

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  01/13/2026
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure that four out of four sampled residents (Residents 1, 2, 3, and 4) had an individualized smoking safety care plan that identified smoking-related risks, resident-specific interventions, and safety measures. Despite the facility's knowledge that these residents smoked, there was no documented care-planning process to address smoking supervision, designated smoking location, safety precautions, or ongoing evaluation and revision of the plan of care. This failure resulted in residents not receiving individualized, person-centered care related to smoking safety, with smoking-related risks remaining unrecognized and unmet, and had the potential to place residents at risk for decline in health status, including injury or other adverse outcomes. During a review of the facility's policy and procedure titled Resident Smoking - Smoke-Free Facility, revised 12/1/25, the policy stated that any resident deemed safe to smoke, with or without supervision, will be allowed to smoke only in designated smoking areas in accordance with the resident's care plan. The policy further stated that all safe smoking measures will be documented in each resident's care plan and communicated to all staff, visitors, and volunteers responsible for supervising residents while smoking, and that supervision will be provided as indicated on the resident's care plan. The policy also stated that if a resident or family does not abide by the smoking policy, the plan of care may be revised to include additional safety measures. During record reviews on 12/19/25, Residents 1, 2, and 3's care plans and physician orders dated December 2025 were reviewed. The care plans lacked documented, individualized interventions to support safe smoking practices, including supervision requirements, designated smoking areas, or other smoking-related safety measures. A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included COPD, Tobacco use, alcohol abuse, ataxia following cerebral infarction, and other psychoactive substance dependence with intoxication delirium. Resident 1's brief interview for mental status (BIMs) score was 15, indicating Resident 1 was cognitively intact. During a review of Resident 1's Interdisciplinary (IDT) Progress Note, dated 12/17/25, the IDT note indicates, despite education the resident continues to smoke cigarettes on facility grounds. Resident has been observed smoking near hazardous areas and sneaking out multiple times during the day and night. Nicotine patch therapy was initiated but Resident refuses to use patches and continues to obtain cigarettes and lighters from outside sources. The note also indicates that the care plan is to be updated to reflect elopement risk, substance use behaviors and refusal of nicotine replacement therapy. During a review of Resident 1's care plan, dated 11/26/25, the Care Plan did not indicate elopement risk or any kind of safe smoking plan. During a review of Resident 2's medical record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis that include schizoaffective disorder, muscle weakness with frontal lobe and executive function deficit. Resident 2's brief interview for mental status (BIMs) score was 15, indicating Resident 2 was cognitively intact.</p> <p>(continued on next page)</p>

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2's care plan, dated 12/12/25, the Care Plan did not indicate a safe smoking plan. During an interview with Resident 2 on 12/17/25 at 2:00 p.m., stated he does smoke cigarettes and he was told he must go off of property. Out of sight, out of mind. The administrator here told me I need to go off the property because they don't allow smoking here. Resident 2 stated he feels like they don't care about him or what he wants. During a review of Resident 3's medical record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that includes pleural effusion, malnutrition, nicotine dependence, difficulty walking, and kidney disease. Resident 3's BIM score is 14, indicating Resident 3 is mentally intact. During a review of Resident 3's care plan, dated 11/19/25 the Care Plan did not indicate a safe smoking plan. During an interview with Resident 3 on 12/19/25 at 10:00 a.m., Resident 3 stated he does go outside to smoke cigarettes 1-2 times a day. Resident 3 stated he goes out by himself but leaves his oxygen in the room. Resident 3 stated he was signed off by physical therapy, which means he is safe to go outside by himself. Resident 3 stated he wishes he did not have to go so far to smoke his cigarette. During a review of Resident 4's medical record indicated Resident 4 was admitted on [DATE] with diagnosis that include diabetes, chronic obstructive pulmonary disease, muscle weakness, and difficulty walking. Resident BIMs score was 15 indicating he is cognitively intact. During a concurrent interview and record review on 12/19/25 at 12:20 p.m. with Registered Nurse (RN) A, Resident 4's care plan and physician orders dated December 2025 were reviewed. The care plan addressed smoking cessation; however, there were no documented interventions or physician orders addressing safe cigarette smoking practices, including supervision requirements, designated smoking location, or other safety measures. RN A stated she was unable to locate a care plan or physician order authorizing Resident 4 to smoke cigarettes and therefore contacted the Administrator to ask whether it was acceptable for the resident to smoke cigarettes due to the absence of documented direction in the medical record. RN A