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	11/25/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of six sampled residents (Resident 1) remained free from restraint when a staff member restrained Resident 1 upright in a wheelchair. This placed Resident 1 at increased risk for injury, accident, and negative health outcomes.Findings: During a review of the facility policy titled, Restraint Free Environment, revised 2025, indicated the facility Prohibits the use of physical restraint for discipline or staff convenience and limits restraint use to circumstances in which medical symptoms warrant the use of such restraints. The policy defined Physical restraint to include the following example: Tucking in a sheet tightly so the resident cannot get out of bed . fastening fabric or clothing so that a resident's freedom of movement is restricted. The policy further clarified; Falls do not constitute . a medical symptom that warrants the use of physical restraints. During a review of Resident 1's clinical record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction related to illness), pneumonia, and Chronic Obstructive Pulmonary Disease (difficulty breathing.) During a review of Resident 1's physician's order, dated 11/10/25, indicated that Resident 1 had capacity and could make his own medical decisions.During an interview on 11/25/25 at 10:40 am, with the DON (Director of Nurses,) the DON stated that the facility had confirmed that Certified Nurse Assistant (CNA) B had restrained Resident 1 on 11/16/25. DON stated CNA B had confirmed she tied Resident 1 to his chair with a sheet and asserted CNA B took this action at Resident 1's request. DON stated that CNA B had been immediately removed from patient care once the facility was notified of the accusation. The facility investigation confirmed that CNA B restrained the resident, and the facility is in the process of terminating the staff member. DON stated that no residents currently have an order for the use of restraints. DON stated that Resident 1 is no longer at the facility, Resident 1 was transferred on to the acute care hospital on [DATE].During an interview on 11/25/25 at 12:35 pm, with the CNA B, CNA B confirmed that she had been working on 11/16/25 and had used a bed sheet to tie Resident 1 upright in a chair. CNA B confirmed she secured the bed sheet with a knot at the back of the chair, and that Resident 1 could not release himself. CNA B stated she did this at Resident 1's request but now realizes she should have refused. CNA B confirmed she had received training on resident abuse and restraints from the facility and as part of her CNA training.

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