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	12/24/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect two of five sampled residents, (Resident 1 and Resident 2) from financial abuse, manipulation and exploitation when:1.The Activity Assistant (AA) J played on Resident 1's sympathy and manipulated Resident 1 out of $800, and promised services she never delivered. 2.AA J loaded Resident 2's bank card onto her personal well-known online shopping website to buy her coffee creamer, when the facility could have bought the coffee creamer for Resident 2, without using her bank card. These failures caused Residents 1 and 2 anxiety, embarrassment, and humiliation and the potential for negative emotional and psychosocial outcomes. Findings: The facility's policy revised 2025, titled, Transactions Involving Resident Funds, was reviewed and indicated it is the practice of this facility that anytime there is a transaction involving resident funds, the resident must be provided with a receipt of such transaction. Copies of each transaction are filed in the business office. Policy Explanation and Compliance Guidelines: The facility will establish and maintain a system that assures a complete and separate accounting of each resident's personal funds and is according to generally accepted accounting principles. The facility will ensure resident funds are not comingled with facility funds or funds of someone other than a resident, such as a staff member managing the resident's personal funds. The Business Office Manager, or his/her designee, is responsible for providing residents with receipts for withdrawals and for requested or needed personal items when such funds are withdrawn from the resident's personal funds account managed by the facility. A copy of such transactions and receipts are maintained by the Business Office Manager, or designee, in order to verify account transactions and to reconcile resident fund balances with withdrawals and expenditures. Personal items purchased by Social Services, or other authorized staff members on behalf of residents, provide the Business Office Manager, or designee, with a copy of receipts upon return to the facility. The facility's policy revised 2025, titled, Abuse, Neglect and Exploitation, was reviewed and indicated the definition of Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. The definition of Mistreatment means inappropriate treatment or exploitation of a resident. The facility's policy revised 2025 titled, Abuse, Neglect and Exploitation, was reviewed and indicated it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 1.A review of Resident 1's record indicated she had been admitted to the facility on [DATE] with diagnoses that included osteomyelitis of cervical vertebra (an infection of the neck bones causing severe pain, stiffness, and can lead to numbness or weakness), acute respiratory failure with hypoxia (sudden loss of oxygen needed in the blood making it hard to breathe), pressure ulcer of sacral region stage 4 (a severe, open sore on the tailbone area that involves full-thickness tissue loss, extending through skin and fat to expose muscle, tendon, ligaments, or even bone), diabetes (too much sugar in the blood), chronic pain (long standing pain that persists), Bi-polar disorder (a mental health condition causing extreme mood swings), attention deficit hyperactivity disorder (condition that makes it hard to manage your attention, control impulses, leading to challenges with focus, organization, and self-control in daily life), history of deep vein thrombosis embolism (DVT, is a blood clot forming in a deep vein, usually the leg) and embolism (when the blood clot or part of it breaks off, travels, and blocks a blood vessel elsewhere, most dangerously in the lungs), major depressive disorder (persistent sadness, and loss of interest), and high blood pressure. The physician noted in his admission orders that Resident 1 was capable of making healthcare decisions and was listed as her own responsible party (RP). Resident 1 was discharged to home on [DATE]. During a review of Resident 1's most recent Minimum Data Set, (MDS, a resident assessment), dated 8/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, memory and decision making skills), score of 15 of 15 and was cognitively intact (able to think and reason). During an phone interview on 12/18/25 at 2:10 pm, Family Member (FM) stated, No one has called or contacted me from the facility about [Resident 1's] money being taken and services not being provided. [Resident 1] told me I about the plan with [AA J] before she was discharged home. [AA J] was supposed to buy groceries and make meals for [Resident 1] after being discharged . [Resident 1] is very detailed when it comes to money, she knows exactly what she has down to the penny. [Resident 1] was really upset over this incident. During a phone interview on 