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	06/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, this facility failed to accommodate the need to communicate with of one (Resident 1) of four sampled residents when the facility failed to provide any means of translation to a Hmong only speaking resident. This failure resulted in Resident 1 not being properly assessed and Resident 1's pain was not treated. Findings: A record review of Resident 1's face sheet indicated an admission date of 4/24/25 for hemiplegia (a condition characterized by paralysis of one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body) following cerebral infarction (tissue death caused by a lack of blood supply to the affected area) affecting right dominant side, and dysphagia (difficulty swallowing). Resident 1 was her own representative. The only language Resident 1 speaks was Hmong. During an interview on 5/9/25 at 11:10 am of Director of Nursing (DON), DON stated that the facility does not have any way of translating for their non-English speaking residents. By a record review of the Minimum Data Set (MDS) assessment completed on 4/27/25, the Section C - Cognitive Patterns indicated Resident 1 to have a code of 0 (resident is rarely/never understood). By a record review of Care Plans (Undated), indicated Resident 1 had a communication deficit related to language barrier primary language is Hmong Social Services (SS) provided a picture binder for communication. The facility indicated it would provide resident with a communication board. On an interview with family member (FM) 1 on 5/8/25 at 1:10 pm by phone, FM 1 stated the facility has no way of translating and Resident 1 only speaks Hmong. On an interview of family member FM 2 on 5/9/25 at 4:00 pm by phone, FM 2 stated Resident 1 only speaks Hmong and the only way the facility has translated is to ask family members. There was no other means of translation by the facility to Resident 1. During an interview on 5/9/25 at 1:23 pm with Certified Nursing Assistant (CNA) 1, CNA 1 stated there is no way to translate or to communicate with Resident 1. The facility does not provide any means of translation or communication. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	By concurrent observation and interview on 5/9/25 at 1:43 pm with CNA 2, went to Resident 1's room (12-2). CNA 2 confirmed the facility does not have a way to communicate with the resident. CNA 2 confirmed there were no communication boards in drawers and no pictures provided by the facility. Observed no communication boards or pictures in Resident 1's room. During an interview of LN 2 on 6/11/25 at 1:40 pm, asked if LN 2 how she communicated with Hmong only speaking Resident 1? LN 2 stated the facility has no way to translate with Resident 1.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, this facility failed to address and treat the pain of one (Resident 1) of four sampled residents when Resident 1 had an accident in the shower chair, sustained an injury, and complained of pain. This resulted in a complete omission of pain treatment and management and Resident 1 suffering without any pain relief. Findings: A policy titled Pain Management (Undated), indicated that the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan . This policy defines acute pain as pain that is usually sudden onset and time-limited with a duration of less than one month and often is caused by injury . The facility will: 1. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated and evaluate the resident for pain, during ongoing scheduled assessments, and when a significant change in condition occurs. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include facial expressions . A record review of Resident 1's face sheet indicated an admission date of 4/24/25 for hemiplegia (a condition characterized by paralysis of one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body) following cerebral infarction (tissue death caused by a lack of blood supply to the affected area) affecting right dominant side, and dysphagia (difficulty swallowing). Resident 1 was her own representative. The only language Resident 1 speaks was Hmong. An interview on 5/9/25 at 1:23 pm of Certified Nursing Assistant (CNA) 1, asked what happened with Resident 1 while in the shower chair on 5/6/25? CNA 1 stated Resident 1 is very tiny, and resident was in the shower chair and she slipped down with her rear-end that fell into the hole in the shower chair. Resident 1's right leg got caught in the opening and it cut the top of her right leg at the thigh. CNA 1 stated she went to get Resident 1 out of the hole in the shower chair. CNA 1 stated the Director of Nursing (DON), and Licensed Vocational Nurse (LN) 1 came running into shower room. CNA 1 stated patient said, pain and pointed to the middle of her right thigh. CNA 1 stated Resident 1 had a grimace on her face. By concurrent observation and interview on 5/9/25 at 1:43 pm with CNA 2, went to Resident 1's room (12-2). Observed a long circular scab on Resident 1's right middle thigh (going perpendicular to the leg, going around the front part of leg, mid-thigh) and on the inner thigh, Resident 1 had a scab that went down the leg, parallel to it. CNA 2 stated, Resident 1 did have pain. By concurrent interview and record review of shower sheet dated 5/6/25 at 1:23 pm by CNA 1 did not chart any evidence of the incident. