

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 01/28/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure protection from sexual abuse (non-consensual sexual contact of any type with a resident) for one of three sampled residents (Resident 1) when Resident 2 touched Resident 1's side of the body on 12/20/25, and touched Resident 1's chest area on 12/22/25. These failures led to the compromised safety of Resident 1 and had the potential to affect Resident 1's emotional and psychosocial well-being as well as putting other residents at risk. Findings: During a record review of facility's policy titled, Abuse, Neglect, and Exploitation dated 2025, indicated Abuse means the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Facility policy also indicated The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and providing emotional support and counseling to the resident during and after the investigation, as needed. Facility policy further indicated sexual abuse is non-consensual sexual contact of any type with a resident. During a record review of Resident 1's admission record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy (a brain disorder from exposure to harmful substances like solvents, heavy metals, drugs), dementia with psychotic disturbance (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's most recent Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/2/24, at section C- Cognitive patterns, indicated that Resident 1's cognition was severe impaired with a Brief Interview for Mental Status (BIMS) score of 5. During a record review of Resident 2's admission record, he was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty in walking. During a review of Resident 2's most recent MDS dated [DATE], at section C- Cognitive patterns, indicated that Resident 2's cognition was intact with a BIMS score of 14. During a record review of Resident 2's progress notes, dated 12/20/25 at 1:53 pm, Registered Nurse (RN) A documented Per staff, stated they saw this resident (Resident 2) sitting next to another female resident (Resident 1), and he was touching her side, grunting. Resident separated from another resident. During a record review of the facility's document titled,</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055612	Facility ID: 055612 If continuation sheet Page 1 of 4

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 01/28/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Communications Report dated 12/20/25 at 1:55 pm, RN A documented Staff member reported that this resident (Resident 2) sitting next to female resident (Resident 1) was rubbing her side, grunting. Monitor behavior. During a record review of Resident 1's Interdisciplinary Team (IDT) notes dated 12/23/25 10:00 am, indicated Resident 1 was touched in the chest area by Resident 2 on 12/22/25 at 4:45 pm. IDT note further indicated staff witnessed the incident. During an interview with Infection Preventionist (IP) on 12/23/25 at 2:02 pm, IP confirmed the incident that occurred on 12/22/25 between Resident 1 and Resident 2. IP confirmed Resident 1 was not evaluated by nursing staff after the incident on 12/22/25. During an observation and interview with Resident 1 on 12/23/25 at 2:15 pm, in Resident 1's room, Resident 1 was in her bed. Resident 1 could not recall incident from 12/20/25 or 12/22/25. Resident 1 stated Something happened that was not good, but now things are good. During an interview with Licensed Vocational Nurse (LN) B on 12/23/25 at 2:17 pm, LN B stated she was told about the incident between Resident 2 and Resident 1 that occurred on 12/22/25. LN B confirmed Resident 1 did not receive a full evaluation by nursing staff after the 12/22/25 incident. LN B confirmed facility expectation was for nursing staff to complete a full evaluation of a resident after an incident or change of condition. LN B confirmed Resident 2 ambulated throughout the entire facility in his wheelchair with no supervision, which included at the end of the hall where Resident 1 resided. LN B confirmed facility did not follow its abuse policy to protect Resident 1 and should have. During an interview with RN C on 12/23/25 at 2:20 pm, RN C confirmed he did not complete a nursing evaluation of Resident 1 after he was notified of the incident on 12/22/25. RN C stated he was not aware he should have completed a full evaluation of Resident 1 per facility policy. RN C stated he could not verify if Resident 1 sustained any physical injuries after the 12/22/25 incident. RN C confirmed facility did not follow its abuse policy to protect Resident 1 and should have. During an observation on 12/23/25 at 2:43 pm, Resident 2 was observed at the nurse's station in his wheelchair. Resident 2 ambulated in his wheelchair down the hallway to the end outside of Resident 1's room. Resident 2 was observed with no direct staff supervision. During an interview with RN A on 12/23/25 at 4:45 pm, RN A stated she texted the Director of Nursing (DON) after the incident on 12/20/25 between Resident 1 and Resident 2. RN A stated she did not remember which staff member witnessed the interaction. RN A stated she did not witness the interaction, so she did not feel compelled to report the abuse from 12/20/25. RN A confirmed she did not complete a nursing evaluation, change in condition, or report the abuse per facility policy. RN A stated, I had a hard day and should have done those things, but the DON told me just to write a progress note. RN A confirmed she only entered a progress note in Resident 2's chart, and not for Resident 1 for the 12/20/25 incident. During an interview with Administrator (Admin) on 12/23/25 at 5:08 pm, Admin stated he was unaware of what happened on 12/20/25. Admin stated it was the nursing staff that failed to notify him of the incident on 12/20/25. Admin confirmed facility did not provide interventions per facility abuse policy for the 12/20/25 incident to protect Resident 1. Admin stated facility staff were supposed to work as a team and decide amongst themselves who was going to supervise Resident 2 to ensure he stayed away from Resident 1. Admin confirmed there was no solid plan on how to keep Resident 2 away from Resident 1. Admin stated he was aware Resident 2 ambulated throughout the facility in his wheelchair without supervision. Admin confirmed the incident on 12/20/25 could have led to the escalation of Resident 2 and the incident on 12/22/25. Admin confirmed Resident 1's safety was a priority, and facility did not implement their abuse policy. Admin stated the DON no longer worked at the facility as of 12/22/25 and would be unavailable for an interview.</p>

