STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055489	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32041 Based on observation, interview, and record review the facility failed to ensure that dignity and privacy were maintained for two residents (Resident 1 and Resident 3) when a psychiatric tele health (appointment with a health care provider conducted remotely on a video screen), visits were conducted in a public location. This had the potential for other residents, staff, and visitors to overhear protected and private information. Findings: Resident 3 was readmitted to the facility on [DATE] with diagnoses that included aphasia (difficulty communicating) and hemiplegia (one sided inability to control body movements) both related to a stroke. During an observation on [DATE] at 10:18 am, Resident 3 was observed to be seated in his wheelchair in the central hallway. This location is across from the nurse ' s station, facing the lobby. Two individuals wearing black scrubs approached Resident 3 while pushing a bedside tray with a laptop (computer) on it. They positioned the laptop screen to face Resident 3 then initiated a tele health visit. The individual on the screen then engaged in conversation with Resident 3 for several minutes. No efforts were made to give visual or auditory privacy to Resident 3. Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia and shizoaffective disorder (a mental illness with symptoms of mood disorder and hallucinations). During an observation on [DATE] begun at 10:18 am, Resident 1 was seated beside Resident 3 and another male resident in the central hallway. After Resident 3 ' s tele health visit, the table and laptop were directed to face Resident 1. She remained seated directly between two other residents and no attempts to provide auditory or visual privacy were made. During the tele health visit, the provider could be heard asking Resident 1 about any symptoms of sadness or depression. Resident 1 became tearful and recounted feeling sad about a deceased friend. At 10:23 am, a visitor, who declined to give her name, approached this surveyor and asked, Should they be doing that out here in front of everyone? I ' m waiting to use the bathroom but that just seems wrong. Both staff abruptly moved the table, laptop, and Resident 1 to the resident ' s room and closed the door. (continued on next page)

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
	055489	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:30 am, Certified Nurse Assistant (CNA) B acknowledged that he was one of the staff members facilitating telehealth visits for the residents. CNA B confirmed that both Resident 1 and Resident 3 had psychiatric tele health visits conducted in a public area. CNA B stated that he was assisting a new staff member and does not normally perform this task. When asked if tele health visits are normally conducted in public areas, CNA B stated that tele health visits are usually conducted in resident rooms. When asked to clarify why this did not occur, CNA B stated, It ' s not something we normally do. I had a lot on my mind. During an interview with Administrator (Admin) on [DATE] at 10:45 am, he stated that the facility expectation is for all tele health visits to occur in private. This is usually in the resident ' s room, but there is a private area available in social services as well. Admin initially stated both individuals were not facility employees, but rather contracted staff. However, after clarification, Admin confirmed CNA B was a facility employee. Admin confirmed awareness of the tele health visits for Resident 1 and Resident 3 in a public area and acknowledged that privacy and dignity were not maintained. The facility policy titled, Promoting/Maintaining Resident Dignity, dated 2023, indicated; All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . avoid discussions about residents that may be overheard . Maintain resident privacy.