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There are no records that indicate an accident on 5/6/25 that occurred with Resident 1 in the electronic medical record. There are no social worker notes, no notes on consulting with the physician, no psycho-social follow up, no care plans, no charting in the system indicating and accident had occurred, or pain was addressed. A record review of the Medication Administration Record (MAR) for 5/1/25 - 5/9/25 indicated Resident 1 was not administered any new pain medication from the incident on 5/6/25, and the MAR indicated Resident 1's pain score was 0 every day. Prior to the accident, Resident 1 had Tylenol ordered, but it was not given to the resident on or after injury. A record review of all active orders for Order Summary Report as of 5/6/25 to 5/9/25 indicated no orders for any physician evaluation of Resident 1 after the accident and sustained injury on 5/6/25. An interview of family member (FM) 1 on 5/8/25 at 1:10 pm by phone call stated Resident 1 did have an accident while in the shower room on 5/6/25. She was told about the incident. FM 1 stated the accident did have something to do with shower chair not fitting Resident 1 and Resident 1 fell in it. FM 1 stated she did hear Resident 1 say the words, pain, pain to staff. FM 1 stated another family member FM 2 was at the facility that day of the accident in the shower chair on 5/6/25. An interview on 5/9/25 at 4:00 pm, called FM 2. FM 2 stated she was in Resident 1's room when the CNA 1 brought Resident 1 back from the shower. CNA 1 reported that Resident 1 had an accident in the shower because her bottom and legs went down into the hole of the shower chair. CNA 1 reported Resident 1 got stuck inside of the hole and the gap in the front of the shower chair. FM 2 stated Resident 1 was complaining about having pain. An interview of Licensed Nurse (LN) 1 on 6/10/25 at 12:20 pm asked if LN 1 remembered the shower chair accident with Resident 1? LN 1 stated LN 1 did come to the shower room on 5/6/25 to assist with Resident 1. LN 1 confirmed there was an accident where the resident was stuck inside the shower chair. Her rear-end went down into the chair and she was twisted and her right leg was sandwiched in the opening in the front of shower chair. LN 1 stated this resident was not her assigned resident that day so she did not chart on it. LN 1 stated she saw an injury to the right middle thigh where resident was stuck in shower chair. LN 1 stated the shower chair had cut the front of Resident 1's right thigh. LN 1 stated Director of Nursing (DON) was aware of incident. An interview of LN 2 on 6/11/25 at 1:40 pm and asked if LN 2 remembered the shower chair accident with Resident 1 on 5/6/25? LN 2 stated LN 2 was the nurse for Resident 1 on this day of 5/6/25. Stated Resident 1 sunk into the shower chair. LN 2 stated staff pulled her out and moved resident onto a different shower chair. LN 2 stated Resident 1's leg was red. LN 2 could not recall any other information. When asked if Resident 1's right middle thigh was bleeding? LN 2 stated, I cannot recall. When asked if LN 2 reported this incident to the physician? LN 2 stated, I cannot recall. When asked if Resident 1's pain was addressed or treated? LN 2 stated, I cannot recall. An interview on 6/11/25 at 2:15 pm with Infection Preventionist (IP), stated he was aware of the accident concerning Resident 1 on 5/6/25. IP stated that this accident and injury was not addressed at all by nursing staff or facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, this facility failed to ensure licensed staff the competencies and skill set necessary to provide nursing care for one (Resident 1) of four sampled residents when: Nursing staff did not assess and document when Resident 1 had an accident and sustained an injury. Nursing staff did not complete a change in condition or alert the physician. There was no care plans completed to address the accident and injury Resident 1 had. This resulted in Resident 1 not receiving the treatment and pain relief needed for Resident 1's injury. Findings: A record review of Resident 1's face sheet indicated an admission date of 4/24/25 for hemiplegia (a condition characterized by paralysis of one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body) following cerebral infarction (tissue death caused by a lack of blood supply to the affected area) affecting right dominant side, and dysphagia (difficulty swallowing). Resident 1 was her own representative. The only language Resident 1 speaks was Hmong. A review of a policy titled, Nursing Assessment Policy (Undated) indicated, Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. A review of a policy titled, Notification of Changes (Undated) indicated, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances that required notification included: accidents resulting in injury. An interview on 5/9/25 at 1:23 pm of Certified Nursing Assistant (CNA) 1, asked what happened with Resident 1 while in the shower chair on 5/6/25? CNA 1 stated Resident 1 is very tiny, and resident was in the shower chair