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	09/09/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715 Based on interview, record review and observation, the facility did not meet this requirement when three of eight sampled residents (Residents 1, 4, and 5) stated their soiled briefs were not changed in a timely manner, including one resident (Resident 1) being left wet for approximately 12 hours until the next day's shift reported for duty. This had the potential to result in negative health outcomes (infection, illness), skin breakdown, and residents' loss of dignity. Findings: Review of the facility's policy titled Activities of Daily Living dated 2023 indicated: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer (moving between two places) and ambulation (walking); 3. Toileting. Review of the facility's record titled CNA (certified nursing assistant) Walking Rounds Shift Report (undated) 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 and medical mishaps. (Walking rounds is a practice used by staff to go together into resident rooms as shift is changing to assure care has been provided). Resident 1 Resident 1 was admitted to the facility for heart and kidney failure, anxiety disorder, diabetes, and severe obesity. A review of Resident 1's Minimum Data Set (MDS, a tool that measures residents' health and ability to function) dated 11/4/23, indicated that the resident was unable to walk 10 feet and required assistance for transfers (movement from one place to another). (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
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/4/24 at 1:35 PM, Resident 1 stated that she sat in her own waste for an entire day on Sunday, 9/1/24. Resident 1 stated, I went all Sunday without being changed until the next shift came in on Monday morning. The CNA was nowhere to be found. The nurses said they were short-staffed when I asked them for help, and never came back in. Resident 1 stated that this made her uncomfortable, and she felt like she didn't matter. Resident 4 Resident 4 was admitted to the facility for diabetes, malnutrition (poor nourishment), osteomyelitis (bone infection), chronic obstructive pulmonary disease (lack of ability to fully breathe) and a history of stroke. A review of Resident 4's MDS dated [DATE] indicated that Resident 4 required Substantial/Maximal assistance to get on or off a toilet and was unable to walk 10 feet. In an interview on 9/4/24 at 1:57 PM, Resident 4 stated that she was routinely not changed at night. There's only one girl at night who changes me regularly. When she's on duty, she'll change me. Resident 5 Resident 5 was admitted to the facility for conditions including a foot amputation and infection, A review of Resident 6's MDS dated [DATE] indicated that he required partial/moderate assistance walking and getting on and off the toilet. In an interview on 9/4/24 at 2:00 PM, Resident 5 stated, They don't come in and change me. Resident 1's family member was present and stated, When we're here visiting, we are the ones who must ask them to come in when he rings the bell. Last week we came in and his diaper was so full and heavy that it had fallen into the leg of his pants. I haven't seen anyone who comes in and checks on him when he needs it. In an interview on 9/4/24 at 2:10 PM, Director of Staff Development (DSD 1) stated that Sunday, 9/1/24 there were staff who called off overnight, and a CNA from registry (temporary agency) showed up but somebody didn't assign her to her rooms, which could have contributed to Resident 1 not having been changed. DSD1 stated that typically she would come in to make the assignment sheet and she assumed someone would have made assignments in her absence.