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	04/30/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safety interventions were provided for one of three sampled residents (Resident 1), when a two-person assist was not implemented according to Resident 1?s plan of care when transferred from the bed to the wheelchair. This failure resulted to Resident 1's fall with injury and had the potential to result in further falls and injuries. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted on 2024 with diagnoses which included morbid obesity and generalized weakness. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/23/25, the MDS indicated, Chair/Bed-to-chair-transfer required substantial/maximal assist. The MDS also indicated Resident 1 had history of fall with injury. During a review of Resident 1's Fall Care Plan (FCP), initiated on 3/28/25 and revised on 4/10/26, the FCP indicated, At risk for falls/self-injury r/t [related to] recent hospitalization, deconditioning, generalized weakness, gait balance problem, incontinence, psychoactive drug use, morbid obesity.special instructions: Hoyer lift 2 person assist. During a review of Resident 1's Nurse's Progress Notes (NPN) dated 12/17/25, the NPN indicated, CNA called this LN [Licensed Nurse] re: patient had a fall in her room during transfer from bed to her w/c [wheelchair] by CNA. Immediately assessed the resident from H/T [head to toe], fell on supine position; head resting on the base of the night stand. Noted bleeding to back of the head and pressed pressure on the site. During a review of Resident 1's History and Physical (H&P) dated 12/17/25, the H&P indicated, CHIEF COMPLAINT: Status post fall.History of present illness: This is a [AGE] year-old female patient, who was brought in from the skilled nursing facility by EMS [Emergency Medical Services] for the status post ground level fall. The patient mentioned that actually she was transferred from the bed to the wheelchair and she fell and she hit her head with the side table. During a review of Resident 1's Physician's Order (PO) dated 1/2/26, the PO indicated [Resident 1] is to be up in w/c [wheelchair] 3 times a week in Am [in the morning] shift (use Hoyer Lift Only). Weight taken dated 12/11/25 was 233.4 lbs. During an interview on 5/15/26 at 10:21 a.m. with the CNA assigned to Resident 1 during the transfer on 12/17/25, the CNA declined to give details about the fall incident. During a concurrent interview and record review on 4/30/26 at 5:05 p.m. with the Director of Nursing (DON), Resident 1's clinical record was reviewed. The DON confirmed Resident 1 had a fall on 12/17/25 with injury, and the assigned CNA did not follow the instructions during resident's transfer using the Hoyer lift. The DON stated her expectation was for the CNA to ensure the safety of the resident during transfers. During a review of the facility's Policy and Procedure (P&P) titled, FALL MANAGEMENT, dated 5/26/21, the P&P indicated, Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.

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