

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  River Pointe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision, per care plan, for a 1:1 sitter (responsible to ensure resident safety with constant supervision) for one of three sampled residents (Resident 1) when Resident 1 was left unattended in his room. This failure had the potential to put Resident 1 at risk for falls, injuries and elopement while being unsupervised. Findings: Resident 1 is a [AGE] year old resident that was admitted to the facility in October 2025 with multiple diagnoses that included encephalopathy (disorder affecting brain function or structure, leading to confusion, memory loss, or coma), hemiplegia (severe weakness on one side of the body), hemiparesis following cerebral infarction (weakness on one side of the body, affecting the arm, leg, and sometimes face, often due to brain injury following a stroke) and dysphagia (difficulty swallowing). A review of the Minimum Data Set (MDS, an assessment tool), dated 10/10/25, indicated Resident 1 had severely impaired cognition. During an interview and concurrent record review on 12/18/25, at 11:07 a.m. with Licensed Nurse 1 (LN 1), LN 1 reported that Resident 1 required a one-to-one sitter for supervision due to being an elopement risk and a high risk for falls. During an observation and interview on 12/18/25, at 11:32 a.m., with Resident 1, Resident 1 was sitting up in bed with both of his legs dangling off the side of the bed and his head leaning on the elevated head of the bed while watching TV. Resident 1's lunch was observed on the bedside table. Resident 1 did not have a sitter in the room supervising him on a one-to-one basis. Resident 1's call light was observed lying on the floor. Resident 1 was unable to answer any questions, only nodding in a yes manner when asked if he was ok. During an interview and observation on 12/18/25, at 11:38 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 confirmed that Resident 1 should have a sitter/staff member supervising him on a one-to-one basis. CNA 1 confirmed that there were no sitter/staff present in the room with Resident 1 at this time. CNA 1 further confirmed that Resident 1's call light was on the floor. CNA 1 confirmed that Resident 1 had lunch sitting on the bedside table. Per CNA 1, Resident 1 requires assistance with meals. CNA 1 stated that, if he [Resident 1] tried to get up, he would probably fall. CNA 1 confirmed that Resident 1 has difficulty speaking. During an observation and interview with Sitter 1 on 12/18/25, at 11:40 a.m., Sitter 1 was observed exiting Resident 1's bathroom located in the resident's room. Sitter 1 confirmed he was assigned to supervise Resident 1 on a one-to-one basis today. Sitter 1 confirmed he should never leave Resident 1 unsupervised as Resident 1 could fall. During a review of Resident 1's care plan titled, [Resident 1] has a behavior problem. date initiated on 11/05/2025, indicated Interventions/Tasks. 1:1 to prevent injury/harm. During an interview and concurrent record review on 12/18/25 at 3:30 p.m. with the Director of Nursing (DON), the DON stated Resident 1 required one-to-one supervision as a Nursing intervention for the residents' safety. During a concurrent record review of Resident 1's medical record titled, Morse Fall Assessment, dated 10/03/25, the DON confirmed that Resident 1 had a history of falls and had a score of 55 which indicated Resident has a high risk of falling. The DON further stated that her expectation is that if a sitter needs a break, such as a bathroom break, she expects the sitter to find staff to relieve them. During a record review of Sitter 1's training record titled, IN SERVICE LESSON PLAN, dated 12/9/25, the lesson plan indicated in Objectives: Participants will be able to: -Staff will prevent one-on-one resident Falls by maintaining continuous supervision and ensuring that resident is never left unattended. During review of the training record attendance sheet titled, ATTENDANCE SIGN IN SHEET dated 12/9/25 for this class, Sitter 1 signed in on the 11th line of this sheet. A policy for Sitter and/or Supervision policy was requested from the DON on 12/18/25 at 4:10 PM; requested and not received by the facility. Another attempt to receive a policy for Sitter and/or Supervision was requested via email on 12/19/25 at 2:29 p.m. and was not received. A review of facility Policy and Procedure (P&amp;P) titled Falls and Fall Risk, Managing, revised 2018, indicated, Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews and record reviews, the facility failed to ensure that the call light system was fully functional and properly maintained for one of three sampled residents (Resident 1) when Resident 1 pressed the call light button and activated the call light above the resident's room door, the corridor call