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	06/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement an individualized patient -center care plan for one of two sampled residents (Resident 1) with dementia (loss of memory, language, and problem-solving) when: 1. Resident 1 became physically aggressive when given a shower and Certified Nursing Assistant (CNA) A did not follow interventions to leave and return 5-10 minutes later and try again. 2. Interventions were not developed to address Resident 1's preference of taking showers in the afternoon. These failure contributed to Resident 1 becoming combative, and CNA A grabbing onto Resident 1's wrist which became red, swollen and tender. Findings: A review of the facility's policy titled Comprehensive Care Plans (undated) indicated that it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident 3. The comprehensive care plan will describe, at a minimum, the following f. Resident specific interventions that reflect the resident's needs and preferences A review of the facility's policy titled Promoting/Maintaining Resident Self-Determination (undated) indicated The care plan will reflect resident choices A review of Resident 1's admission record indicated she was admitted on [DATE] with diagnoses that included dementia and Alzheimer's. A review of Resident 1's Quarterly Minimum Data Set (MDS, a data driven clinical assessment) dated 2/21/25, section C indicated Resident 1's ability to remember, think clearly, perceive what was happening to and around her, and problem-solve was severely impaired. Section GG indicated that Resident 1 required moderate assistance from staff with bathing and dressing. 1. During an observation and interview on 5/27/25 at 1:02 pm, Resident 1 was observed lying in bed. Her right wrist was red and slightly swollen. Resident 1 indicated that her wrist was sore, and she guarded (protected it) it with her other hand when she was asked about it. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with CNA C on 5/27/25 at 1:05 pm, Resident 1's wrist was observed. CNA C confirmed that Resident 1's right wrist was red, swollen and she had complained of it hurting. CNA C indicated that over the weekend Resident 1 got combative when staff gave her a shower during the morning. A review of Resident 1 ' s Alert Note dated 5/25/25 at 2:21 pm, the note indicated At approximately 10:00 am it was reported that CNA [CNA A] had assisted pt [patient] for a shower. During transfer of patient into a shower chair, it is reported that pt has become combative and the CNA had grasped or otherwise applied pressure to pt's hands/wrists. Pt was then showered at which time the CNA has noticed swelling and pain to Pt's right wrist. A review of Resident 1's Emergency Department (ED) documentation dated 5/25/25, ED physician noted [Facility Name] staff reported to EMS [Emergency Medical Service] that while in the shower this morning, pt became violent with staff and while attempting to restrain her, her wrist incurred an injury. Presents with swelling and tenderness to L wrist. X-ray of the right wrist with no evidence of acute fracture. Patient however does have some swelling as well has mild erythema [redness], difficult to distinguish whether this is from trauma verses early cellulitis (a skin infection). Will prescribe prophylactic (a course of action to prevent disease) antibiotics (medication used to treat a skin infection). A review of Resident 1's care plans reflecte a care plan titled Resident 1 is resistive to care, refuses to be changed, refuses showers/bathing revised 5/23/24. Interventions included If resident resists with ADL's (activities of daily living, including showering), reassure resident, leave and return 5-10 minutes later and try again. During a phone interview on 5/27/25 at 1:51 pm, CNA A indicated that on 5/25/25 between 9:30 am and 10:00 am, she proceeded to get Resident 1 ready to take a shower. CNA A stated She [Resident 1] started to hit me, and I grabbed both her hands. CNA A indicated that she continued to put Resident 1 into a shower chair and give her a shower. CNA A stated We are supposed to walk away when they (residents) refuse or fight back. I did not try and walk away because I needed help from my hall partner (CNA B) and she wanted to do the shower right then because she had other work to do. We should have walked away and come back later. During a concurrent interview with the Director of Nursing (DON) and record review on 6/6/25 at 12:47 pm, Resident 1's care plans were reviewed. The DON confirmed that Resident 1 had an intervention that if she resists showering the staff were to reassure resident, leave and return 5-10 minutes later and try again. The DON confirmed that CNA A did not do this, and she should have. 2. During a concurrent observation and interview with CNA C on 5/27/25 at 1:05 pm, CNA C indicated that she usually cared for Resident 1, and normally, Resident 1 liked to get up and around at 2:00 pm and that was when Resident 1 was more likely to take a shower. CNA C indicated that Resident 1's family had indicated that Resident 1 was not a morning person and that she liked to get up later in the day. CNA C indicated that she was unaware if there was an intervention in Resident 1's care plan concerning this preference. CNA C indicated that she knew this about Resident 1 because she always took care of her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 1:24 pm, Registered Nurse (RN) indicated that two days ago Resident 1 was being cared for by CNA A. RN indicated that CNA A gave Resident 1 a shower in the morning and Resident 1 got combative and tried to scratch CNA A. RN stated, She (CNA A) was from registry (a traveling CNA that was contracted to work at different facilities) and she was not aware that [Resident 1's name] prefers to be left alone in the morning. RN indicated that this information should have been in Resident 1's care plan. During a concurrent interview with the DON and record review on 6/6/25 at 12:47 pm, Resident 1's care plans were reviewed. DON confirmed that nowhere in Resident 1's care plans had it indicated that Resident 1 was not a morning person and to shower her in the afternoons. DON indicated that this should be in Resident 1's care plan to minimize Resident 1's combative behavior and to prevent the potential for injury with showering.