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	06/06/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect one of two sampled residents (Resident 2) from abuse when Resident 2 was pushed out of her wheelchair to the floor by Resident 1. This failure had the potential to cause physical and psychosocial harm to Resident 2. Findings: A review of the undated facility policy titled Abuse, Neglect and Exploitation indicated It is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing, and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility policy indicated, III. Prevention of Abuse, Neglect and Exploitation, D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect. A review of Resident 1's record indicated he was transferred from a skilled nursing facility and admitted to the new facility on 3/31/25 with diagnoses which included stroke affecting right dominant side and depression unspecified. A review of Resident 1's transfer record included a nurse practitioner note dated 3/17/25 at 1:33 pm, indicated he had Bipolar II disorder (cycle of mood swings from high to low) continue sertraline (medication for depression). Social Service Assistant notes indicated Resident 1 had four appointments with psychology on 03/17/25, 3/20/25, 3/24/25, and 3/27/25 before transfer to another skilled nursing facility. A review of a Minimum Data Set (MDS, resident assessment) dated 03/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, cognitive screening tool) and scored 9 determining moderate cognitive impairment. The Patient Health Questionnaire (PHQ-9, used to screen level of depression indicated Resident 1 was experiencing mild depression. Resident 1 was wheelchair dependent and moderately dependent for support from caregivers to navigate daily activities. A review of Resident 1's progress notes dated 5/20/25 at 1:52 pm, indicated Resident 1 exhibited one episode of aggression toward staff. Resident 1 threatened to kill staff after being wheeled out of the dining room and after choking from eating too fast. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress notes dated 5/20/25 at 3:00 pm, a indicated a change in condition (agitation, psychosis). During morning report, nurse noted that Resident 1 threatened to kill the nurse during medication administration. Resident 1 was uncooperative with increased agitation and behaviors. At approximately 2:40 pm, Resident 1 threw an empty urinal at the Certified Nursing Assistant (CNA) while the CNA was performing resident care. Shortly after at 2:50 pm, Resident 1's nurse was made aware by CNA that Resident 1 was wheeling self-outside hallway naked. A review of Resident 1's progress notes dated 5/21/25 at 3:31 pm, indicated CNA was made aware that resident had one episode of hitting himself with palm of hand on shift. Resident was redirected with small conversation successfully. Resident 1 monitored during shift. A review of Resident 1's progress notes 5/21/25 at 11:15 pm, indicated Resident 1 began making statements of wanting to take his life or wanted his life to end. One statement was hoping that one of his wounds would start bleeding out so much to the point that he would die. Another statement was he was going to bash his head onto the railing in the hallway by the nurse's station until he was no longer alive. He also sat and make motions of slicing his throat open multiple times along with stating he was going to kill himself one way or another once he figured it out. Resident 1 didn't relax or calm down until midnight. The physician was notified at 12:09 am, it was advised a staff member was to ensure their safety and wellbeing, be assigned to closely always watch and stay with Resident 1 (1:1, staff always assigned to monitor). A review of Resident 1's progress notes dated 5/22/25 at 5:22 pm, indicated at 3:20 pm, Resident 1 was in hallway in his wheelchair near the breakroom/hallway. Resident 2 was in vicinity of Resident 1. Resident 1 approached Resident 2 yelled get out of my way then shoved her out of her wheelchair and on to the floor. While under continuous 1:1 monitoring, Resident 1 was still able to initiate an altercation with Resident 2. A review of Resident 2's record indicated she was admitted to the facility on [DATE], with diagnoses which included stroke, manic depression and Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly). A review of a MDS dated 03/2025, indicated Resident 2 had a (BIMS) score of 3 (severe cognitive impairment). Resident 2 was wheelchair dependent and significantly dependent for support from caregivers to navigate daily activities. A review of Interdisciplinary Team (IDT, is a group of professionals from different specialties who work together to plan and provide coordinated care for a resident) records dated 5/28/25 at 9:32 am, indicated they did not meet to discuss the resident-to-resident altercation until six days after the event. The IDT note indicated Resident will remain on 1:1 monitoring and will be reevaluated in one week. During a concurrent interview and record review on 6/4/265 at 1:05 pm, the Director of Nursing (DON) confirmed the admission team did not identify that Resident 1 had Bipolar II disorder or that he was participating in psychology visits at the other facility. DON was not aware that his MDS PHQ-9 indicated Resident 1 was mildly depressed upon admission. DON confirmed there were no behavioral health care plans in his record, nor were there any mental health appointments provided to Resident 1 at the facility since admission.