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	12/18/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, and record review, the facility failed to ensure a care plan for one of three sampled residents (Resident 2) was revised and updated to reflect current individual needs for a change in condition after a hospitalization to include comfort care (end of life care wishes) with new pain medications. This failure resulted in Resident 2's individualized care needs to go unrecognized, and the potential for a further decline in Resident 2's physical, mental, and psychological status. Findings: During a review of a policy revised 8/2024, titled, Care Plan Revisions Upon Status Change, indicated the purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. The care plan will be updated with the new or modified interventions. Staff involved in the care of the resident will report resident response to new or modified interventions. During a review of Resident 2's medical record, the Admission Record , indicated Resident 2 was admitted to the facility on [DATE] for diagnosis that included heart failure, chronic obstructive pulmonary disease (COPD, a progressive lung disease), pressure ulcer of sacral region (areas of damage to the skin and the tissue beneath, sometimes called bed sores), tobacco use, acquired absence of both right and left leg below the knee, and unspecified protein-calorie malnutrition (poor nutrition). During a review of Resident 2's medial record, a record dated 4/29/24, titled, Admission Record, indicated Resident 2 was his own responsible party, and able to make decisions for himself. During a review of Resident 2's medical record, a record dated 12/15/24, titled, Inter/Facility Transfer Report, indicated Resident 2 was admitted to a local hospital on 12/13/24, and Resident 2 was readmitted to the facility on [DATE] with new orders including comfort care with new medications. During a concurrent interview and record review on 12/18/24 at 4:05 pm, the administrator (Admin) and Director of Nursing (DON) confirmed there were no revisions or updates to Resident 2's care plan after re-admission to the facility on [DATE]. Admin stated, The last update to the care plan for [Resident 2] was on 12/10/24, no comfort medications or new problems are listed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 4:50 pm, the DON confirmed the care plan for Resident 2 had not been revised or updated after a significant change, and Resident 2 had new needs that were not listed. DON stated, I do understand how this affects [Resident 2's] care, these processes should have been done. During an interview on 12/18/24 at 4:58 pm, the Admin confirmed the care plan for Resident 2 had not been revised or updated to meet the current needs identified for Resident 2.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, and record review, the facility failed to ensure a skin assessment was completed upon re-admission to the facility for one of two sampled residents, (Resident 2). This failure had the potential for a negative clinical outcome, re-hospitalization , and Resident 2 had specific skin treatment needs that were not identified in a timely manner. Findings: The facility's policy dated 2/2023, titled, Admission Orders, indicated the orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. This facility's policy also indicated the admission orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. The facility's policy not dated titled, Charting Guidelines, indicated new admissions requirement in Point Click Care (PCC) included functional abilities and goals completed every shift for three days. Under progress notes in PCC alert charting every shift for three days to include any new falls, any change of condition, new medications, Re-admit, new skin issue/wound, room change or incident. During a review of Resident 2's medical record, the Admission Record, indicated Resident 2 was admitted to the facility on [DATE] for diagnosis that included heart failure, chronic obstructive pulmonary disease (COPD, a progressive lung disease), pressure ulcer of sacral region (areas of damage to the skin and the tissue beneath, sometimes called bed sores), tobacco use, acquired absence of both right and left leg below the knee, and unspecified protein-calorie malnutrition (poor nutrition). During a review of Resident 2's medial record, a record dated 4/29/24, titled, Admission Record, indicated Resident 2 was his own responsible party, and able to make decisions for himself. During a review of Resident 2's medical record, a record dated 12/15/24, titled, Inter/Facility Transfer Report, indicated Resident 2 was admitted to a local hospital on 12/13/24, and Resident 2 was readmitted to the facility on [DATE] with new orders including comfort care (end of life care wishes). During a concurrent interview and record review on 12/18/24 at 2:30 pm, the administrator (Admin) and Licensed Nurse (LN) 1 confirmed there was no re-admission skin assessment for Resident 2 in the medical record, and this was an incomplete re-admission. During an interview on 12/18/24 at 4:02 pm, Registered Nurse (RN) 2 confirmed she did not complete a skin assessment on Resident 2 on 12/15/24 when he returned to the facility, and she did not review any records for Resident 2 to make sure the admission had been completed per the facility's policy. RN 2 stated, I thought [LN 4] completed the re-admission for [Resident 2], and I did not ask or follow up to make sure the admission assessments were completed for [Resident 2]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 4:50 pm, the Director of Nursing (DON) confirmed there was no re-admission skin assessment completed for Resident 2 upon return to the facility. DON stated, I told the nurses on 12/15/24 to treat this re-admission like an admission, I do not know why this was missed. During an interview on 12/18/24 at 4:58 pm, the Admin confirmed the skin assessment had not been completed for Resident 2 on 12/15/23, per their policy and procedure.