STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056101	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Pointe Post-Acute	6041 Fair Oaks Blvd 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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from physical abuse when Resident 2 struck Resident 1 with her fist, hitting her on the left side of her forehead. This failure resulted in Resident 1's bruised left forehead and fear manifested by crying.During a review of Resident 1's admission Record (AR), dated 10/1/24, the AR indicated Resident 1 was admitted to the facility in late 2024 with diagnoses which included aphasia (a disorder that makes it difficult to speak), cognitive communication deficit and right-side body weakness. During a review of Resident 1's Physician's Orders (PO), dated 10/1/24, the PO indicated Resident 1 was incapable of making her own healthcare decisions.During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/5/25, the MDS indicated Resident 1 had no mood or behavioral symptoms of crying or verbalization of fear. During a review of Resident 1's hospital emergency department (ED) notes, dated 11/23/25, the ED notes indicated the chief complaint was assault with fist, hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) on forehead, had a bruise to the left forehead. During a review of the SBAR (Situation, Background, Assessment, Recommendations; a form used for urgent resident updates to communicate between healthcare professionals), and initial change of condition (COC) alert charting, dated 11/23/25, the SBAR indicated Resident 1 was punched by Resident 2 in the left side of her head with a closed fist. The SBAR also indicated Resident 1 manifested fear by crying after being struck by Resident 2. During a review of Resident 2's AR, dated 2/21/25, the AR indicated Resident 2 was admitted to the facility in early 2025 with diagnoses which included bipolar (mental health condition causing extreme mood swings) disorder and aggression. During a review of Resident 2's PO dated 2/21/25, the PO indicated Resident 2 was capable of making her own healthcare decisions and was her own responsible party. During a review of Resident 2's Nursing Care Plan (NCP), dated 3/21/25, the NCP indicated, [Resident 2] has demonstrated physical behavior r/t [related to] uncontrolled anger, poor impulse control.aggressive verbal and physical behaviors.assess and anticipate resident's needs, immediately separate any party members involved in confrontation. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had physical behavioral symptoms directed towards others that occurred daily. During a review of the SBAR and COC alert charting dated 11/23/25, the SBAR indicated Resident 2 punched Resident 1, made verbal threats, and displayed physical aggression. The SBAR and COC also indicated Resident 2 punched Resident 1 in the left side of her head with a closed fist. During an interview on 12/4/25 at 12:30 with the Director of Nursing (DON), the DON stated her expectation was that no resident should be hit and no one deserved to be hit. During a concurrent observation and interview on 12/4/25 at 12:52 p.m. inside Resident 1's room, Resident 1 was seated in her wheelchair with no distress. When asked if Resident 1 recalled someone who hit her forehead, she lowered her head to her left shoulder and cried but could not verbalize why she was crying. Resident 1 shook her head and flailed her hands when Resident 2's name was mentioned. During an interview on 12/4/25 at 1:13 p.m. with Certified Nurse Assistant 2 (CNA 2), CNA 2 confirmed Resident 2 hit Resident 1 with her fist. CNA 2 stated Resident 1 feared Resident 2 because Resident 2 cursed, yelled, shouted and said bad words. CNA 2 indicated Resident 1 did not want to stay in her room when Resident 2 was also inside the room and Resident 1 would cry when Resident 2 was present in the room. During an interview on 12/4/25 at 2:03 p.m. with the Social Services Director (SSD), the SSD indicated as reported, Resident 2 hit Resident 1 with her fist. The SSD confirmed Resident 2 was verbally abusive and could hit someone with her temper. SSD stated Resident 2 had this outburst of anger even with little things. SSD stated Resident 1 could not verbally express herself. SSD validated No one deserved to be hit, everybody should be equal here. The SSD indicated, because she was hit, Resident 1 could be traumatized, could be more scared and be more aloof. During an interview on 12/4/25 at 3:01 p.m. with the Administrator (ADM), the ADM indicated Resident 2 was a very difficult and complicated resident and as reported and witnessed by the nurse, Resident 2 hit Resident 1. The ADM stated, No one deserved to be hit, everybody had the right to be safe. During an interview on 12/9/25 at 1:49 p.m. with the Licensed Nurse (LN), the LN confirmed she witnessed Resident 2, with her fist, hit Resident 1 in her left temple. The LN confirmed that when the police came and spoke with Resident 1, Resident 1, because she could not fully verbalize, she demonstrated to the police and said hit, hit with her fist to indicate she was hit by Resident 2. The LN confirmed Resident 1 was very scared of Resident 2. LN