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	04/23/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to meet the professional standards of quality for one of three sampled residents (Resident 2) when a physician's post-surgical care orders were not implemented for Resident 2. This failure resulted in incomplete post-surgical assessments and monitoring for Resident 2 and placed the resident at higher risk for complications.Findings:Resident 2 was admitted to the facility in early 2026 with diagnoses which included fracture of upper arm bone and sepsis (body's extreme response to an infection).A review of Resident 2's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 2/15/26, indicated Resident 2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident had no cognitive impairment.A review of Resident 2's Order Summary Report (OSR) indicated, Resident [Resident 2] is capable of making her own health decisions.A review of Resident 2's Physician Progress Note (PPN), dated 2/10/26 indicated, .SKILLED admission SNF:.hospitalized [DATE] for septic shock [a serious condition that occurs when a body-wide infection leads to excess inflammation].She [Resident 2] was noted to have dry gangrene [death of body tissue due to a lack of blood flow or a serious bacterial infection] of the left 2nd toe .podiatry was consulted.recommended amputation of that toe outpatient. which indicated that Resident 2 was admitted to the facility with dry gangrene of the left 2nd toe. A review of Resident 2's Nursing Progress Note (NPN), dated 3/3/26 indicated, .pt [patient] out to podiatry, 2nd toe amputated and new orders received.A review of Resident 2's OSR included the podiatrist's post-surgical orders, Amputation of Left 2nd toe Activity: Restrict activities and rest. No heavy lifting, no pushing, no straining until cleared by MD [Medical Doctor]. In the next 2 weeks keep the surgical foot/ankle above the heart as much as possible. For bathing you may use sponge bathe or cover the case/bandage with a trash bag and tape above the knee with duct tape. Do not get the cast/bandage wet. If it gets soaked, it will need to be changed. Amputation of Left 2nd toe operative site: Keep the cast/bandage clean, dry, and intact until follow up with your surgeon. Do not remove the cast/bandage. If bleeding through the bandages is noted. add some more bandages. If the bleeding continues then call: [Hospital Name]: [Phone Number] [Hospital Name and Department] [Phone Number]. Amputation of Left 2nd toe s/s to report to physician Temp >100.4 degrees F or higher, excessive pain not controlled with pain medications, excessive nausea and/or vomiting, increased bleeding from the incision site. These orders were entered in OSR on 3/2/26.A review of Resident 2's SBAR [Situation Background Assessment Recommendation] & INITIAL COC [Change of Condition]/ALERT CHARTING 7 SKILLED DOCUMENTATION 9WCG0-V4 [a structured documentation method used in healthcare] dated 3/10/26, indicated that Resident 2 was transferred to a hospital on 3/10/26 due to abnormal lab results.A review of Resident 2's Treatment Administration Record (TAR, a record that contains physician orders and treatment instructions for nursing staff to implement) for March 2026 did not include the podiatrist's post-surgery care orders on 3/2/26 related to Resident 2's left secondˆtoe amputation. During a concurrent interview and records review with the Treatment Nurse (TN) on 4/23/26 at 12:49 p.m., the TN verified Resident 2's March 2026 TAR did not reflect the Podiatrist's orders on 3/2/26 and stated once the physician orders were placed in TAR, wound care nurses and other nurses carried out the orders and documented in the resident's TAR. The TN stated (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she did not carry out the postˆamputation orders for Resident 2 since the orders were not in TAR. The TN confirmed that there were no other notes documenting the podiatrist's postˆamputation orders for Resident 2 were implemented between 3/2/26 through 3/10/26 when the resident was sent out to the hospital. During a concurrent interview and records review with Licensed Nurse (LN) 1 on 4/23/26 at 4:58 p.m., LN 1 stated she worked on morning shifts on 3/4/26 and 3/9/26 and was assigned for Resident 2's care on those days. LN 1 explained that the facility treatment nurses were responsible for wound care and stated, There were no orders on my MAR [Medication Administration Record] or TAR, so I was not able to do it [implement orders].During a telephone interview on 4/24/26 at 11:43 a.m. with LN 2, LN 2 who worked on evening shifts in March stated that he did not implement the podiatrist's post-surgery care orders for Resident 2 because there were no specific postˆamputation orders for LN 2 to follow.During a telephone interview on 4/27/26 at 3:35 p.m. with LN 4, LN 4 confirmed being assigned to Resident 2 and stated that she was aware Resident 2 had an amputation of the left second toe; however, she did not perform the podiatrist's order for Resident 2 because there was no orders to implement in TAR or MAR. During a telephone interview on 4/27/26 at 4:10 p.m. with LN 5, LN 5 indicated that she took care of Resident 2 in March and stated she was not informed that Resident 2 had an amputation of the left second toe. LN 5 stated that she was not aware of any specific postˆamputation orders for Resident 2.During a concurrent interview and records review with the Director of Nursing (DON) on 4/23/26 at 3:05 p.m., the DON stated that the admitting nurse was responsible for entering physician and facility orders into PCC (an Electronic Health Record software), and those orders should appear in the resident's MAR or TAR so nurses to carry them out. The DON confirmed that the postˆamputation care and monitoring orders on 3/2/26 for Resident 2 were not in the resident's TAR and acknowledged that there was no documented evidence that the podiatrist's postˆamputation care order for the resident had been carried out. The DON emphasized that orders must be completed and documented in the resident's record and failing to correctly follow and document orders could be a significant issue that adversely affects resident care and health.During an interview with the facility Administrator (ADM) on 4/23/26 at 5:39 p.m., the ADM explained that a coding error was made by the nurse who entered the podiatrist's orders for Resident 2 on 3/2/26 which resulted in the orders not appearing in the TAR for nurses to implement. A review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation revised July 2017 indicated, All services provided to the resident.shall be documented in the resident's medical record.The following information is to be documented in the resident medical record. Treatments or services performed.Documentation in the medical record will be.complete and accurate.A review of of the facility's P&P titled, Medication and Treatment Orders, Revised 2016 indicated, Orders for medications and treatments will be consistent.and effective order writing.