STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Crest Post-Acute	50 Concordia 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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F 0684 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 interviews, and record review, the facility failed to provide needed care and service for one of three sampled residents (Resident 1), when:1. A change in condition was not recorded and reported to the Medical Director (MD) when Resident 1 experienced a decrease in the frequency of her daily brief (type of adult disposable underwear) changes, which was a significant indicator of decreased urine output. 2. A laboratory blood test (labs - the process of analyzing a blood sample to measure specific substances) order placed by the MD on [DATE], was not fulfilled, resulting in Resident 1's lab not being drawn as instructed.These failures led to Resident 1 not receiving appropriate medical assessments and treatment, ultimately resulting in her death on [DATE].Findings:During a review of the facility policy titled Change in a Resident's Condition or Status, revised 11/2015, the policy indicated that: The facility will promptly notify the resident, their attending physician, and their representative of any changes in the resident's medical or mental condition and/or status. The Charge Nurse (CN) will notify the resident's attending or on-call physician of significant changes in the resident's physical, emotional, or mental condition, or if there is a need to transfer the resident to a hospital or treatment center. A Significant Change is defined as a decline or improvement in the resident's status that will not resolve without staff intervention or standard clinical interventions and impacts more than one area of the resident's health. Before notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant information, including using the SBAR communication tool (Situation, Background, Assessment, and Recommendation. It provides a structured, concise, and standardized way for healthcare professionals to communicate important patient information.) The CN will document changes in the resident's medical or mental condition in the resident's medical record. If a significant change occurs, a comprehensive assessment of the resident's condition will be conducted, and any changes will be reported to the Director of Nursing Services to ensure the resident's medical record is updated accordingly.During a review of Resident 1's admission record, the admission record indicated that Resident 1 was admitted on [DATE] with diagnoses that included type 2 diabetes (high blood sugar), unspecified dementia (a progressive state of decline in mental abilities), hypertensive chronic kidney disease (a condition where high blood pressure damages the kidneys, causing them to lose function over time), need for assistance with personal care. Resident 1 was not her healthcare decision maker. 1. During a review of Resident 1's record titled Bladder Elimination, dated [DATE] - [DATE], the record indicated Resident 1 had: Four brief changes on [DATE], One brief change on [DATE], Three brief changes on [DATE], Four brief changes on [DATE], Two brief changes on [DATE], Two brief changes on [DATE], Two brief changes on [DATE], Three brief changes on [DATE], Two brief changes on [DATE], One brief change on [DATE].During an interview with Certified Nursing Assistant (CNA) D on [DATE] at 9:40 am, CNA D stated Resident 1 was a heavy wetter and had a lot of brief changes. During an interview with CNA E on [DATE] at 9:50 am, CNA E stated [Resident 1] usually received 15-20 brief changes every 24 hours. CNA E confirmed Resident 1 was a Heavy wetter. CNA E stated that facility staff were generally aware that Resident 1 was Very incontinent. CNA E stated, It would be strange for [Resident 1] to receive only 2-4 brief changes in a 24-hour period. During an interview with CNA F on [DATE] at 10:03 am, CNA F confirmed she worked the Night shift for [DATE], [DATE], and [DATE]. CNA F confirmed Resident 1 was a Heavy wetter and 15-20 brief changes in a 24-hour period was Normal for her. During an interview with CNA G on [DATE] at 11:06 am, CNA G confirmed 2-4 brief changes in a 24-hour period for Resident 1 was Not enough. Because [Resident 1] was always incontinent.During an interview with Licensed Nurse (LN) H on [DATE] at 11:14 am, LN H stated [Resident 1] needed multiple brief changes a day, and 2-4 brief changes a day was not like her elimination baseline. During an interview with Director of Nursing (DON) on [DATE] at 12:19 pm, DON stated he was not aware there was a decrease in the number of brief changes for Resident 1. DON confirmed this was considered a change in condition and both MD and DON should have been notified of this, especially since Resident 1 had a history of Urinary tract infection (UTI - an infection in any part of the urinary system). 2. During a review of Resident 1's clinical record titled Blood Sugar Summary, dated [DATE] - [DATE], indicated Resident 1's average blood sugar levels were between 250 - 300 milligrams per deciliter (mg/dL, a unit of measurement) and Resident 1's Blood Sugar level elevated to above 320 to 430 mg/dL from [DATE] to [DATE]. (blood sugar level above 400 was very dangerous and could lead to a life-threatening condition) [DATE] 7:49 am - Blood Sugar level of 268 mg/dL [DATE] 7:40 am - Blood Sugar level of 265 mg/dL [DATE]