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the accuracy of a Preadmission Screening and Resident Review (PASRR, evaluation for serious mental illness and intellectual disability,) for one of two sampled residents (Resident 1) during an admission from another Skilled Nursing Facility. This failure had the potential for Resident 1 not to receive a plan of care to meet his behavioral and mental health needs. Findings: An undated copy of the facility policy titled, Resident Assessment – Coordination with PASRR Program indicated, This facility coordinates assessments with the readmission screening and resident review (P ASARR) program under Medicaid to ensure that individuals with a mental disorder intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Recommendations, such as any specialized services, from a P ASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. A review of Resident 1's record indicated he was transferred from a skilled nursing facility and admitted to the new facility on 3/31/25 with diagnoses which included stroke affecting right dominant side and depression unspecified. A review of Resident 1's transfer record included a nurse practitioner note dated 3/17/25 at 1:33 pm, indicated he had Bipolar II disorder (cycle of mood swings from high to low) continue sertraline (medication for depression). Social Service Assistant notes indicated Resident 1 had four appointments with psychology on 03/17/25, 3/20/25, 3/24/25, and 3/27/25 before transfer to another Skilled Nursing Facility (SNF). A review of a Minimum Data Set (MDS, resident assessment) dated 03/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, cognitive screening tool) and scored 9 determining moderate cognitive impairment. The Patient Health Questionnaire (PHQ-9, used to screen level of depression indicated Resident 1 was experiencing mild depression. Resident 1 was wheelchair dependent and moderately dependent for support from caregivers to navigate daily activities. A review of Resident 1's PASRR dated 11/4/24 done at the previous SNF admission, indicated under Section III - Serious Mental Illness, question number 9 Diagnosed Serious Mental Illness, was answered no, question number 10 Suspected Mental Illness was answered no, and question number 11 Psychotropic Medication was answered no. A review of Resident 1's record indicated when he was transferred/admitted to the current SNF on 3/31/25, the facility staff did not validate or reassess his PASRR done on 11/4/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/265 at 1:05 pm, with the Director of Nursing (DON) confirmed the admission team did not reassess Resident 1's PASRR upon admission to this facility. DON confirmed the PASRR dated 11/4/24 was not accurate related to Resident 1's depression, Bipolar II, and use of sertraline (psychotropic medication for depression) and no behavioral health care plan in his record. During a phone interview 6/5/25 at 11:00 am with Social [NAME] Director (SSD) who was involved in the PASRR screenings for new admits stated We were told we did not have to repeat it. SSD stated they did not validate the accuracy of the PASRR dated 11/11/24, that was received from prior SNF.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), had a comprehensive care plan that was person-centered to meet his mental health needs. This failure resulted in a resident-to-resident altercation and a transfer to the hospital for suicidal ideation. Findings: A review of the undated facility policy titled Comprehensive Care Plans indicated it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A review of Resident 1's record indicated he was transferred from a skilled nursing facility and admitted to the new facility on 3/31/25 with diagnoses which included stroke affecting right dominant side and depression unspecified. A review of Resident 1's transfer record included a nurse practitioner note dated 3/17/25 at 1:33 pm, indicated he had Bipolar II disorder (cycle of mood swings from high to low) continue sertraline (medication for depression). Social Service Assistant notes indicated Resident 1 had four appointments with psychology on 03/17/25, 3/20/25, 3/24/25, and 3/27/25 before transfer to another skilled nursing facility. A review of a Minimum Data Set (MDS, resident assessment) dated 03/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, cognitive screening tool) and scored 9 determining moderate cognitive impairment. The Patient Health Questionnaire (PHQ-9, used to screen level of depression indicated Resident 1 was experiencing mild depression. Resident 1 was wheelchair dependent and moderately dependent for support from caregivers to navigate daily activities. A review of Resident 1's progress notes dated 5/20/25 at 1:52 pm, indicated Resident 1 exhibited one episode of aggression toward staff. Resident 1 threatened to kill staff after being wheeled out of the dining room and after choking from eating too fast. A review