

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Feather River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and record review the facility failed to ensure the right to personal privacy for one of one resident (Resident 1), when medical treatment was provided to Resident 1 without privacy being provided by staff. This failure had the potential to cause distress for Resident 1 and threaten her health and well-being.</p> <p>Findings:</p> <p>A review of the facility's, undated, policy titled Resident Rights revealed Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>A review of Resident 1's undated Admission Record , indicated Resident 1 was admitted on [DATE], with diagnoses including lung disease, diabetes (high sugar in the blood), heart disease, blindness, and bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks).</p> <p>During an observation on 6/6/24 at 11:59 am, the Maintenance Director (MD) and this Surveyor were in Resident 1's room discussing a maintenance issue. Licensed Vocational Nurse (LVN) B came into the room with a small alcohol pad and a syringe with medication in it. LVN B pulled up Resident 1's gown and started to rub her abdomen with an alcohol wipe. Resident 1's bra, abdomen, and briefs were in full view. No privacy curtain was pulled around the resident.</p> <p>During an interview on 6/6/24 at 12:01 pm, LVN B confirmed that she did not provide privacy for Resident 1, and she should have. LVN B stated it did not cross her mind.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation, interview, and record review the facility failed to ensure room temperatures were at a comfortable level for six of 21 resident rooms sampled. This failure had the potential for 11 of 44 residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) to be susceptible to loss of body heat, risk of hyperthermia and the actual feelings of being hot, sweaty, having difficulty breathing and not wanting to stay in their room.</p> <p>Findings</p> <p>A review of the facility's, undated, policy titled Resident Rights revealed, The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>A review of the facility's, undated, policy titled Safe and Homelike Environment revealed, 7. The facility will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71- and 81-degrees Fahrenheit (F).</p> <p>During an interview on 6/6/24 at 10:47 am, the Maintenance Director (MD) indicated the main unit air-conditions (located on the roof of the building) had not been working and the Heating, Ventilation, and Air Conditioning (HVAC) company came out yesterday and got them up and working again.</p> <p>A review of Resident 1's undated Admission Record , indicated Resident 1 was admitted on [DATE], with diagnoses including lung disease, diabetes (high sugar in the blood), heart disease, blindness, and bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks).</p> <p>A review of Resident 2's undated Admission Record , indicated Resident 2 was admitted on [DATE], with diagnoses including right hip fracture, diabetes, (high sugars in the blood), heart disease, and anxiety.</p> <p>During an observation and interview on 6/6/24 at 11:28 am, in Resident 1 and 2's room, the room felt hot and muggy. Resident 1 stated The temperature is hot in here; I have a hard time breathing, it is too hot for me in here. There was a swamp cooler (Portacool Cyclone , a swamp cooler that has a motorized fan that pushes air through damp pads, which moisten and cool the air before blowing it into its surroundings) aimed into the room and an unplugged portable air-conditioner by the sliding glass door that led to the outside. Resident 1 stated the air-conditioner was unplugged because if plugged in, it would trip the breaker (an electrical safety device that can interrupt [when tripped] current flow to protect an electrical circuit from damage caused by overcurrent, ground faults, or short circuits). Resident 2 indicated It is hot in here, I am hot and sweaty, is the air- conditioner running?</p> <p>A review of an online weather resource on www.timeanddate.com, indicated that on 6/6/24 at 12:00 pm the outside temperature was 106 degrees Fahrenheit (F).</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 6/6/24 at 12:08 pm, the MD said his goal for the room temperatures were 72 degrees F.</p> <p>During an observation and interview on 6/6/24 from 12:38 pm to 1:15 pm, with the MD, 21 resident rooms were checked for temperature readings with the MD's laser thermometer (a thermometer that measures the temperature of an object from a certain distance). Three resident room temperatures on the east wing were recorded to be: room [ROOM NUMBER] was 82.9 degrees F, room [ROOM NUMBER] was 84.2 degrees F, and room [ROOM NUMBER] was 82 degrees F. Three resident room temperatures on the west wing were recorded to be: room [ROOM NUMBER] was 81.3 degrees F, room [ROOM NUMBER] was 83 degrees F, and room [ROOM NUMBER] was 83 degrees F. The MD indicated this was too hot. He had been working on different ways to control the temperature. There were four swamp coolers in the west hallway and one large portable air-conditioner by the west exit door. There were two swamp coolers in the east hallway and one large portable air-conditioner by the east exit door. Some rooms had portable air-conditioners. The MD indicated; some of the portable air-conditioners would trip the circuit breaker so it was a challenge finding places to plug them in.