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	08/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update the care plan for three of three residents when:Resident 1's care plan was not updated with a 24 hour 1:1 monitor (where one staff member is assigned to continuously monitor a single resident for behaviors, needs, etc.) and visual checks every 15 minutes at night.Resident 2's care plan did not state an intervention of a 1:1 monitor.Resident 3's care plan did not state an intervention of a 1:1 monitor.This failure had the potential to result in physical and/or psychosocial harm to other residents and staff.During a record review of facility policy titled Care Plan Revisions Upon Status Change dated August 2024, indicated the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Facility policy further indicated the care plan will be updated with the new or modified interventions. Facility policy also indicated care plans will be modified as needed by the MDS coordinator or other designated staff member.A record review of Resident 1's admission record indicated she was re-admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, including both high and low periods), schizoaffective disorder (a mental health condition characterized by symptoms of both schizophrenia (like hallucinations and delusions) and a mood disorder (like depression or mania), adjustment disorder with mixed anxiety and depressed mood (a mental health condition where an individual experiences an excessive emotional or behavioral reaction to a stressful life event or change), and parkinsonism (symptoms can include tremor, bradykinesia (slowed movement), rigidity (stiffness), and postural instability).During a record review of Progress Notes Situation-Background-Assessment-Recommendation (SBAR - a communication technique used to structure and improve communication, especially in high-[NAME] situations like healthcare) Note for Providers dated 4/22/25 4:40 pm, indicated provider was notified of incident between Resident 1 and another resident. Provider recommended a 1:1 until further notice.During a record review of Interdisciplinary Team (IDT - a group of healthcare professionals who collaborate to develop and implement care plans for residents) Interdisciplinary Post Event Note dated 4/23/25 11:50 am, indicated IDT met and discussed the incident between Resident 1 and another resident on 4/22/25. IDT note further indicated a 1:1 will be in place until behaviors are decreased.During a record review of Resident 1's progress notes 7/31/25 2:29 pm, indicated IDT met to discuss resident. Progress note further indicated Resident 1 placed on visual checks every 15 minutes overnight when she was asleep by staff.During a record review Resident 1's care plan dated 6/25/25, indicated Resident 1 was placed on a 1:1 supervision until behaviors decreased. Care plan further indicated Resident 1's behaviors fluctuated. Care plan also indicated when Resident 1 was not having active behaviors, frequent checks were acceptable. Care plan indicated when Resident 1's behaviors increased, a 1:1 was to be provided. Care plan also indicated 1:1 supervision would continue to be reviewed by the IDT team for the need of a 1:1 vs frequent supervision to avoid distress to the resident and avoid further antagonizing her frustration and behaviors. Care plan did not indicate a 24 hour 1:1 monitor as an intervention for Resident 1. Care plan did not indicate visual checks every 15 minutes as an intervention for Resident 1.A record review of Resident 2's admission record indicated he was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury (a disruption of normal brain function caused by an external force, like a bump, blow, or jolt to the head, or a penetrating head injury), traumatic subdural hemorrhage (a collection of blood between the brain's outer covering (dura mater) and the brain itself, caused by head trauma), and aphasia (a language disorder that affects a person's ability to communicate). During a record review of Resident 2's progress notes dated 7/12/25 11:40 pm, indicated Resident 2 noted with multiple episodes of threatening to kill 1:1 staff. Resident on 1:1 watch due to being a high fall risk. During a record review of Resident 2's progress notes dated 8/4/25 6:52 am, indicated Resident on 1:1 due to increased behaviors; banging head on wall.During a record review of Resident 2's IDT notes dated 7/31/25 9:40 am, indicated Resident has impulsive behaviors related to traumatic brain injury. Resident has behaviors of striking out, becoming easily agitated, and exit seeking. IDT determines that resident remain on 1:1 for this time.During a record review of Resident 2's care plan, there was no documentation of a 1:1 monitor intervention.A record review of Resident 3's admission record indicated he was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels, alternating between periods of mania (or hypomania) and