12/18/25 at 3:11 pm, Resident 1 indicated between August 2025 and October 2025, AA J played on her sympathy and borrowed money from Resident 1. Resident 1 stated, [AA J]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 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 interview and record review, the facility failed to thoroughly investigate a financial abuse allegation and report the results of their investigation within five (5) days to the California Department of Public Health (CDPH) for one of five sampled Residents. (Resident 1)Refer to F600 This failure had the potential to result in further financial abuse to other residents.Findings: The facility's policy revised 2025 titled, Abuse, Neglect and Exploitation, was reviewed and indicated, Investigation of Alleged Abuse, Neglect and Exploitation, will include the following: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations that are included: Identifying staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); Investigation of different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and provide a completed and thorough documentation of the investigation.The facility's policy revised 2025 titled, Abuse, Neglect and Exploitation, was reviewed and indicated it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. A review of Resident 1's record indicated she had been admitted to the facility on [DATE] with diagnoses that included osteomyelitis of cervical vertebra (an infection of the neck bones causing severe pain, stiffness, and can lead to numbness or weakness), acute respiratory failure with hypoxia (sudden loss of oxygen needed in the blood making it hard to breathe), pressure ulcer of sacral region stage 4 (a severe, open sore on the tailbone area that involves full-thickness tissue loss, extending through skin and fat to expose muscle, tendon, ligaments, or even bone), diabetes (too much sugar in the blood), chronic pain (long standing pain that persists), Bi-polar disorder (a mental health condition causing extreme mood swings), attention deficit hyperactivity disorder (condition that makes it hard to manage your attention, control impulses, leading to challenges with focus, organization, and self-control in daily life), history of deep vein thrombosis embolism (DVT, is a blood clot forming in a deep vein, usually the leg) and embolism (when the blood clot or part of it breaks off, travels, and blocks a blood vessel elsewhere, most dangerously in the lungs), major depressive disorder (persistent sadness, and loss of interest), and high blood pressure. The physician noted in his admission orders that Resident 1 was capable of making healthcare decisions and was listed as her own responsible party (RP). During a review of Resident 1's most recent Minimum Data Set, (MDS, a resident assessment), dated 8/31/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a test of memory and decision making abilities) score of 15 of 15 and was cognitively intact (able to think and reason). During a review of a facility document titled, Facility, dated 10/29/25, indicated CDPH received a verbal report of an allegation of financial abuse on 10/30/25 at 8:37 am to Resident 1 by the facility's Activity Assistant (AA) J. A 5 day report of the results of the facility's abuse investigation should have been submitted to CDPH by 11/3/25. During a review of the facility's document titled, Update for Facility Reported Event dated 11/5/25, indicated CDPH received the facility's 5 day abuse investigation results report on 11/5/25 at 2:42 pm, two days late, from the facility. The report indicated, [AA J] will be in-serviced regarding receiving money from residents and that will go in her employee file. The facility will reimburse [Resident 1] $300.00. During an interview on 12/18/25 at 12:03 pm, Administrator (Admin) B confirmed the investigation of alleged abuse by AA J towards Resident 1 was submitted late to CDPH. Admin B stated, I entered the facility on 11/3/25, and the report was dated 11/5/25. It was only a few days late. During a follow up interview on 12/18/25 at 12:25 pm, Admin B confirmed the facility had not reimbursed Resident 1 the $300 as they indicated in their 5 day abuse allegation investigation results on 11/5/25. Admin B stated, I did not substantiate the abuse. I didn't have any proof that it happened. There was no written contract statement, it was a verbal agreement if she wanted [AA J] to cook meals. [Resident 1] confirmed there was a car problem or a delay, but I have no proof. [AA J] explained she needed to replace her tires and there was a conversation between them both, so I cannot substantiate it. During an interview on 12/18/25 at 1:55 pm, the Director of Nursing (DON) confirmed the abuse allegation for Resident 1 was not complete or thorough. DON stated, I confirm the investigation was no complete, we need more witnesses and more interviews. During a