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 01/28/2026
NAME OF PROVIDER OR SUPPLIER Feather River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Gilmore Lane Orville, 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of sexual abuse (non-consensual sexual contact of any type with a resident) for one of 3 sample residents (Resident 1), when a staff member witnessed Resident 2 touch Resident 1's side of body on 12/20/25. This failure led to the compromised resident safety and contributed to a subsequent incident on 12/22/25, when Resident 2 was witnessed with a hand on Resident 1's chest area. During a record review of facility's policy titled Abuse, Neglect, and Exploitation dated 2025, indicated Abuse means the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Facility policy also indicated The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and providing emotional support and counseling to the resident during and after the investigation, as needed. Facility policy further indicated sexual abuse is non-consensual sexual contact of any type with a resident. Facility indicated Reporting of all alleged violations to the Administrator (Admin), state agency, adult protective services and to all other required agencies within specified timeframes: immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. During a record review of Resident 1's admission record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy (a brain disorder from exposure to harmful substances like solvents, heavy metals, drugs), dementia with psychotic disturbance (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's most recent Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/2/24, at section C- Cognitive patterns, indicated that Resident 1's cognition was severe impaired with a Brief Interview for Mental Status (BIMS) score of 5. During a record review of Resident 2's admission record, he was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty in walking. During a review of Resident 2's most recent MDS dated [DATE], at section C- Cognitive patterns, indicated that Resident 2's cognition was intact with a BIMS score of 14. During a record review of Resident 2's progress notes, dated 12/20/25 at 1:53 pm, Registered Nurse (RN) A documented Per staff, stated they saw this resident (Resident 2) sitting next to another female resident (Resident 1), and he was touching her side, grunting. Resident separated from another resident. During a record review of the facility's document titled, Communications Report dated 12/20/25 at 1:55 pm, RN A documented Staff member reported that this resident (Resident 2) sitting next to female resident (Resident 1) was rubbing her side, grunting. Monitor behavior. During a record review of Resident 1's Interdisciplinary Team (IDT) notes dated 12/23/25 10:00 am, indicated Resident 1 was touched in the chest area by Resident 2 on 12/22/25 at 4:45 pm. IDT</p> <p>(continued on next page)</p>		

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 01/28/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>note further indicated staff witnessed the incident. During an observation and interview with Resident 1 on 12/23/25 at 2:15 pm, Resident 1 was in her bed. Resident 1 could not recall incident from 12/20/25 or 12/22/25. Resident 1 stated Something happened that was not good, but now things are good. During an observation on 12/23/25 at 2:43 pm, Resident 2 was observed at the nurse's station in his wheelchair. Resident 2 ambulated in his wheelchair down the hallway to the end outside of Resident 1's room. Resident 2 was observed with no direct staff supervision. During an interview with RN A on 12/23/25 at 4:45 pm, RN A stated she texted the Director of Nursing (DON) after the incident on 12/20/25 between Resident 1 and Resident 2. RN A stated she did not remember which staff member witnessed the interaction. RN A stated the staff member told her Resident 2 touched Resident 1's chest area on her side. RN A stated because she did not witness the interaction, she did not feel compelled to report the abuse from 12/20/25. RN A confirmed she did not complete a nursing evaluation, change in condition, or report the abuse per facility policy. RN A stated, I had a hard day and should have done those things, but the DON told me just to write a progress note. RN A confirmed she only entered a progress note in Resident 2's chart, and not for Resident 1 for the 12/20/25 incident. RN A confirmed she did not follow facility abuse policy and should have. During an interview with Administrator (Admin) on 12/23/25 at 5:08 pm, Admin stated he was unaware of what happened on 12/20/25. Admin stated it was the nursing staff that failed to notify him of the incident on 12/20/25. Admin confirmed this incident did not get reported per facility policy. Admin confirmed facility did not provide interventions to protect Resident 1 per facility policy. Admin stated facility staff were supposed to work as a team and decide amongst themselves who was going to supervise Resident 2 to ensure he stayed away from Resident 1. Admin confirmed there was no solid plan on how to keep Resident 2 away from Resident 1. Admin stated he was aware Resident 2 ambulated throughout the facility in his wheelchair without supervision. Admin confirmed the incident on 12/20/25 could have led to the escalation of Resident 2 and the incident on 12/22/25. Admin stated the DON no longer worked at the facility as of 12/22/25 and would be unavailable for an interview.</p>		