and she slipped down with her rear-end that fell into the hole in the shower chair. Resident 1's right leg got caught in the opening and it cut the top of her right leg at the thigh. CNA 1 stated she went to get Resident 1 out of the hole in the shower chair. CNA 1 stated the Director of Nursing (DON), and Licensed Vocational Nurse (LN) 1 came running in. CNA 1 stated patient said, pain and pointed to the middle of her right thigh. CNA 1 stated Resident 1 had a grimace on her face. A review of a PubMed study cited nonverbal ways to assess pain, Ghayem H, [NAME] MR, Aghaei B, Norouzadeh R. The Effect of Training the Nonverbal Pain Scale (NVPS) on the Ability of Nurses to Monitor the Pain of Patients in the Intensive Care Unit. Indian J Crit Care Med. 2023 Mar;27(3):195-200. doi: 10. 5005/jp-journals-10071-24425. PMID: 36960117; PMCID: PMC10028721. The study indicated, Nonverbal pain scale is a combination of behavioral and physiological measurements and provides a more reliable assessment of pain. The study also indicated an example of facial expressions nurses could assess are the following: grimacing, frowning, or other expressions that might indicate pain. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Medication Administration Record from 5/1/25 through 5/9/25 indicated Resident 1 was not administered any pain medication from the incident on 5/6/25, and indicated Resident 1's pain score was 0 every day. By concurrent interview and record review of shower sheet dated 5/6/25 at 1:23 pm by CNA 1 did not chart any evidence of the incident. By concurrent observation and interview on 5/9/25 at 1:43 pm with CNA 2, went to Resident 1's room (12-2). Observed a long circular scab on Resident 1's right middle thigh (going perpendicular to the leg, going around the front part of leg, mid-thigh) and on the inner thigh, Resident 1 had a scab that went down the leg, parallel to it. CNA 2 stated, Resident 1 did have pain. An interview on 5/9/25 at 11:10 am of the DON, DON stated she was unaware of the accident and the injury of Resident 1 in the shower chair that occurred on 5/6/25. An interview of family member (FM) 1 on 5/8/25 at 1:10 pm by phone call stated Resident 1 did have an accident while in the shower room on 5/6/25. She was told about the incident. FM 1 stated the accident did have something to do with shower chair not fitting Resident 1 and Resident 1 fell in it. FM 1 stated she did hear Resident 1 say the words, pain, pain to staff. FM 1 stated another family member FM 2 was at the facility that day of the accident in the shower chair on 5/6/25. An interview on 5/9/25 at 4:00 pm, called FM 2. FM 2 stated she was in Resident 1's room when the CNA 1 brought Resident 1 back from the shower. CNA 1 reported that Resident 1 had an accident in the shower because her bottom and legs went down into the hole of the shower chair. CNA 1 reported Resident 1 got stuck inside of the hole and the gap in the front of the shower chair. FM 2 stated Resident 1 was complaining about having pain. An interview of Licensed Nurse (LN) 1 on 6/10/25 at 12:20 pm asked if LN 1 remembered the shower chair accident with Resident 1? LN 1 stated LN 1 did come to the shower room on 5/6/25 to assist with Resident 1. LN 1 confirmed there was an accident where the resident was stuck inside the shower chair. Her rear-end went down into the chair and she was twisted and her right leg was sandwiched in the opening in the front of shower chair. LN 1 stated this resident was not her assigned resident that day, so she did not chart on it. LN 1 stated she saw an injury to the right middle thigh where resident was stuck in shower chair. LN 1 stated the shower chair had cut the front of Resident 1's right thigh. LN 1 stated Director of Nursing (DON) was aware of the incident. An interview of LN 2 on 6/11/25 at 1:40 pm and asked if LN 2 remembered the shower chair accident with Resident 1 on 5/6/25? LN 2 stated LN 2 was the nurse for Resident 1 on this day of 5/6/25. Stated Resident 1 sunk into the shower chair. LN 2 stated staff pulled her out and moved resident onto a different shower chair. LN 2 stated Resident 1's leg was red. LN 2 could not recall any other information. When asked if Resident 1's right middle thigh was bleeding? LN 2 stated, I cannot recall. When asked if LN 2 reported this incident to the physician? LN 2 stated, I cannot recall. When asked if Resident 1's pain was addressed or treated? LN 2 stated, I cannot recall. A record review of the Nursing Progress Notes and Alert Charting from 5/5/25-5/8/25, there were no notes or assessments on Resident 1's accident or injury. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Care Plans (all undated) from admission on [DATE] through day of injury on 5/9/25 for Resident 1, there was no care plan for the accident and injury indicated. A record review of the Minimum Data Set (MDS) assessment completed on 4/27/25, the Section C - Cognitive Patterns indicated Resident 1 to have a code of 0 (resident is rarely/never understood). An interview on 6/11/25 at 2:15 pm with Infection Preventionist (IP), stated he was aware of the accident concerning Resident 1 on 5/6/25. IP stated that this accident and injury was not addressed at all by nursing staff or facility.