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	08/08/2025

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 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. (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

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	08/08/2025

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 0550 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 observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) rights were protected when the facility attempted to transfer Resident 1 to another facility out of the area without his permission, or the permission of his Responsible Party (RP). This failure caused Resident 1 to feel anxious and had the potential to result in emotional stress, embarrassment, feelings of neglect, and the potential for negative clinical outcomes. Findings: During a review of the facility's policy revised 2025, titled, Resident Rights, indicated the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This facility's policy also indicated self-determination: The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. During a review of Resident 1's medical record, the admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur (upper thigh bone, sometimes referred to as hip fracture), metabolic encephalopathy (problem in the brain caused by a physical illness, or by organs not functioning properly), dysphagia (difficulty swallowing), cardiomegaly (enlarged heart), pleural effusion (fluid buildup between the lungs and chest cavity), hypotension (low blood pressure), anxiety (feeling of worry, nervousness, or unease), urinary tract infections (UTI, infection of any part of the urinary system, usually the bladder), and [NAME]-Barre Syndrome (a rare neurological disorder that causes the body's immune system to attack nerves outside the brain and spinal column causing inflammation, weakness and pain), and a history of of falling. A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 7/15/25, indicated that Resident 1 had a Brief Interview for Mental Status, (BIMS) score of 6 out of 15 and had a severe cognitive (able to think and reason) deficit. During an interview on 8/1/25 at 11:15 am, the admission Coordinator stated, I did not know we had to give every resident a 30-day notice to discharge residents. During an interview on 8/1/25 at 11:45 am, the Social Worker (SW) stated, The Family Member (FM) is the RP for [Resident 1] and she agreed to the transfer at a meeting on 7/30/35 with the business office manager present. [Resident 1] also agreed to the transfer. He barely got out of the parking lot, and I called the driver to turn around, he only went a few blocks down the road. The FM called and stopped it. During a concurrent observation and interview on 8/1/25 at 12:45 pm, Resident 1 was sitting in his wheelchair beside the bed, well groomed. Resident stated, I am glad you are here; I was so upset yesterday. I did not know where they were taking me. I never agreed to moving out. My [FM] stopped it, thank you for checking in on me, I feel better now. During a review of Resident 1's medical record there is no documentation of an Interdisciplinary Team (IDT, gathering of healthcare professionals from various disciplines who collaborate to provide comprehensive care to a resident to ensure patient centered care) meeting that discussed a transfer or discharge, and no progress note entered on 7/30/25 for a planned and safe discharge. During a review of Resident 1's medical record, a document dated 7/31/25 pm, titled, Social Services Progress Note, indicated the following, Called Resident 1's [FM] to provide information related to a lateral transfer. [FM] became verbally aggressive, stating she called administration this morning and stopped the discharge. [FM] states she no longer wants [Resident 1] moved to another facility, and stated, he will stay there until I say so. SW explained that resident and FM previously agreed to this as a way to get resident into a assisted living waiver program so he can transition to memory care. FM states, Do not send him to any other facility or else. Resident returned to the facility. During a phone interview on 8/8/25 at 9:41 am, FM confirmed she had never approved the transfer to another facility. FM stated, I told the facility staff I would consider looking into finding another facility when we had a meeting, but I never agreed to a transfer on 7/30/25. I would never agree to a facility so far away, I would want to visit, and [Resident 1] does not have dementia, he has never been diagnosed with it, so I don't understand why they thought he needed memory care. I called and demanded that they bring [Resident 1] back to the facility because I had not approved this transfer so far away. During a interview on 8/8/25 at 11:15 am, the facility Administrator confirmed the transfer to another facility that started on 7/31/25 for Resident 1 was a violation of his rights.