of Resident 1's progress notes dated 5/20/25 at 3:00 pm, a indicated a change in condition (agitation, psychosis). During morning report, nurse noted that Resident 1 threatened to kill the nurse during medication administration. Resident 1 was uncooperative with increased agitation and behaviors. At approximately 2:40 pm, Resident 1 threw an empty urinal at the Certified Nursing Assistant (CNA) while the CNA was performing resident care. Shortly after at 2:50 pm, Resident 1's nurse was made aware by CNA that Resident 1 was wheeling self-outside hallway naked. A review of Resident 1's progress notes dated 5/21/25 at 3:31 pm, indicated CNA was made aware that resident had one episode of hitting himself with palm of hand on shift. Resident was redirected with small conversation successfully. Resident 1 monitored during shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress notes 5/21/25 at 11:15 pm, indicated Resident 1 began making statements of wanting to take his life or wanted his life to end. One statement was hoping that one of his wounds would start bleeding out so much to the point that he would die. Another statement was he was going to bash his head onto the railing in the hallway by the nurse's station until he was no longer alive. He also sat and make motions of slicing his throat open multiple times along with stating he was going to kill himself one way or another once he figured it out. Resident 1 didn't relax or calm down until midnight. The physician was notified at 12:09 am, it was advised a staff member was to ensure their safety and wellbeing, be assigned to closely always watch and stay with Resident 1 (1:1, staff always assigned to monitor). A review of Resident 1's progress notes dated 5/22/25 at 5:22 pm, indicated at 3:20 pm, Resident 1 was in hallway in his wheelchair near the breakroom/hallway. Resident 2 was in vicinity of Resident 1. Resident 1 approached Resident 2 yelled get out of my way then shoved her out of her wheelchair and on to the floor. While under continuous 1:1 monitoring, Resident 1 was still able to initiate an altercation with Resident 2. A review of Social Services note dated 5/21/25 at 8:29 am, indicated Social Services Director (SSD), met with Resident 1 who was resting in bed, calm and social. SSD asked Resident 1 if he wanted to talk about incident and resident replied no not at this time. Resident 1 was placed on 1:1 intervention for 72 hours. A review of Resident 1's progress notes dated 5/22/25 at 5:22 pm, indicated at 3:20 pm, Resident 1 was in hallway in his wheelchair near the breakroom/hallway. Resident 2 was in vicinity of Resident 1. Resident 1 approached Resident 2 yelled get out of my way then shoved her out of her wheelchair and on to the floor. While under continuous 1:1 monitoring, Resident 1 was still able to initiate an altercation with Resident 2. During a phone interview 6/25/25 at 11:00 am, SSD explained she participates in creating care plans for residents along with nursing and Interdisciplinary Team (multiple disciplines who evaluate and develop care plans for residents). SSD confirmed she uses all progress notes in the record and was behind on developing resident plan of care. SSD confirmed Resident 1 did not have a care plan that addressed his behavioral health needs. During a concurrent interview and record review and interview on 6/4/265 at 1:05 pm, the Director of Nursing (DON) confirmed the admission team did not identify that Resident 1 had Bipolar II disorder or that he was participating in psychology visits at the other facility. DON was not aware that his MDS PHQ-9 indicated Resident 1 was mildly depressed upon admission. DON confirmed there were no behavioral health care plans in his record, nor were there any mental health appointments provided to Resident 1 at the facility since admission.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Resident 1 had a behavioral health evaluation and services to meet Resident 1's psychiatric behavioral needs. This failure resulted in a resident-to-resident altercation and a transfer to the hospital for suicidal ideation. Findings: A review of Resident 1's record indicated he was transferred from a skilled nursing facility and admitted to the new facility on 3/31/25 with diagnoses which included stroke affecting right dominant side and depression unspecified. A review of Resident 1's transfer record included a nurse practitioner note dated 3/17/25 at 1:33 pm, indicated he had Bipolar II disorder (cycle of mood swings from high to low) continue sertraline (medication for depression). Social Service Assistant notes indicated Resident 1 had four appointments with psychology on 03/17/25, 3/20/25, 3/24/25, and 3/27/25 before transfer to another skilled nursing facility. A review of Resident 1's PASRR dated 11/4/24 done at the previous SNF admission, indicated under Section III - Serious Mental Illness, question number 9 Diagnosed Serious Mental Illness, was answered no, question number 10 Suspected Mental Illness was answered no, and question number 11 Psychotropic Medication was answered no. A review of Resident 1's record indicated when he was transferred/admitted to the current SNF on 3/31/25, the facility staff did not validate or reassess