STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect one of ten sampled residents (Resident 2) when: 1. Registered Nurse (RN) B willfully took the bed remote from Resident 2 and hid it out of reach.2. RN B willfully shut the door while Resident 2 was yelling for help. 3. RN B willfully left Resident 2 in isolation and neglected to provide services needed. This failure caused involuntary seclusion (isolation) to Resident 2, and the potential for emotional distress, and a fall.Findings: During a review of the facility's policy revised 7/15/21 titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property Prohibition, indicated each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Each resident also has the right to be free from mistreatment, neglect and misappropriation of property. The definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, or pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means that the individual must have acted deliberately, not that the individual must have unintended to inflict injury or harm. The definition of Involuntary Seclusion is the separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative. The definition of neglect is failure of the Center, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. 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 cerebral infarction (common known as a stroke), hemiplegia (inability to move one side of the body) affecting the left side, frontal lobe and executive function deficit (the parts of your brain that control self-motivation, planning, and inhibition do not work, affecting the ability to follow a sleep pattern, and navigating social situations), dysphagia (difficulty swallowing), depression (persistent feelings of sadness and a loss of interests in daily tasks), diabetes (too much sugar in the blood), hypokalemia (low potassium in the blood), high blood pressure, heart disease, atrial fibrillation (fast and irregular heart beat), and toxic encephalopathy (a change in how the brain works due to an underlying health condition). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool), indicated that Resident 2 had a Brief Interview for Mental Status, (BIMS) score of 2 out of 15 and had a severe cognitive (able to think and reason) and communication (ability to verbalize needs) deficits. A review of a facility document dated 7/27/25 titled, Suspected Abuse, indicated Licensed Nurse (LN) C walked by Resident 2's room and found RN B exiting the room and closing the door. RN B explained to LN C she had been in the room to lower the bed from a high position to a low position and left the bed remote on the bed. LN C reported RN B stated, We are not supposed to do this, but I am not going to put up with bad behavior. RN told LN C to leave the door closed and then walked away. During an observation and attempted interview on 8/7/25 at 12:58 pm, Resident 2 was lying in bed with eyes closed. The surveyor attempted to speak with and interview Resident 2, but she did not speak. Resident 2 opened her eyes and then shut them again, but did not verbally respond. During a follow up observation and attempted interview on 8/7/25 at 2:50 pm, Resident 2 was lying in bed, on her left side, no signs or symptoms of pain or discomfort, but did not try to communicate. Resident 2 had no restlessness noted or any signs of anxiety, opened her eyes, then quickly shut them without speaking. During an interview on 8/7/25 at 3:12 pm, LN C confirmed she had reported RN B for closing the door to Resident 2's room, while resident 2 was yelling for help and was asked by RN B to not open the door. LN C confirmed RN B stated to her at the time of closing the door we are not going to put up with these bad behaviors and RN B then walked away. During an interview on 8/7/25 at 3:45 pm, the Executive Nurse Director (END) confirmed RN B had abused Resident 2 by withholding services and confinement. END stated, I will send you the termination report, RN B will no longer work at this facility. We will not tolerate abuse. During a review of a facility document dated 8/8/25 titled, Employee Termination Report, indicated RN B to be in violation of the Code of Conduct and the Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, Prohibition Policy and has brought