

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 08/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to appropriately implement their infection control program to mitigate the spread of COVID-19 (symptoms include fever, fatigue, cough, breathing difficulties, loss of smell, and taste). Both Certified Nursing Assistant (CNA) A and Activity Assistant (AA) did not adhere to the necessary precautions for isolation rooms when they did not follow the proper procedures for putting on or taking off Personal Protective Equipment (PPE, masks, gowns, gloves and eye protection) as per the facility policy. These lapses in following standard protocols posed a significant risk by potentially facilitating the development and transmission of COVID-19 within the facility. This could lead to severe adverse consequences for residents, staff, and visitors. During a record review of facility policy titled COVID-19 Prevention, Response and Reporting dated 2024, indicated Healthcare Personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator with N95 (have the ability to filter particulates, while surgical masks do not) filters or higher, gown, gloves and eye protection. During an observation of signage posted outside of room four on 8/27/25 at 10:02 am, indicated Contact Precautions and Droplet Precautions included everyone must clean their hands, including before entering and when leaving the room; put on gloves before room entry, discard gloves before room exit; put on gown before room entry, discard gown before room exit, do not wear the same gown and gloves for the care of more than one person; make sure their eyes, nose and mouth are fully covered before room entry, remove face protection before room exit; use dedicated or disposable equipment. During a concurrent observation and interview on 8/27/25 at 10:12 am, with AA, AA entered room [ROOM NUMBER] with a snack cart and handed snacks to the three residents inside the room. Room four had signage on the outside of the door that indicated, Contact Precautions and Droplet Precautions (a resident inside the room was positive with COVID-19). AA entered the room with no gown or gloves. AA did not perform hand hygiene when he exited the room. AA did not wear eye protection while in the room. AA did not remove his N95 mask when he left the room. AA stated he forgot there was a resident in room four that had COVID-19. AA confirmed the signage on the outside of the room indicated staff needed to complete hand hygiene when they exited the room, wear eye protection while inside the room, wear gloves while inside the room, and remove N95 mask when he exited the room. AA confirmed he did not adhere to any of those instructions and should have. AA also stated he probably shouldn't have taken the snack cart into the room and created a risk of spreading COVID-19 to other residents and staff by doing so. During a concurrent observation and interview on 8/27/25 at 10:40 am, with CNA A, room [ROOM NUMBER] had signage on the outside of the door that indicated Contact Precautions and Droplet Precautions (a resident inside the room was positive with COVID-19). CNA A put on a gown and gloves inside of room [ROOM NUMBER]. CNA A did not tie her gown at the neck or waist. CNA A did not throw her N95 mask away when she exited the room. CNA A did not perform hand hygiene. CNA A performed care to more than one resident in the room and did not change her gown or gloves in between resident care. CNA A stated she did not know she was supposed to put on gown, gloves, eye protection and mask prior to entering the room. CNA A confirmed she did not perform hand hygiene. CNA A confirmed she did not change her gown or gloves in between residents because I didn't know I needed to. CNA A confirmed she attended the PPE, N95 masking and hand hygiene in service on 8/21/25 with Infection Preventionist (IP). During an interview with IP on 8/27/25 at 11:00 am, IP stated she held a staff in service on 8/21/25 and 8/25/25 for N95 masking etiquette, hand hygiene, and PPE requirements with all staff members. IP stated staff are required to put on a gown, mask, eye protection, and gloves prior to entering the resident's room from the PPE supply drawers outside of the room. IP stated when staff exited the resident's room, staff were required to take gloves, eye protection, gown and mask off, dispose of them, exit the residents room, and perform hand hygiene. IP stated staff must use a new N95 mask every time they exited a room. IP confirmed AA and CNA A did not follow facility policy for putting on and taking off PPE for contact and droplet precautions and should have. During an interview with Administrator (Admin) on 8/27/25 at 11:45 am, Admin stated she was not happy with the staff that did not follow facility policy because IP had recent in-services with staff regarding PPE, N95 masks, and hand hygiene. Admin confirmed staff did not adhere to facility policy and should have.</p>		