STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055612	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Feather River Care Center	1 Gilmore Lane Oroville, CA 95966

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure that resident assessments accurately reflected the resident's current status for one of five sampled residents (Resident 1) when his admission Minimum Data Set (MDS, a standardized resident assessment) dated 3/3/2024, inaccurately assessed that Resident 1 was admitted with an indwelling catheter (a catheter that is maintained within the bladder for the purpose of continuous drainage of urine into a drainage bag). This failure had the potential for the resident to not receive treatments and care that met their individual needs. Findings: During a review of the facility ' s policy titled, Conducting an Accurate Resident Assessment, no revised date provided, indicated: 1. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident ' s status, needs, strengths, and area of decline. The assessment will be documented in the medical record. 2. The appropriate, qualified health professional will correctly document the resident ' s medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. During a review of The Resident Assessment Instrument (RAI) Version 3.0 Manual, updated 10/2023, indicated: 1. Minimum Data Set (MDS). A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for the residents of nursing homes. 2. The Resident Assessment Instrument (RAI) Manual offers clear guidance on how to complete the MDS correctly and effectively. The RAI helps nursing home staff gather definitive information on a resident ' s strengths and needs, which must be addressed in an individualized care plan. 3. The RAI Version 3.0 Manual, Section H, indicated the steps for assessment is to examine the resident to note the presence of any urinary or bowel appliances . (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s clinical record, indicated that he was initially admitted to the facility on [DATE] with diagnoses which included arthritis (painful inflammation and stiffness of the joints), end stage renal disease (a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), and muscle weakness. Resident 1 was transferred to the acute hospital for uncontrolled high blood pressure on 2/22/2024 and readmitted to the facility on [DATE]. He was his own health care decision maker. During a review of Resident 1 ' s Minimum Data Set (MDS - an assessment and care screening tool), dated 3/1/2024, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 10, at section C Cognitive Patterns indicating that his cognition was moderately impaired. During a review of Resident 1 ' s MDS, section H - Bladder and Bowel, dated 3/3/2024, indicated that Resident 1 had indwelling catheter (an indwelling catheter collects urine by attaching to a drainage bag). During a concurrent observation and interview on 3/13/2024 at 11:39 am with Certified Nursing Assistant (CNA) 1, in Resident 1 ' s room, observed Resident 1 sitting up in a chair next to the bedside table with no indwelling catheter and drainage bag. CNA 1 stated that Resident 1 did not have indwelling catheter and he still urinated. CNA 1 stated she just helped Resident 1 used the restroom this morning. During a concurrent interview and record review on 3/14/2024 at 10:17 am with the Director of Nursing (DON), Resident 1 ' s MDS, dated [DATE], was reviewed. The DON acknowledged that Resident 1 ' s MDS assessment for section H- Bladder and Bowel indicated that he had an indwelling catheter and that was inaccurate. The DON stated I looked at the resident yesterday and I checked the order, the resident did not have a Foley catheter (a common type of indwelling catheter) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview and record review, the facility failed to develop individualized and comprehensive care plans that identified the needs for one of five sampled residents who was exhibiting a behavior issue by constantly removing all his clothes (Resident 1). These failures had the potential for Resident 1 not to receive the necessary care and services to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings: During a review of the facility ' s policy titled, Comprehensive Care Plans, no revised date provided, indicated: 1. It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the resident ' s comprehensive assessment. 2. The care planning process will include an assessment of the resident ' s strengths and needs, and will incorporate the resident ' s personal and cultural preferences in developing goals of care . 3. The comprehensive care plan will describe, Resident specific interventions that reflect the resident ' s needs and preferences and align with the resident ' s cultural identity, as indicated . During a review of Resident 1 ' s clinical record, indicated that he was initially admitted to the facility on [DATE] with diagnoses which included arthritis (painful inflammation and stiffness of the joints), end stage renal disease (a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), and muscle weakness. Resident 1 was transferred to the acute hospital for uncontrolled high blood pressure on 2/22/2024 and readmitted to the facility on [DATE]. He was his own health care decision maker. During a review of Resident 1 ' s Minimum Data Set (MDS - an assessment and care screening tool), dated 3/1/2024, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 10, at section C Cognitive Patterns indicating that his cognition was moderately impaired. During a concurrent observation and interview on 3/13/2024 at 7:22 am at the doorway of Resident 1 ' s room, observed Resident 1 sitting at the side of the bed, covered with a blanket which only covered the backside of Resident 1, Resident 1 was wearing nothing, but a ripped incontinence brief. Resident 1 stated he did not know what happened to his clothes and he was cold. