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	02/10/2026

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** Based on interview and record review, the facility failed to revise a wound care plan for one of three sampled residents, (Resident 1) when a new physician wound care order was prescribed for a wound vacuum-assisted closure (wound vac, medical device that uses gentle, constant suction to heal complex wounds), to be placed and maintained to the left hip pressure ulcer (a deep wound caused from pressure to the area). This failure had the potential for Resident 1's wound care not to be managed appropriately which could result in discomfort, further deterioration of the wound, and possible infection and hospitalization. Findings: The facility's policy revised 2025, titled, Care Plan Revisions Upon Status Change, was reviewed and 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. A review of Resident 1's clinical record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included paralytic syndrome following cerebral infarction affecting right side (stroke that caused permanent loss of voluntary movement), diabetes (too much sugar in the blood), chronic obstruction pulmonary disease (COPD, a progressive lung disease), dysphagia (difficulty swallowing), pressure ulcers (open areas to the skin and underlying tissues) chronic kidney disease (permanent damage and loss of the ability to filter wastes out of the blood), high blood pressure, [NAME] cell carcinoma (rare and fast growing type of skin cancer), pulmonary embolism (a blood clot that has traveled to the lungs) and chronic pain (persistent pain that lasts more than three to six months). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 1, dated 1/27/26, indicated that Resident 1 had a moderate cognitive (ability to think, reason and remember) deficit, with a brief interview for mental status (BIMS) score of 9 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating). During a record review a document date range 9/3/25 to 1/31/26, titled, Order Summary Report, indicated Resident 1 was ordered a wound vac to the left hip on 1/20/26: Change every Monday, Wednesday and Friday am shift and as needed. Ensure wound vac dressing is sealed and intact with a setting of 125 millimeters of mercury pressure (mm/hg, a unit of measure) every shift every day. During a concurrent record review of Resident 1's care plans and interview on 2/5/26 at 1:10 pm, with the Director of Nursing (DON), the DON confirmed the wound care plan for Resident 1 needed to be revised with specific interventions for Resident 1's new wound care orders to include the new order for a wound vac. During a follow up interview on 2/5/26 at 1:15 pm, the DON stated, I confirm the care plan for [Resident 1] is not revised and needs to be more specific for non-compliance for wound care. [Resident 1] will allow one nurse (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to complete her wound care, we could add this to the care plan. We could also add to call the family member [FM, who was involved in Resident 1's care], if needed to assist us if [Resident 1] refuses wound care treatments, to make sure all wound care is completed per physician orders.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their Infection Control Program policies and procedures for controlling the spread of a communicable disease and infection when four of seven sampled residents (Resident 4, 5, 6 and Resident 7), tested positive for Influenza A (influenza, a contagious respiratory illness caused by the influenza), and all residents in close contact were not tested in a timely manner, in accordance with the facility's infection control policy. This failure put the residents, staff and families at risk for contracting Influenza A infections and had the potential to result in serious negative clinical outcomes for this vulnerable population.Findings: The facility's policy revised 1/2026, titled, Influenza Exposure Control, was reviewed and indicated the purpose of this policy to establish procedures for prevention of and controlling exposure to influenza (a contagious respiratory illness caused by the influenza virus). The facility shall take a multifaceted approach to preventing transmission of the influenza viruses, including vaccination, testing, infection control, antiviral treatment, and antiviral chemoprophylaxis (taking medication to prevent illness). This policy indicated on page two, 14. b: Test for influenza for ill persons who are in the affected units as well as previously unaffected units in the facility. A review of Resident 4's clinical record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses that included fracture of sacrum (broken bone that connects the spine to the pelvis), multiple fracture of ribs of the right side (broken bones protecting the lungs), acute respiratory failure (sudden condition when the lungs cannot properly get oxygen into the blood), chronic obstruction pulmonary disease (COPD, a progressive lung disease), dysphagia (difficulty swallowing), diabetes (too much sugar in the blood), paranoid schizophrenia (a brain condition when a person loses touch with reality and has mistrust of others), and heart disease. A review of Resident 5's clinical record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure, sepsis (the body's severe reaction to an infection), pneumonia (infection that inflames the air sacs in the lungs), dysphagia (difficulty swallowing), atrial fibrillation (fast and irregular heart beat), peripheral vascular disease (PVD, poor circulation in the legs and feet or hardening of the arteries), heart disease, major depressive disorder (persistent sadness, hopelessness, and loss of interest), and Bi-polar disorder (intense, extreme mood swings affecting behaviors). A review of Resident 6's clinical record indicated Resident 6 was admitted to the facility on [DATE], with diagnoses that included dementia with agitation (a term for for impaired ability to remember, think, reason, or make decisions that interfere with daily life with irritability), heart disease, high blood pressure, repeated falls, anxiety (feelings of dread, fear, and uneasiness), shortness of breath uncomfortable feeling you cannot get enough air into your lungs), and major depressive disorder. A review of Resident 7's clinical record indicated Resident 7 was admitted to the facility on [DATE], with diagnoses that included COPD, diabetes, dysphagia, heart disease, major depressive disorder, chronic kidney disease (permanent damage and loss of the ability to filter waste out of the blood), and cirrhosis of the liver (permanent, severe scarring and damaged liver). During an interview on 2/5/26 at 1:40 pm, the Infection Prevention Nurse (IP) stated, The local hospital called the facility and updated us that [Resident 6] was positive for Influenza A on 1/29/26, that is when we knew we had influenza in the facility. We had plenty of masks, gowns, and gloves, but no test kits for influenza in the facility. The Director of Nursing [DON] purchased 12 kits on 1/30/26, and I purchased 9 kits on 2/3/26. During an interview on 2/5/26 at 1:45 pm, the IP confirmed there have been four positive cases of Influenza A since 1/29/26. IP stated, [Resident 6] passed at the hospital, [Resident 5] is back in the facility, and [Resident 4] and [Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7] are still at the hospital. During an interview on 2/5/26 at 2:00 pm, IP confirmed she had only tested residents living in the same rooms with the other residents who tested positive for Influenza A and residents with flu-like symptoms. IP stated, The consultant told me I did not have to test all the residents. No, I did not look at our policy for an Influenza exposure. During a phone interview on 2/5/26 at 2:22 pm, Registered Nurse (RN) C confirmed she was the new consultant for the facility and did not review the facility's policy before advising IP on which residents needed to be tested for influenza. RN C stated, I have only been here a week, I am still learning. I will look at our policies moving forward. I confirm we should have tested more residents. During an interview on 2/5/26 at 2:25 pm, the DON confirmed the facility was not prepared for an influenza outbreak and the facility's policy for influenza was not followed for testing residents. DON stated, I confirm we should have tested all residents because they dined together and do activities together, and we had sick employees. We should have tested all residents to be safe.