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	06/26/2024

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 - Some	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** 41715 Based on interview, observation, and record review, the facility failed to meet this regulation when two of eight sampled residents (Residents 1 and 2) reported to the facility that Licensed Vocational Nurse (LVN A) spoke to them in a disrespectful manner; that LVN A threatened to withhold medication from Resident Two; residents indicated they were fearful of him. This had the potential to result in psychosocial (mental) harm, pain, and adverse medical outcomes. Findings: A review of the facility's Employee Handbook (undated), provided by the facility's administrator on 6/28/24, indicated policy as follows: We are a service business and all of us must remember that while the resident is not always right, the resident is never wrong, and, Our residents have the right to be free from verbal, sexual, physical and mental abuse, corporal [physical] punishment, neglect, and involuntary seclusion; and, Residents are to be treated courteously and always given proper attention. Never regard a resident's question or request for assistance as an interruption or an annoyance. Resident and family member inquiries, whether in person or by telephone, must be addressed promptly and professionally. Review of the policy further indicated, Customer Relations: Never argue with a resident or a family member. If a problem develops or if the person you are dealing with remains dissatisfied, refer the matter to your supervisor or the Administrator. Review of the policy also indicated that the action represented Gross Misconduct: Failing to respond when residents need assistance, and Neglect of resident care duties directly related to the safety, health and/or physical comfort and well-being of a resident. Resident 1 Resident 1 was admitted to the facility on [DATE] for conditions including chronic obstructive lung disease, anxiety, depression, and dependence on assistance with personal care. (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

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	06/26/2024

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 - Some	Review of Resident One's progress notes dated 6/11/24 indicated that Resident 1 stated that she felt unsafe and that that male nurse [LVN A] yelled at her about requesting pain medication that she did not get them on time. Review of Resident 1's Social Services notes dated 6/6/24 indicated that social services was notified that SOC 341 (an abuse reporting document) was filed on behalf of [Resident 1], so I went to speak with the resident to inquire about her well-being and to see if she still felt unsafe. Although she was not in good spirits regarding the situation, she did not feel unsafe at the time. In an interview on 6/30/24 at 4:10 PM, LVN B stated that it was reported to her by CNA C that Resident 1 had turned on her call light asking for medication and LVN A was arguing back and forth with her about the medication, and she told LVN A to get out of my room. LVN B stated that she spoke to Resident One about the incident and the resident told her that she was glad [LVN A] would not be her nurse anymore; now she could ' rest.' LVN B stated that LVN A had worked a double that night, He had an attitude. LVN B added that Resident One complained that [LVN A] gave medicine too fast and wants her to swallow. It was his approach that was the problem. In an interview on 7/1/24 at 9:02 AM, CNA C stated that she witnessed LVN A giving a medication to a resident 1, who has a history of anxiety and confusion and is not comfortable around males; LVN A was male. CNA C stated, I was trying to calm [Resident 1] down and [LVN A] got the pills and said to the resident, 'There. I'm a girl, and dumped the pills into her mouth and walked out of the room. Resident Two Resident Two was admitted to the facility on [DATE] for conditions including heart failure, bipolar disorder and need for assistance with personal care and has blindness category three (low vision) in both eyes. A review of Resident Two's Social Services notes dated 6/9/24 indicated, This Social Worker discussed last night's events with [Resident Two]. Resident stated the following: ' Yesterday, I had asked to get my bandage changed. The nurse told me that he didn'th ave time so I asked if the other nurse on duty could do it for him . I told him it had not been changed in three days and that I need it changed now. I tried to call for an ambulance with my personal phone so that I can go to the hospital to get it changed because you guys weren't doing it here and I need it done! I don't want for it to get worse and end up having my foot cut off! I didn't know what to do so I called [my son]. He was upset at the situation. He called the front desk and put me on a three-way call with [LVN A]. [LVN A] was very rude to my son and insinuated we are being rude because he's brown. We are not racist and I don't like being called one.' Resident Two indicated that she ' did not feel safe' with last night's nurse and ' he might be capable of poisoning her.' The record indicated further that she assured Resident Two that LVN A would not be providing care to her at this time until further notice due to this complaint and her feeling of being unsafe. (continued on next page)