</p> <p>During a review of the Portacool Cyclone (swamp coolers) owner's manual with the MD, at 12:44 pm, the manual revealed Your Portacool Cyclone, portable evaporative cooler is meant to be used in an open-air environment, such as a patio. If you plan to use your evaporative cooler in a more closed environment - such as a garage, sunroom or barn - you must provide adequate ambient airflow to ensure your evaporative cooler works at its highest efficiency. When using in a semi-closed environment, be sure to leave a door or window open to allow for the proper amount of airflow. MD confirmed the swamp coolers were not being used as per the manual because there was no air flow in the hallway and no open window.</p> <p>An interview on 6/6/24 at 1:10 pm, with a family member (FM) of Resident 3, FM stated The temperature was terrible the last few days.</p> <p>During an interview on 6/6/24 at 1:17 pm, Certified Nursing Assistant (CNA) C stated, it (the temperature in the facility) had been awful. She indicated that residents had complained to her about it. She stated, It started to feel overbearing last week. Every summer they use the swamp coolers and they do not work unless you stand in front of them.</p> <p>During an interview on 6/6/24 at 1:34 pm, The MD continued to say, the HVAC company said the ductwork (a system of tubing that is used to transfer cool or warm air from the air conditioning unit or furnace to the air vents distributed throughout the home) had holes in it which let cold air out and let hot air in and that would need fixing. The MD said they were scheduled to come back because there was more work to be done.</p> <p>During an observation at the nurse's station on 6/6/24 at 1:46 pm, Resident 4 came to the Nursing station and asked the Licensed Vocational Nurse (LVN) A for some medication. LVN A indicated for Resident 4 to go to her room, and he would bring the medication there. Resident 4 said It is too hot to be staying in the room.</p> <p>During an interview on 6/6/24 at 2:22 pm, the Unlicensed Administrator, indicated the HVAC company had been notified and was working on the problem now.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</p> <p>Based on observation and interview the facility failed to ensure the communication call light system was working for two of three residents (Resident 1 and 2), sampled for working call lights, when Resident 1 and Resident 2's call light would not stay on after the button was depressed. This failure had the potential for Resident 1 and 2 to be at risk for accidents and their care needs not to be met.</p> <p>Findings</p> <p>A review of the facility's, undated, policy titled Call lights: Accessibility and timely Response indicated The purpose for this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.</p> <p>A review of Resident 1's undated Admission Record , indicated Resident 1 was admitted on [DATE], with diagnoses including lung disease, diabetes (high sugar in the blood), heart disease, blindness, and bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks).</p> <p>During an observation and interview with Resident 1 on 6/6/24 at 11:32 am, Resident 1's call light in her room was observed. Resident 1 turned on her call light and the light in the hallway attached to the button went on them immediately went off. Resident 1 said her call light was broken.</p> <p>During an interview with Resident 1 on 6/6/24 at 11:47 am, Resident 1 stated that two nights ago she needed help to go to the bathroom at about 4:20 in the morning. I turned my light on and off so they would see the light, they never came. At about 6:20 am, I called the front desk with my cell phone and the kitchen help answered the phone and then someone came and helped me.</p> <p>A review of Resident 2's undated Admission Record , indicated Resident 2 was admitted on [DATE], with diagnoses including right hip fracture, diabetes, (high sugars in the blood), heart disease, and anxiety.</p> <p>During an observation and interview with the Maintenance Director (MD) on 6/6/24 at 11:57 am, Resident 1 and Resident 2's call lights were observed. Both call light buttons were pushed to the on position and the light outside the room did not stay on. The light blinked on for a minute then turned off. The MD confirmed that Resident 1 and 2's call light were not working and they were supposed to be working. He said he would replace them.</p>