

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>45315</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident care equipment was maintained in a safe operating condition when a large metal meal tray cart (tray cart, large metal cart on wheels that was used to transport resident meal trays) fell over when the housekeeper (HK) moved the tray cart out of her way.</p> <p>This failure had the potential to cause physical and psychosocial injury to residents.</p> <p>Findings:</p> <p>A review of the facility's undated policy and procedure (P&P) titled, Physical Environment: Space and Equipment, indicated, Inspection of resident care equipment will be completed routinely and as needed to maintain and ensure safe operating conditions according to manufacturer's recommendations.</p> <p>During an observation on 6/21/24 at 8:44 am, residents were observed sitting in the lobby and near the nurse's station upon entry to the facility. A tray cart was observed falling over and landing approximately 7 feet away from a resident who jumped and yelled, Oh my God that scared me, that scare me.</p> <p>During a concurrent observation and interview on 6/21/24 at 8:52 am, with dietary aide (DA), DA stated the wheel on the tray cart had been broken for awhile. DA stated, being a DA for one and a half months, and the wheel to the tray cart was broken when DA started working in the kitchen. An orange Post-it-Note was observed taped to the side of the tray cart. In black writing, the note indicated, Fix wheels. On the upper right corner of the tray cart was a caution sticker that someone wrote on with black ink: Broken. DA did know who placed the note there and was not sure how long the Post-it-Note had been on the tray cart.</p> <p>During a concurrent interview and record review on 6/21/24 at 8:58 am, with Maintenance Supervisor (MS), the TELS system (a computerized system that tracked and logged all work orders, repairs, and maintenance performed) was reviewed. MS confirmed having knowledge of the wheel on the tray cart being broken, was not able to state how long the wheel to the tray cart had been damaged, and stated MS had ordered replacement wheels. MS was not able to provide documentation from the TELS system to support the damaged wheel to the tray cart had been logged as needing repair and was not able to provide documentation indicating replacement wheels had been ordered. MS stated the replacement wheels had arrived and was not able to verbalize when the replacement wheels arrived.</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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/21/24 at 9:03 am, security stated, the wheel on the meal cart was damaged and stated it was supposed to fixed and it was not.</p> <p>During an interview on 6/21/24 at 10:41 am, housekeeper (HKR) stated, I pushed the tray cart to move it and it just fell over.</p> <p>During an interview on 6/21/24 at 12:07 pm, MS stated it was MS's responsibility to inspect the meal carts. MS stated, MS had not inspected the meal carts for operational safety in the past. MS acknowledged the shipping label located on the box of replacement wheels was dated 4/23/24 and stated, when the damaged wheel was brought to MS's attention, MS inspected the damaged wheel in April and determined there was no safety concern. MS confirmed, not performing any additional inspections during the last 2 months to ensure the damaged wheel and tray cart were safe to use while waiting for the repair to be made. MS confirmed, the tray cart had an orange Post-it-Note that indicated, the wheels needed to be fixed and stated, MS placed the note on the tray cart. MS stated, MS should have opened a work order in the TELS system that indicated the tray cart needed to be repaired. MS stated, MS should have removed the tray cart from use and confirmed MS didn't.</p> <p>During an interview on 6/21/24 at 12:24 pm, the facility's Administrator (Admin) confirmed the tray cart had fallen over. Admin stated the expectancy was, when the damaged wheel to the tray cart was brought to MS's attention, it should have been fixed that day.</p>