losing control and afraid of what he might do. CNA 3 stated Resident 1 caregiver's behavior was potential abuse. CNA 3 stated the incident occurred on 1/31/26 and was reported to the nurse. CNA 3 stated it should have been reported the same day to The Department. CNA 3 stated, Don't know why it was not done that day (1/31/26). During an interview on 2/24/26 at 1:56 p.m. with CNA 4, CNA 4 stated Resident 1's roommate reported to him on 1/31/26 that Resident 1's caregiver was becoming verbally aggressive to Resident 1. CNA 4 stated he notified LN 1 of the situation. When asked what the policy is for abuse reporting, CNA 4 stated he would notify the nurse, and the nurse should report it the same day as the suspected abuse. CNA 4 stated he was not sure of the regulatory timeframes for abuse reporting. During a subsequent interview on 2/24/26 at 2:22 p.m. with LN 1, when LN 1 was asked why she did not complete and file the report on1/31/26 and send to The Department, LN 1 stated Resident 1 did not indicate he was being abused and the roommate who reported incident was not reliable. LN 1 stated she did document the incident in the chart in case it needed to be reported later. During an interview on 2/24/26 at 2:25 p.m. with LN 2, LN 2 stated if a resident was reported as being abused by a visitor, he would notify the ADM and report to The Department as soon as possible. LN 2 stated he was not aware of the abuse reporting timeframes. During a telephone interview on 2/25/26 at 9:13 a.m. with LN 3, LN 3 stated she filed the report on 2/2/26 for incident with Resident 1 based on Resident 1's progress note on 1/31/26. LN 3 stated she completed the report on 2/2/26 because LN 1 was off that day but did not have any first-hand knowledge of the incident. A review of the facility's Policy and Procedure (P&P), titled Abuse Investigation and Reporting, revised 7/17, indicated .All reports of resident abuse .mistreatment shall be promptly reported to local, state and federal agencies .and thoroughly investigated by facility management .All alleged violations involving abuse . or mistreatment .will be reported .to the following persons or agencies .The State incensing/certification agency responsible for surveying licensing the facility .The Local/State Ombudsman . Law enforcement officials .An alleged violation of abuse .mistreatment .will be reported immediately, but not later than: .Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury, or .Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resolved in serious bodily injury . A review of the facilities P&P titled Abuse Prohibition Policy and Procedure, dated 2/23/21, indicated .HealthCare Centers prohibit abuse, mistreatment .and exploitation for all residents .The Center will implement an abuse prohibition program through the following: .Prevention of occurrences .Identification of possible incidents or allegations which need investigation .Investigation of incidents and allegations .Abuse is defined as the willful infliction of injury .intimidation . with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulting .mental anguish .Instances of abuse of all patients, irrespective of any mental or physical condition, cause .mental anguish. It includes verbal abuse .mental abuse .Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation .Upon receiving information concerning a report of suspected or alleged abuse, mistreatment .the CED [Center Executive Director] or designee will perform the following .Report allegations involving abuse (physical, verbal, sexual, mental) not later than two (2) hours after allegation is made .Notify local law enforcement, Ombudsman, Licensing District Office .