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	04/29/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for one of five sampled residents (Resident 1), when Resident 2 punched Resident 1 in the face and head.This failure caused Resident 1 to have a small laceration to the corner of his eye and a bruise on the back of his head.Findings:Resident 1 was admitted to the facility in early 2026 with diagnoses which included muscle weakness and difficulty with mobility.During a review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 4/5/26, the MDS showed a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 15/15 which indicated no cognitive impairment.Resident 2 was admitted to the facility in early 2026 with diagnoses which included bone infection of the right foot and anxiety disorder.During a review of Resident 2's MDS, dated [DATE], the MDS showed a BIMS score of 14/15 which indicated no cognitive impairment.During a review of Resident 1's progress note (PN) dated 4/8/26 at 9:49 p.m., the PN indicated, [Resident 1] was noted to have been struck to the face and back of head.Noted smallskin (sic) tear [laceration] on the outer corner of right eye and a small hematoma (bruise) on the back of the head. He c/o [complained of] mild tenderness on the back of his head.During a review of Resident 2's PN dated 4/9/26 at 9:40 p.m., the PN indicated, [Resident 2] got into an argument with [Resident 1]. [Resident 2] attacked [Resident 1] by throwing punches.[Resident 1] was on the seat as he was being hit by [Resident 2] who was standing.During an interview on 4/29/26 at 1:09 p.m. with Licensed Nurse (LN 1), LN 1 stated he was working at the nurse's station when he heard another staff member yell for help. When he arrived to help, he observed a fight between Resident 1 and Resident 2. LN 1stated Resident 1 was sitting in a chair attempting to block punches from Resident 2. LN 1 stated Resident 2 was throwing punches at Resident 1 and there were a few punches that hit [Resident 1].During an interview on 4/29/26 at 2:24 p.m. with the Director of Nursing (DON), the DON confirmed the incident occurred between Resident 1 and Resident 2 and stated her expectations were for residents to be free from any abuse.During a review of the facility policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedures, dated 2/21, the P&P indicated, .prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents.Abuse is defined as the willful infliction of injury.Physical Abuse includes hitting, slapping, pinching, kicking, etc.

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