further stated she was aware of the facility's non-smoking policy and routinely educates residents regarding the policy. RN A stated she believed residents who smoke cigarettes go outside around the corner of the building and clarified that she has not supervised any residents while smoking cigarettes. RN A stated she had been told that residents were not allowed to smoke cigarettes and there was no documentation in the care plan directing staff to allow or supervise cigarette smoking. During an observation on 12/19/25 at 10:20 a.m., Resident 4 exited the facility and wheeled himself in his wheelchair across uneven terrain in cold weather conditions to an area off facility property. The resident was observed smoking in that area. The location observed was not identified as a designated smoking area. No staff supervision or redirection was observed during the observation period. During an interview on 12/19/25 at 12:40 p.m. with the Administrator, the Administrator confirmed awareness that Residents 1, 2, 3, and 4 smoked cigarettes. The Administrator stated that the residents went outside to smoke cigarettes but acknowledged the facility did not have a designated smoking area at the time of the interview. The Administrator further stated that the facility was not currently following its smoke-free facility policy and indicated the facility was in the process of obtaining supplies and equipment to establish a designated smoking area and revise the smoking policy. The Administrator confirmed that Residents 1, 2, 3, and 4 did not have individualized cigarette smoking safety care plans, including documented interventions addressing cigarette smoking supervision, designated smoking location, or safety measures.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement and enforce its smoking policy when four of four residents were identified as smokers and the facility did not establish a designated smoking area as required by facility policy. This had the potential to place residents who smoke at increased risk for injury due to smoking in undesignated areas. During a review of the facility's Resident Smoking Policy, dated 12/01/25, the policy indicated that residents deemed safe to smoke, with or without supervision, are permitted to smoke only in designated smoking areas, at designated times, and in accordance with the resident's individualized care plan. During a review of the facility's Resident Smoking - Smoke-Free Facility Policy, dated 12/01/25, the policy indicated that smoking, including the use of electronic cigarettes, is prohibited in all areas except the designated smoking area, and that a designated smoking area sign will be prominently posted. During an interview on 12/17/25 at 10:30 a.m. with Registered Nurse (RN) A, RN A stated that there are four residents who smoke. RN A confirmed the facility is a non-smoking facility and stated that, per facility policy, residents who choose to smoke are instructed to leave the facility property to do so. The RN further stated that residents' cigarettes are stored in the medication cart, residents must request their cigarettes from nursing staff, and residents are required to sign a log prior to leaving the facility to smoke, documenting that they are leaving the property. During an observation on 12/19/25 at 9:00 a.m., the facility grounds and exterior areas and did not observe a designated smoking area or designated smoking area signage on or off facility property. During an observation on 12/19/25 at 10:20 a.m., Resident 4 exited the facility and wheeled himself in his wheelchair across uneven terrain in cold weather conditions to an area off facility property. The resident was observed smoking in that area. The location observed was not identified as a designated smoking area. No staff supervision or redirection was observed during the observation period. During an interview on 12/19/25 at 10:00 a.m. with Resident 3, Resident 3 stated that he smokes and obtains his cigarettes from nursing staff. The resident stated that he is instructed to leave the facility property in order to smoke. The resident further stated that he propels himself in his wheelchair out of the facility and onto the public sidewalk along the street, where he has been instructed to smoke. The resident stated that he was instructed to remain out of sight while smoking. During an interview on 12/17/25 at 1:00 p.m. with Resident 2, Resident 2 stated that he was instructed to smoke off the facility grounds. Resident 2 stated that he smokes twice per day and must propel himself in his wheelchair up a hill and off the facility property in order to smoke. Resident 2 stated that he was informed the facility is a non-smoking facility and that residents who smoke are permitted to go off the grounds to do so. During a record review of Resident 1's smoking assessment dated [DATE], the assessment indicated that Resident 1 does smoke but does not follow the non-smoking policy. Determined Resident 1 can smoke independently. Education provided to Resident 1 on facility smoking policies and risk of smoking. During an interview on 12/19/25 at 12:00 p.m., with the Administrator, the administrator revealed he was aware that four residents go outside the facility to smoke. The Administrator confirmed the facility is not following its smoke-free facility policy because the facility does not have a designated smoking area. The Administrator stated the facility is working on obtaining supplies and equipment to build a designated smoking area and stated the facility plans to revise its smoking policy once a designated smoking area is established.</p>		