lights located on the wall and above the double door failed to illuminate. This incomplete functionality of the call light system had potential to delay staff response to Resident 1's needs and impede Resident 1's ability to effectively communicate for assistance when required. Findings: Resident 1 was admitted to the facility in early Winter of 2025 with diagnoses which included respiratory and heart failure. A review of Resident 1's Order Summary Report (ORS) indicated, Resident is capable of making his own health decisions. A review of Resident 1's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 12/8/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognitive function. A review of Resident 1's Nurse Notes (NN), dated 12/5/25, indicated, Patient verbalized ongoing concern regarding call light not being answered in a timely manner. During an interview on 12/18/25 at 12:31 p.m., Resident 1, Resident 1, stated concerns with staff unable to respond timely with his call lights. Resident 1 further stated, My call lights constantly go forever. 15 minutes or less is acceptable but more than that is not. During the tour of the facility on 12/18/25 at 12:18 p.m., it was observed that Resident 1's room was the second room from the exit, located along a hallway that branches off from the main corridor. Staff must be physically near Resident 1's room to determine whether the call light above the door was on. During a concurrent observation and interview on 12/8/25 at 1:18 p.m. in the facility hallway with Certified Nurse Assistant (CNA 1), CNA 1 verified that the corridor call lights did not illuminate when Resident 1 pressed their call light buttons and stated, It helps us tell when the resident needs help. During concurrent observations and an interview with the Assistant Maintenance Supervisor (AMS), The AMS confirmed that the call lights on the corridor wall and above the double doors did not illuminate when Resident 1 put the call light on and stated that Resident 1's call light system had not been reprogrammed after it was serviced by the technicians. The AMS stated, The resident won't get the chance to receive appropriate care when the call lights are not working. The AMS also stated that nobody had reported that the corridor call lights were not working for Resident 1. The facility's maintenance request log and call light maintenance log were requested but they were not provided as of 12/23/25. During an interview with CNA 2 on 12/18/25 at 1:29 p.m., CNA 2 verified when Resident 1 put the call light on, it did not light up the corridor call lights. CNA 2 stated, If something was going on with the resident, nobody will notice if the call light does not light in the main hallway [corridor], unless staff are already going to the resident's room. CNA 2 also added that staff would not know if residents needed medications or assistance in the bathroom without the corridor call lights functioning. During an interview with Licensed Nurse (LN 1) on 12/18/25 at 1:34 p.m., LN 1 stated, Every time the call lights light up on the resident hallway section, the main hallway [corridor] call lights should also light up as well. When asked about the importance of corridor call lights illuminating when residents needed assistance, LN 1 stated, So we can provide care as soon as possible regardless of who it is [staff]. During an interview on 12/18/25 at 3:41 p.m. with the Social Services Director (SSD), The SSD stated that immediate repair was required if a call light was not functioning. The SSD also stated that maintaining fully operational call light systems was essential, as any malfunction directly impacts staff response times and resident safety. During an interview on 12/18/25 at 2:31 p.m. with the Director of Nursing (DON), the DON stated that call lights help indicate resident needs or concerns and notify staff. The DON also stated that the facility provides an alternative, such as call bells and contact maintenance immediately if a call light was not working. The DON stated, We have to call maintenance right away, and the supervisor needs to provide an alternative to the residents. The DON further stated that she was not aware of the corridor call lights not working and that no staff had informed her about this issue. A review of the facility's Policy and Procedures (P&amp;P) titled, Call Light Policy and Procedures. The P&amp;P indicated, Malfunctioning of the resident's call light system for 24 hours or more is a reportable incident to the maintenance department. Maintenance department should re-check call light system. Maintenance department should also inspect call light system. If malfunctioning of call light system occurs, the Registered Nurse Supervisor or charge nurse should notify the Administrator, Director of Nurses and Maintenance Supervisor immediately.</p>		