

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 06/04/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the conservator (an individual appointed by a court to oversee the mental health care of an individual with a serious mental illness who is unable to make decisions themselves) of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers in advance of a medication change for one of two sampled residents (Resident 1). Resident 1 was receiving Clozapine (medication used to treat severely ill patients with Schizophrenia who have used other medicines that did not work well) for her diagnosed Schizophrenia (a chronic mental health disorder characterized by a disconnection from reality) prior to her admission to the facility and upon admission to the facility on 7/22/2024, and it was placed on hold for an unknown reason from 8/3/2024 until discharge from facility on 10/25/2024, without conservator knowledge.</p> <p>This deficient practice caused a decline in Resident 1's mental health status and resulted in a hospital readmission for treatment of her Schizophrenia.</p> <p>Findings:</p> <p>A review of a facility policy titled, Resident Representative, with a revised date of February 2021, indicated, The facility treats the decisions of the resident representative as the decisions of the resident . to the extent required by the court . If the resident is determined to be incompetent . the rights of the resident will devolve to and will be exercised by the resident representative appointed to act on the resident ' s behalf. This document indicated that a resident representative can be defined as a court-appointed guardian or conservator of the resident. The facility will treat the decisions of a resident representative as the decisions of the resident .</p> <p>A review of a facility policy titled, Use of Psychotropic Medication(s), with no revised date, indicated, The indications for initiating, maintaining, or discontinuing medication(s) . will be determined by evaluating the resident . including the assessment of relative benefits and risks, and the preferences and goals for treatment. This document further indicated, The resident ' s medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication . Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication . in advance of such initiation or increase. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care . and the preferred option to accept or decline .</p> <p>(continued on next page)</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s records indicated Resident 1 was admitted to the facility on [DATE] and discharged to the acute care hospital on [DATE]. Resident 1 had diagnoses that included Schizophrenia, dysphagia (difficulty swallowing) and sepsis (life threatening medical emergency when a body ' s response to an infection harms its own tissues and organs). Resident 1 had a conservator contact on file indicated as their Responsible Party to make decisions.</p> <p>A review of a document titled, Informed consent, indicated that Resident 1 had signed an informed consent form on 9/3/2024 for Paliperidone 1.5 mg daily (an antipsychotic medication used to help treat schizophrenia). This form was signed by a licensed staff member and the Medical Physician; however, it was not signed by the resident ' s responsible party.</p> <p>A review of the facility ' s progress note dated 10/18/2024 at 1:01 PM by Licensed Vocational Nurse (LVN1), indicated, Nursing observations, evaluation, and recommendation are: on 10/18/24. After reviewing medications, it was determined that resident should be taking Clozapine, MD (Medical Physician) made aware due to unable to be prescribed by MD he gave new order to transfer to acute. RP aware.</p> <p>A review of the facility ' s Medication Administration Record (MAR), indicated that Clozapine Oral Tablet 100 mg for Schizophrenia had a start date at the facility for 7/22/2024, a hold date on 8/3/2024 and an eventual discontinuation date on 10/4/2024. Paliperidone Extended Release Oral Tablet 1.5 mg for Schizophrenia had a start date on 7/23/2024 until Resident 1 discharged from the facility.</p> <p>During an interview on 5/14/2025 at 4:50 PM with Behavioral Health (BH1), stated, Resident 1 had to get hospitalized due to psychiatric medications being changed without her conservator ' s permission, causing deterioration in her health. BH1 further stated that Resident 1 was on a [NAME]-Petris-Short (LPS) Conservatorship (a legal arrangement where a court appoints a conservator to be responsible for the comprehensive medical treatment of an adult who has a serious mental illness and is deemed gravely disabled. The appointed conservator has the legal authority to make decisions regarding the resident ' s mental health treatment, including consenting to medication. The conservator has the authority to ensure they receive mandatory medication).</p> <p>During an interview on 5/28/2025 at 9:24 AM with LVN1, stated Resident 1 did need the medication Clozapine and since the medical physician was unable to prescribe it, Resident 1 was transferred to acute care. LVN1 stated he was unsure of why the physician could not prescribe the medication.</p> <p>During an interview on 5/28/2025 at 9:40 AM with BH2, stated Resident 1 was LPS conserved which meant that medication can be forced if need be in an appropriate manner. BH2 stated that the facility changed Resident 1 ' s medication without consent from the conservator and discontinued her medication without the conservator ' s knowledge, and they should have been contacted. They didn ' t notify us they changed her medication. We don ' t know why they put the medication on hold, you can ' t just stop that medication they completely decompensate. She just got worse and worse. BH2 stated the conservator was never consulted until Resident 1 was already decompensated, and she had been on these medications for a long period of time given that she had been under a conservatorship for about 20 years. I think they didn ' t follow protocol. Maybe they felt they got consent from her, but they needed it from the conservator who should have been called and informed each time Resident 1 had refused medications. BH2 stated the conservator must consent to medication changes; however, no consent was given to the doctor to pull Resident 1 off of her medications or change her medications. They need to have a consequence for doing this, so they don ' t do it again.</p> <p>(continued on next page)</p>

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