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/13/2024 at 7:32 am, outside Resident 1 ' s room, Certified Nursing Assistant (CNA) 2 stated Resident 1 liked to take off his clothes and ripped open his incontinence breif. CNA 2 stated we just let him be like this, because he would still take the clothes off if we tried to put them back . During a review of Resident 1's care plans on 3/13/2024 at 10 am, revealed that there had been no care plans developed which described what Resident 1's specific behaviors were, what interventions were necessary to control those behaviors, or how Resident 1 would benefit from the interventions. During a concurrent interview and record review on 3/13/2024 at 11:45 am with the Administrator (ADMIN) and the Assistant of Director of Nursing (ADON), ADMIN stated that if a resident was having a behavior issue, it would be care planned. The ADON acknowledged that Resident 1 did remove his clothes often and there ' s no care plan developed to intervene this type of behavior. The ADON stated It should be care planned . The staff were expected to cover the resident, pull the privacy curtain, and close the door to protect the resident ' s privacy . During an interview on 3/13/2024 at 12:40 pm with CNA 1, the CNA 1 stated Resident 1 often took his clothes off, she would explain to Resident 1 why he should not take the clothes off and try to put it back on, CNA 1 said Resident 1 would let me put his clothes back on, he would not fight back .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure the appropriate care and services were provided to one of five sampled residents (Resident 1) who was exhibiting the sign and symptoms of urinary tract infection (UTI, bacteria in urinary system) when Urinalysis (UA, a urine specimen that determines if there is a bacterial infection in the urine)) was not done in a timely manner as ordered. This failure had the potential for delaying Resident 1 ' s treatment and to develop urosepsis (systemic body infection) and other related clinical complications. Findings: During a review of Resident 1 ' s clinical record, indicated that he was initially admitted to the facility on [DATE] with diagnoses which included arthritis (painful inflammation and stiffness of the joints), end stage renal disease (a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), and muscle weakness. Resident 1 was transferred to the acute hospital for uncontrolled high blood pressure on 2/22/2024 and readmitted to the facility on [DATE]. He was his own health care decision maker. During a review of Resident 1 ' s Minimum Data Set (MDS - an assessment and care screening tool), dated 3/1/2024, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 10, at section C Cognitive Patterns indicating that his cognition was moderately impaired. During a review of Resident 1 ' s progress note, dated 3/8/2024 at 2:26 pm, by Licensed Nurse (LN) 3, indicated Resident is alert and verbally responsive. Able to make needs known. Resident appeared to have an episode of vomiting x 1 this morning. Resident states he doesn ' t remember but it was noted to have stained his sheets. This nurse assisted in changing resident sheet. Urine is dark and foul smelling. Resident is also complaint bladder pain. Medical Doctor (MD) notified of symptoms, awaiting orders at this time. During an interview on 3/13/2024 at 11:39 am in Resident 1 ' s room with Certified Nursing Assistant (CNA) 1 and Resident 1, CNA 1 stated that Resident 1 urinated daily even though he was on dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Resident 1 confirmed that he had pain over his bladder last week which was the week that he was experiencing symptoms of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/2024 at 11:55 am with the Assistant Director of Nursing (ADON), Resident 1 ' s medical record and the text messages between Licensed Nurse (LN) 3 and MD, dated 3/8/2024, were reviewed. The ADON confirmed that LN 3 sent MD a text message on 3/8/2024 at 1:25 pm, indicated Resident 1, Dark/Foul smelling urine, episode of vomiting x 1 and bladder pain. Can we order a UA with C & S (urine culture sensitivity test - to diagnose a UTI and to identify the bacteria or yeast causing the infection). MD responded to LN 3 ' s message on 3/8/2024 at 2:54 pm, indicated Yes and Yes. The ADON admitted that he could not locate UA and C & S order in Resident 1 ' s medical record as it should have been entered into Resident 1 ' s record once MD confirmed with the order on 3/8/2024. During a concurrent interview and record review on 3/13/2024 at 12 pm with the ADON, Resident 1 ' s UA clinical laboratory report, dated 3/10/2024, was reviewed. The ADON confirmed that Resident 1 ' s UA was collected on 3/10/2024 at 7:47 pm, the UA report was sent to the facility on [DATE] at 10:29 am, and the report indicated that Resident 1 did have a UTI, 3 days after Resident 1 experiencing symptoms of UTI. The ADON stated that he had no explanation on why Resident 1 ' s UA was not collected on 3/8/2024 as it should have been. The ADON also stated that the staff were expected to document in Resident 1 ' s record whether a UA was collected or not on 3/8/2024. The ADON confirmed that he could not locate such note in Resident 1 ' s medical record.