his PASRR done on 11/4/24. A review of a Minimum Data Set (MDS, resident assessment) dated 03/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, cognitive screening tool) and scored 9 determining moderate cognitive impairment. The Patient Health Questionnaire (PHQ-9, used to screen level of depression indicated Resident 1 was experiencing mild depression. Resident 1 was wheelchair dependent and moderately dependent for support from caregivers to navigate daily activities. A review of Resident 1's progress notes indicated 5/20/25 at 1:52 pm, Resident 1 exhibited one episode of aggression toward staff. Resident 1 threatened to kill staff after being wheeled out of the dining room and after choking from eating too fast. A review of Resident 1's progress notes dated 5/20/25 at 3:00 pm, a indicated a change in condition (agitation, psychosis). During morning report, nurse noted that Resident 1 threatened to kill the nurse during medication administration. Resident 1 was uncooperative with increased agitation and behaviors. At approximately 2:40 pm, Resident 1 threw an empty urinal at the Certified Nursing Assistant (CNA) while the CNA was performing resident care. Shortly after at 2:50 pm, Resident 1's nurse was made aware by CNA that Resident 1 was wheeling self-outside hallway naked. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress notes dated 5/21/25 at 3:31 pm, indicated CNA was made aware that resident had one episode of hitting himself with palm of hand on shift. Resident 1 was redirected with small conversation successfully. Resident 1 monitored during shift. A review of Resident 1's progress notes 5/21/25 at 11:15 pm, indicated Resident 1 began making statements of wanting to take his life or wanted his life to end. One statement was hoping that one of his wounds would start bleeding out so much to the point that he would die. Another statement was he was going to bash his head onto the railing in the hallway by the nurse's station until he was no longer alive. He also sat and make motions of slicing his throat open multiple times along with stating he was going to kill himself one way or another once he figured it out. Resident 1 didn't relax or calm down until midnight. The physician was notified at 12:09 am, it was advised a staff member was to ensure their safety and wellbeing, be assigned to closely always watch and stay with Resident 1 (1:1, staff always assigned to monitor). A review of Resident 1's progress notes dated 5/22/25 at 5:22 pm, indicated at 3:20 pm, Resident 1 was in hallway in his wheelchair near the breakroom/hallway. Resident 2 was in vicinity of Resident 1. Resident 1 approached Resident 2 yelled get out of my way then shoved her out of her wheelchair and on to the floor. While under continuous 1:1 monitoring, Resident 1 was still able to initiate an altercation with Resident 2. A review of Social Services note dated 5/21/25 at 08:29 am indicated, Social Services Director (SSD) met with resident who was resting in bed, calm and social. SSD asked Resident if he wanted to talk about incident and resident replied no not at this time. Resident 1 was placed on 1 to 1 intervention for 72 hours. A review of Resident 1's progress notes indicated 5/22/25 at 5:22 pm, approximately 3:20 pm, resident was in hallway in wheelchair near breakroom/laundry room. Resident 2 was in vicinity of Resident 1. Resident 1 approached Resident 2, he yelled get out of my way then proceeded to shoved her out of her wheelchair and on to the floor. Residents were immediately separated by staff. Resident 1 then wheeled himself over to the handrail and began to repeatedly bang his head against it. Resident 1 was pulled away from the railing and Resident 1 stated call the police, I don't care. The nurse stayed with Resident 1 and took him to the end of the hallway to attempt to deescalate the situation. The nurse got on the phone with the physician who gave the order to send Resident 1 to the hospital for psychiatric evaluation. The nurse called 911. Resident 1 again wheeled up to the handrail and started banging his head repeatedly. Emergency Medical Team (EMT) and policy arrived at the facility. The Police advised EMT to place Resident 1 on a 72-hour hold at the hospital. During a concurrent interview and record review and interview on 6/4/265 at 1:05 pm, the Director of Nursing (DON) confirmed the admission team did not identify that Resident 1 had Bipolar II disorder or that he was participating in psychology visits at the other facility. DON was not aware that his MDS PHQ-9 indicated Resident 1 was mildly depressed upon admission. DON confirmed there were no behavioral health care plans in his record, nor were there any mental health appointments provided to Resident 1 at the facility since admission. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview 6/5/25 at 11:00 am with Social [NAME] Director (SSD) who was involved in the PASRR screenings for new admits stated We were told we did not have to repeat it. SSD stated they did not validate the accuracy of the PASRR dated 11/11/24, that was received from prior SNF. When asked if Resident 1 had seen psychology since he has been there? SSD stated, he was offered a psych appointment but can't find date.