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	06/20/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) was treated with dignity and respect while eating meals. This deficient practice had the potential to negatively affect Resident 2's psychosocial well-being and did cause Resident 2 to become frustrated. Findings: The facility ' s policy dated 2/2023, titled, Promoting/Maintaining Resident Dignity, indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident ' s quality of life by recognizing each resident ' s individuality. This facility ' s policy also indicated all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights and respond to requests for assistance in a timely manner. During a review of Resident 2 ' s medical record, the Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included specified sepsis (body ' s extreme response to an infection), cellulitis (potentially serious bacterial infection of the skin) of chest wall, abdominal wall, right upper arm, both lower legs, high blood pressure, Bullous Pemphigoid (rare skin condition that causes large, fluid filled blisters), and severe obesity (being overweight). During a review of Resident 2 ' s medial record, a record dated 6/18/24, titled, Admission Record, indicated Resident 2 was his own responsible party, and able to make decisions for himself. During a concurrent observation and interview on 6/20/24 at 1:45 pm, Resident 2 had dark, dried, red colored stains on his shirt. Resident 2 stated, while pointing to his shirt, Can you get someone to help me, I am covered in blood because no one has changed my dressings. I have asked the staff, but no one has come in here to help me. During an interview on 6/20/24 at 2:32 pm, Certified Nursing Assistant (CNA) 4, stated, I told Licensed Nurse (LN) 3 [Resident 2 ' s] shirt was bloody, and his shirt needed to be changed, but he was waiting on her to change his dressings. LN 3 said she would do it. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/24 at 3:35pm, LN 3 confirmed she had been updated to change Resident 2 ' s dressings and stated, I just have not got to it yet. During an interview on 6/20/24 at 4:20 pm, the Director of Nursing (DON) confirmed Resident 2 should have never been served his meals with soiled dressings, and a dirty shirt. DON agreed this was a dignity problem, and stated, No one told me, or I would have already completed his wound care and changed his clothes.

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure physician orders for wound care were obtained upon admission to the facility for one of three residents, (Resident 2) sampled for new admission. This failure had the potential for a negative clinical outcome, re-hospitalization , and Resident 2 did have specific needs that were not identified in a timely manner. Findings: The facility ' s policy dated 2/2023, titled, Admission Orders, indicated the orders should allow facility staff to provide essential care to the resident consistent with the resident ' s mental and physical status on admission. This facility ' s policy also indicated the admission orders should provide information to maintain or improve the resident ' s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. The facility ' s policy dated 2/2023, titled, Walking Rounds Shift Report, indicated it is the policy of this facility to use walking round shift reporting to promote successful transfer of information between nursing staff at shift change in an effort to prevent adverse events, medication errors and medical mishaps. This facility ' s policy also indicated walking rounds shift report will be used for a 24-hour period to ensure continuity of care and the night shift nurse will enter the necessary information on the shift report for the following day. During a review of Resident 2 ' medical record, the Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included specified sepsis (body ' s extreme response to an infection), cellulitis (potentially serious bacterial infection of the skin) of chest wall, abdominal wall, right upper arm, both lower legs, high blood pressure, Bullous Pemphigoid (rare skin condition that causes large, fluid filled blisters), and severe obesity (being overweight). During a review of Resident 2 ' medial record, a record dated 6/18/24, titled, Admission Record, indicated Resident 2 was his own responsible party, and able to make decisions for himself. During a record review of Resident 2 ' s medical record, a record dated 6/18/24 was incomplete for admission orders that did not include wound (a break or open area of the skin) care orders for multiple open areas to the resident including the chest area, upper right arm, abdomen area (stomach), and both lower legs. During a record review of Resident 2 ' s medical record, a record dated 6/18/24, titled, Admission Orders, did not include any wound care orders for Resident 2 ' s wounds to both lower legs, upper chest, right arm, and abdomen areas. During a record review of Resident 2 ' s medical record, an admission assessment, and all progress notes from 6/18/24 to 6/20/24 did not contain pertinent information needed to identify wounds that needed specific physician orders for Resident 2 ' s care. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 2 ' s medical record, a record dated 6/20/24, titled, Skin/Wound Note, indicated Late Entry, included all measurements for open areas of skin for Resident 2, that should have been completed on 6/18/24 when Resident 2 was admitted to the facility. During an interview on 6/20/24, at 2:05 pm, the Director of Nursing (DON) confirmed there were no active wound care orders for the admission for Resident 2. DON confirmed there were no wound assessments completed, no measurements obtained, and no documentation for any open areas to Resident 2 in the medical chart. During an interview on 6/20/24, at 2:50 pm, the Medial Director (MD) confirmed the DON had just called for wound care orders and incomplete admission orders is a problem. MD stated, Someone missed the admission orders, but I will talk to the staff about this. During an interview on 6/20/24 at 3:10 pm, Licensed Nurse (LN) 1 stated, I cannot believe this admission was missed, these wounds should have been measured and documented on 6/18/24 when [Resident 2] arrived. We need a desk nurse or an admission nurse. During an interview on 6/20/24 at 3:15 pm, RN 4 stated, I did have [Resident 2] the past two evenings. To be honest I did not do any wounds or check for any orders. I did not get a verbal report for Resident 2. I do not have a reason except I did not do it; it gets busy around here. I should have called the doctor and finished the admission for Resident 2. During a follow up interview on 6/20/24 at 4:15 pm, the DON confirmed the admission process was not followed and the admission assessments were not completed for Resident 2, and there was a delay in care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, record review, and the facility ' s policy, the facility failed to develop a baseline care plan within 48 hours for one of three residents (Resident 2). This failure had the potential to not meet the individual needs of the resident and cause a negative clinical outcome. Findings: A review of the facility ' s policy dated 2/2023, titled, Baseline Care Plan, indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. This policy also indicated the baseline care plan will be developed within 48 hours of a resident ' s admission. The baseline care plan policy will include the minimum healthcare information necessary to properly care for a resident. During a review of Resident 2 ' medical record, the Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included specified sepsis (body ' s extreme response to an infection), cellulitis (potentially serious bacterial infection of the skin) of chest wall, abdominal wall, right upper arm, both lower legs, high blood pressure, Bullous Pemphigoid (rare skin condition that causes large, fluid filled blisters), and severe obesity (being overweight). During a review of Resident 2 ' medial record, a record dated 6/18/24, titled, Admission Record, indicated Resident 2 was his own responsible party, and able to make decisions for himself. During a review of Resident 2 ' s medical record there was no base line care plan developed. During an interview on 6/20/24 at 3:15 pm, Licensed Nurse (LN) 4 confirmed there was no baseline care plan in the medical record for Resident 2 for staff to have pertinent information to take care of Resident 2 to identify specific needs. During an interview on 6/20/24 at 4:00 pm, the Director of Nursing (DON) confirmed there were no admission records completed for Resident 2 which included the base line care plan.