

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 08/01/2025
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)
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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 2) was protected from physical abuse when Resident 3 hit Resident 2 with a closed fist which resulted in a bruised right eye. This failure caused Resident 2 to feel anger and discomfort, and had the potential to result in emotional stress, embarrassment, feelings of neglect, and the potential for negative clinical outcomes. Findings: A review of the facility's policy revised 2025, titled, Abuse, Neglect, and Exploitation, indicated it is the policy of this 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. Physical Abuse included, but is not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior through corporal punishment. This facility's policy also indicated the facility will develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. During a review of Resident 2's medical record, the admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis (MS, a progressive debilitating disease of the nervous system), dehydration (absence of enough water needed in the body), diabetes (too much sugar in the blood), dementia (progressive loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life), depression (prolonged feelings of sadness, hopelessness and loss of interests), high blood pressure, heart disease, dysphagia (difficulty swallowing), and the need for personal care and dependence on wheelchair. A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 8/4/25, indicated that Resident 2 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). During a review of Resident 2's medical record, a document dated 6/14/25, titled, Progress Note, from a local hospital indicated chief complaint right eye swelling status post assault. Resident stated he was punched once in the eye by a resident at his care facility. During a review of Resident 3's medical record, the admission Record, indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular and fast heart beat), heart disease, diabetes (too much sugar in the blood), Bi-polar disorder (mental health condition with severe mood swings), severe protein malnutrition (poor nutrition), chronic gout (a type of inflammatory arthritis caused by too many wastes particle of uric acid), chronic obstructive pulmonary disease (COPD, a chronic and progressive lung disease), depression (prolonged feelings of sadness, hopelessness and loss of interests), high blood pressure, history of venous thrombosis and embolism (a blood clot that travels to the lungs) and osteoarthritis (joint pain and stiffness). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 6/12/25, indicated that Resident 3 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). During an interview on 7/10/25 at 3:20 pm, Resident 2 stated, I was sitting at my doorway, and I asked [Resident 3] to stop talking so loud and to leave the room, he just hit me in the eye. I admit, I probably yelled at him before he hit me because I am hard of hearing (HOH). It just all happened so fast. I did feel discomfort for a few days. During an interview on 7/10/25 at 3:50 pm, Resident 3 stated, Listen, I know it was wrong, I just have a lot of stress on me, it just happened. I never planned to hit [Resident 2]. I just had a reaction to his yelling. I was just trying to talk with my friend that also lives in that room. I told him I was sorry; I never meant to hurt him. During an interview on 7/10/25 at 4:25 pm, Registered Nurse (RN) B stated, I was in another room, and we heard a lot of yelling. I along with other staff went into the room but [Resident 3] had already hit [Resident 2] in the eye. Two men fighting is what happened. We then called 911 and sent [Resident 2] to the hospital to make sure he was okay. During an interview on 7/10/25 at 5:45 pm, the Director of Nursing (DON) confirmed Resident 2 was physically abused by Resident 3. DON stated, [Resident 2] did have a Right black eye for a few days, and I do confirm he stated he was having discomfort. During a phone interview on 7/17/25 at 12:30 pm, the administrator confirmed Resident 3 physically abused Resident 2 when he was hit in the right eye.</p>		

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<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.</p> <p>(continued on next page)</p>

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<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's nursing staff failed to recognize and report a change in condition for one of eight sampled residents (Resident 7). This failure caused Resident 7 to have a delay in acute care treatment required, and the need for new placement after a hospitalization related to the lack of communication when Resident 7 had a change in condition. A review of the facility's policy revised 8/2024, titled, Notification of Changes, indicated the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. During a review of Resident 7's medical record, the admission Record, indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular and fast heart beat), aortic valve disorder (a major heart valve that narrows, decreases blood circulation), bilateral pneumonia (infection of both lungs), Bi-polar disorder (mental health condition with severe mood changes), Chronic Obstructive Pulmonary Disease (COPD, a chronic and progressive lung disease), Major depressive disorder (prolonged feelings of sadness, hopelessness and loss of interests), history of sepsis (a severe reaction to an infection), benign prostatic hyperplasia (BPH, enlarged prostate), hyponatremia (low level of sodium in the blood), history of venous thrombosis and embolism (a blood clot that travels to the lungs) and schizophrenia (a condition that has severe effects on your physical and mental well-being. It disrupts how your brain works, interfering with things like your thoughts, memory, senses and behaviors). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 6/17/25, indicated that Resident 7 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). During a review of Resident 7's medical record, a document dated 7/2/25, titled, Blood Pressure Summary, the blood pressure (B/P, measured by two numbers, the top number systolic when your heart beats, and the bottom number diastolic is when your heart rests by Millimeters of Mercury, (mmHg, a unit of measure) normal range for B/P adults are 120/80. Resident 7's B/P was documented at 82/64 mmHg with a note that indicated the following: Systolic low of 90 exceeded. During a review of Resident 7's medical record, a document dated 7/2/25 at 8:07 pm, titled, Progress Note, indicated Resident 7's blood pressure was 82/64 mmHg, and this note did not indicate more than one measurement, or which position Resident 7 was in when taking the B/P. MD orders to push fluids, but no noted documentation to send Resident 7 for an evaluation. This progress note indicated resident was own Responsible Party (RP). During a review of Resident 7's medical record, a document dated 7/2/25 at 11:32 pm, titled, Progress Note, indicated the following: At about 22:25 the cops arrived at facility. The cops went in to see resident. Resident was talking on the phone with daughter at the time the cops arrived. Per resident and daughter's request, resident agreed with his daughter to be sent out to the hospital due to daughter's concern of resident's possible allergic reaction to Buspirone. Resident has NKA and did not show any signs of allergic reactions prior to being discharged. Resident is his own RP. MD notified and aware. During a review of Resident 7's medical record, a document dated 7/2/25 at 11:57 pm, titled, Progress Note, indicated the following: Police officers spoke with resident, and after a half hour, officers inform nurse that resident would like to be sent out to the hospital, per his request (resident full code). Notified MD at 22:51, given okay. Called EMS at 22:51 to request transfer. 2300 EMS arrives to take resident via gurney to hospital. Resident brought along his Continuous Positive Airway Pressure (CPAP, machine), a suitcase, wallet, and a black bag. Resident was on phone with daughter on speaker phone, having EMS repeat conversation having in room. Daughter stated she is recording conversation. Resident stated that he did not want to come back and was informed that a family member may return to pick up the rest of his belongings. EMS left the facility with resident at 23:25. During a concurrent interview and record review on 7/10/25 at 5:25 pm, the Director of Nursing (DON) confirmed the Family Member (FM) should be updated with any change of condition even if they are their own RP by the nursing staff. DON confirmed their facility policy for change of condition was not followed for Resident 7. The DON agreed the FM and Resident 7 were upset and this was avoidable if their policy had been followed. During a follow-up interview on 7/10/25 at 5:40 pm, the DON confirmed Resident 7 had a change of condition with an extremely low blood pressure and should have been sent to the local hospital for an evaluation without the police being called for help on 7/2/25. DON stated, I confirm Resident 7 had a delay in care and should have been sent out to the local hospital earlier. I do confirm Resident 7 was admitted to a local hospital for an extended period, and they were not happy with</p>		