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	12/19/2025

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observation, interview, and record review, the facility failed to ensure assistance with the use of dentures was provided for one of three sampled residents (Resident 1).This failure increased the potential for Resident 1 to refuse meals and lose weight.A review of the admission Record indicated Resident 1 was admitted early December 2025 with diagnosis including generalized muscle weakness. Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 12/10/25 indicated Resident 1 was cognitively intact, had impairment on both upper extremities and required substantial or maximal assistance (helper does more than half the effort) for oral hygiene which included ability to insert and remove dentures into and from the mouth. Further review of Resident 1's clinical records indicated the following:-Care plan, initiated 12/4/25 indicated, Resident 1 had Activities of Daily Living (ADL) self care performance deficit and at risk for ADL decline related to generalized weakness, carpal tunnel syndrome (a pinched nerve of the wrist causing numbness, pain and weakness in the hand) and macular degeneration (age related eye disease affecting central vision); and, -Nutritional assessment dated 12/8 25 indicated Resident 1 had dentures. During a concurrent observation and interview on 12/19/25 at 10:46 a.m., Resident 1 was lying in bed, with eyeglasses on, edentulous. Resident 1 stated nobody assisted her with her dentures this morning. Resident 1's denture cup was observed on top of the dresser. During an interview on 12/19/25 starting at 10:52 a.m. with Certified Nursing Assistant 1 (CNA 1) inside Resident 1's room. The CNA 1 stated she assisted Resident 1 with her breakfast tray. The CNA 1 further stated she did not notice Resident 1 had no teeth and she did not know Resident 1 had dentures. Resident 1 stated she asked a staff to help her with her dentures at around 8:30 a.m. and staff did not come back. During an interview on 12/19/25 starting at 2 p. m. with the Director of Nursing (DON), the DON stated it is important for staff to offer Resident 1's dentures. The DON further stated Resident 1 will not be able to chew her food, and the potential for Resident 1 to eat less and lose weight without the dentures. A review of the facility's policy and procedure revised March 2018 and titled, Activities of Daily Living (ADLs), Supporting indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with.Dining (meals and snacks).

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

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	12/19/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication was stored in a safe manner for one of three sampled residents (Resident 1).This failure had the potential for diversion or unauthorized use of medication not being securely stored. A review of the admission Record indicated Resident 1 was admitted early December 2025 with diagnosis including generalized muscle weakness. Resident 1's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) dated 12/10/25 indicated Resident 1 was cognitively intact with a score of 15. During a concurrent observation and interview on 12/19/25 at 11:16 a.m. , three unlabeled medication cups with white cream were observed inside a white plastic rectangular container on top of Resident 1's dresser. Resident 1 stated the little cups were lidocaine cream (topical cream used to relieve pain) brought in by the nurse, and the cream was applied to her hands twice a day. During a concurrent observation and interview on 12/19/25 at 12:31 p.m., with Certified Nursing Assistant 1 (CNA 1), the CNA 1 confirmed the container where the three unlabeled medication cups were found belonged to Resident 1. During a concurrent observation and interview on 12/19/25 at 12:34 p.m., the CNA 2 stated the white cream should not be there. The CNA 2 further stated the medication cups were not labeled, and a confused resident might grab and eat the cream. The CNA 2 added it was not safe to leave the cream at bedside. During a concurrent observation and interview on 12/19/25 at 12;44 p.m., with the Treatment Nurse (TN) inside Resident 1's room. The TN stated the medication cups were not labeled and the white cream inside the cups looked like barrier cream (topical solution that forms a physical shield between the skin and irritants). During an interview on 12/19/25 at 2 p.m., with the Director of Nursing (DON), the nurse surveyor showed the picture of the white cream in Resident 1's room. The DON stated this was not acceptable and licensed staff cannot leave creams or unknown substances or medication at bedside. A review of the facility's policy and procedure revised November 2020 and titled, Storage of Medications indicated, .Drugs and biologicals used in the facility are stored in locked compartments.