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	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Pointe Post-Acute	6041 Fair Oaks Boulevard 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure safe administration of supplemental oxygen (a colorless and odorless gas used when a person's body is unable to get enough oxygen from normal air) in accordance with the physician's order for one of three sampled residents (Resident 1), when staff administered supplemental oxygen at 5 liters per minute (L/min, unit of measurement) to Resident 1 continuously without a physician's order.This failure did not reflect Resident 1's treatment needs and placed the resident at risk for oxygen toxicity, worsening of respiratory and cardiac (related to the heart) status, and had the potential to compromise Resident 1's well-being. Findings:A review of admission record indicated the facility admitted Resident 1 early 2026 with multiple diagnoses, including acute respiratory failure with hypoxia (when lungs are unable to pass enough oxygen to the blood, or when fail to remove carbon dioxide (colorless and odorless gas humans breath out) from the blood), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), and ischemic cardiomyopathy (the heart muscle is too weak to pump blood leading to fluid built-up in the lungs or body). Resident 1's clinical records indicated that the resident had obstructive sleep apnea (intermittent airflow blockage during sleep).A review of Resident 1's physician's order dated 3/25/26 indicated, Oxygen: Administer O2 [oxygen] @ [at] 1 L/min [oxygen measured in liters per minute] via NC [Nasal Cannula, a thin plastic tube applied to nostrils to provide supplemental oxygen] at bedtime.Every shift. DX [diagnosis]: Sleep Apnea.A review of the Minimum Data Set (MDS-federally mandated assessment tool) dated 4/1/26 indicated that Resident 1 was cognitively intact and did not experience hallucinations or delusions.During an observation on 5/19/26 at 11:50 a.m., Resident 1 was observed in her bed with supplemental oxygen through NC. Resident 1's oxygen concentrator (OC, a medical device that take in air from the room and filter out nitrogen to provide oxygen) was set at 5 liters/minute. Resident 1 looked at the concentrator and stated, It's at 5 liters, that is way too much for me. Resident 1 denied having shortness of breath and added, They used to have it at 3 liters, not sure when and who increased it for me. Resident 1 explained that she did not want to wear a CPAP (a breathing machine that helps person's breathing by pushing air into lungs through a mask worn over the face) at night and her physician recommended that she used supplemental oxygen at night. Resident 1 stated she was receiving oxygen at night and during daytime.During a concurrent interview and record review with Licensed Nurse (LN 1) on 5/19/26 at 12:05 p.m., LN 1 stated she was overseeing and assisting LN 2 who was a newly hired nurse. LN 1 stated she was not sure if Resident 1 was receiving oxygen continuously. LN 1 reviewed physician order for oxygen administration and stated that Resident 1 was prescribed to have supplemental oxygen at 1 L/min at night only. LN 1 entered Resident 1's room and confirmed that Resident 1 had NC with continuous oxygen flow rate set at 5 L/minute. LN 1 acknowledged that the physician order for oxygen administration was not followed. LN 1 explained that if resident complained of shortness of breath and her oxygen level was too low, the nurse would notify the physician and obtain an order for continuous oxygen administration.During an interview and record review with LN 2 on 5/19/26 at 12:11 p.m., LN 2 stated she received a report from night shift nurse that Resident 1 was on continuous oxygen. LN 2 stated she was not sure of the flow rate of oxygen Resident 1 received and stated she did not check the resident's concentrator and oxygen flow (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate since she took over care of Resident 1 earlier this morning. LN 2 confirmed that Resident 1 was supposed to be on oxygen at 1 L/min at night per physician's order.During an interview and concurrent record review on 5/19/26 at 1:50 p.m., the facility's process of oxygen administration was discussed with Director of Nursing (DON). The DON stated that treatment with oxygen required to have a valid physician order with flow rate specified. The DON validated that Resident 1's physician order indicated to administer oxygen at 1 L/min at night. After searching Resident 1's clinical records, the DON stated that the resident did not have an order for continuous oxygen administration. Upon reviewing nurses' documentation for daily oxygen saturation (percentage of oxygen in a person's blood), the DON acknowledged that on multiple days throughout the month of May, nurses documented that Resident 1 was on oxygen during daytime and nighttime contrary to the physician orders. The DON stated that the physician order for oxygen was not followed and if Resident 1 complained of shortness of breath, the physician should be notified and the order for continuous oxygen administration initiated. The DON agreed that administering oxygen at high rate (5 liters/minute) placed Resident 1 at risk for health complications.A review of the facility's policy and procedure (P & P) titled, Oxygen Administration, dated 10/2010, indicated, Purpose .To provide guidelines for safe oxygen administration. The P & P directed nursing, Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident .Adjust the oxygen delivery device so that is comfortable for the resident, and the proper flow of oxygen is being administered.