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	06/26/2024

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 - Some	In an interview on 6/26/24 at 11:45 AM, Director of Nursing (DON A) acknowledged that staff LVN A had been terminated for arguing with and yelling at resident Two as witnessed by staff and that Resident Two reported she didn't feel safe, and that Certified Nursing Assistant (CNA C) overheard LVN A arguing with Resident Two regarding medications. DON A stated that LVN A confirmed that he argued back to Resident Two, and was told that this is residents' home and we don't argue with them. It's not up to our standards. After CNA C confirmed the incident we determined it violated the resident's rights. In an interview on 6/26/24 at 12:05 PM, Resident Two stated that she wanted to talk to LVN A on a recent night about some items that were thrown away from her bedside table. Resident Two stated, He came in at 10 PM and knocked on the door so loud it startled me. If I copied how loud he knocked, I would hurt my knuckles. I told him about the things that had been thrown away from my table and he said, ' This didn't happen on my shift. This isn't my problem.' He has a history of talking to me inappropriately. In an interview on 7/30/24 at 4:10 PM, LVN B reaffirmed that LVN A had worked a double shift and was not fast enough in changing Resident Two's wound dressing on her leg and argued with her about it. LVN B also stated that Resident Two complained about LVN B giving medication too fast, and that several other residents were not fond of him. In an interview on 6/26/24 at 10:03 AM, a local community advocate stated [ADV 10] that he received complaints about LVN A from both Residents One and Two after investigating the reported incident. He stated LVN A also worked at a nearby facility and he has received complaints from residents that were dismissed only because the residents decided not to pursue their complaints. In an interview on 7/1/24 at 9:02 AM, CNA C stated that on the night of 5/29/24 she accepted Resident 2 as her assignment. CNA C stated that Resident 2 was asking for a pain pill at 3 AM when she normally gets it. Her nurse [LVN A] had told her that he wasn't going to give her pain medicine unless she respected him, and that he was not going to be dismissed by her. CNA C stated that LVN A dragged it on and on insisting on 'respect.' CNA C stated that Resident 2 then asked LVN A to please give her her pill and get out. He gave it to her and walked out. [NAME] stated that LVN A was rude to multiple residents. She stated that he focused on being respected and that he also complained about a CNA stating, No CNA is going to undermine me and tell me what to do.

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	06/26/2024

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 41715 Based on interview, observation, and record review, this requirement was not met when a staff member closed the room door for one of eight sampled residents (Resident 3), and silenced the resident's call light. This resulted in the potential for psychological harm and adverse outcomes and was contrary to the facility's stated policy. Findings:Resident 3 was admitted to the facility 4/29/24 for respiratory failure, a worsening brain disease, anxiety, need for assistance with personal care, and difficulty communicating. The resident had a history of calling out loudly from her room and a history of being fearful of confinement following trauma from a local wildfire disaster. A review of Resident 3's Basic Interview for Mental Status (BIMS) indicated that her score was 2, Severe cognitive impairment. A review of the facility's Employee Handbook policy (undated), provided by the facility's administrator on 6/28/24, indicated policy as follows: We are a service business and all of us must remember that while the resident is not always right, the resident is never wrong, and, Our residents have the right to be free from verbal, sexual, physical and mental abuse, corporal [physical] punishment, neglect, and involuntary seclusion; and, Residents are to be treated courteously and always given proper attention. Never regard a resident's question or request for assistance as an interruption or an annoyance. Resident and family member inquiries, whether in person or by telephone, must be addressed promptly and professionally. Review of the policy further indicated, Customer Relations: Never argue with a resident or a family member. If a problem develops or if the person you are dealing with remains dissatisfied, refer the matter to your supervisor or the Administrator. Review of the policy also indicated that the action represented Gross Misconduct: Failing to respond when residents need assistance, and Neglect of resident care duties directly related to the safety, health and/or physical comfort and well-being of a resident. A review of Resident 3's Progress Notes dated 6/24/24 indicated (Director of Nursing) DON notified by Ombudsman that an anonymous report regarding LN on NOC shift shut resident door and disables call light. SOC341 [a required official abuse reporting document] was filed, RP and MD were made aware. Staff member in question was separated immediately. Review of Resident 3's Care Plan dated 4/30/24 indicated that she was fearful of confinement: Potential for signs and symptoms of depression or anxiety related to: Resident has PTSD from [a wildfire disaster]. Resident dislikes the door in her room closed. Keep room door open for resident's comfort. (continued on next page)

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	06/26/2024

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/24 at 11:45 AM, DON A stated that an investigation of this matter was underway but incomplete and that LVN B has been taken off duty. She confirmed that LVN B admitted to having closed the door on Resident Three, it is never appropriate to isolate residents. She indicated that investigation into the call light silencing was pending. Staff were inserviced this morning that doors are not to be closed on residents and call lights must remain within reach. DON A further stated that Resident 3 was particularly vulnerable to isolation because of a traumatic history, and acknowledged the care plan prohibiting the Resident Three's door from being closed. In an interview on 6/26/24 at 4:17 PM, Resident 3's daughter in law (FAM 9) stated that her mother told her staff had closed the door on her several times. In an interview on 6/26/24 at 5:06 PM, Certified Nursing Assistant (CNA D) stated that she had witnessed LVN B shutting the door and disarming the call light to Resident Three's room. CNA D stated that Resident Three suffers from paranoia, she's scared of the dark and doesn't like to be left alone. She doesn't like the door shut. CNA D stated that there were several times when LVN B had stated regarding Resident Three, Quiet her down or I'll shut the door. Further, CNA D stated that LVN B had made changes to the central box on the call light system to silence the alarm by disconnecting two wires at the central alarm box. In an interview on 7/30/24, LVN B acknowledged closing Resident Three's door, stating that she didn't know the door was not allowed to be closed. LVN confirmed that she had dialed down the volume of the alarm to silence it, but denied disconnecting the wires, stating, ' I'm not an electrician, but one night I opened the metal box [for the call light system] and the wires were disconnected. LVN B stated that she reported the call light system being out to Maintenance Director (MAINT) the next morning. In an interview on 7/1/24 at 9:30 AM, MAINT stated that he had not received a report from LVN B about the call lights as she stated, rather, several CNAs brought it to his attention. He confirmed that two wires had been disconnected in the box, it is being repaired, and that We have to have it on to let us know if someone needs assistance.