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	02/26/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility did not ensure the process for discharging residents was followed for two out of two residents (Residents 1 and 2) when they were provided with an incomplete notice of discharge and there was no discharge plan in place. This failure could prevent the resident from attaining or maintaining his/her highest practicable level or result in a decline in the resident's physical, mental or psychosocial well-being.Findings: A review of the facility's undated P&P titled, Transfer and Discharge (including AMA) (AMA meant leaving the facility against medical advice), indicated, the discharge notice would be provided in a way that they could understand. The P&P indicated the discharge notice would include the specific reason for discharge, the date of the discharge, the specific location the resident will be discharged to, the name and address of the local Ombudsman (state agency program that protected resident rights), and information for the state agency responsible for protecting the rights for people with mental health illness. The P&P indicated the notice for discharge was provided 30-days prior to discharge and facility would notify the local Ombudsman's office when a resident was provided a 30-day notice for discharge. A review of Resident 1's admission Record, dated 8/23/24, indicated, admission to the facility on 8/23/24 with the diagnoses of borderline personality disorder (a mental health illness that included intense emotions, fear of abandonment, and impulsive behaviors), bipolar disorder (a mood disorder that caused intense mood swings), suicidal ideation (thoughts about taking one's own life), and chronic obstructive pulmonary disease (COPD, a group of lung diseases that made it difficult to breathe). Resident 1 was her own responsible party (RP, decision maker). A review of Resident 1's Quarterly Minimum Data Set (MDS, an assessment tool), dated 1/2/26, indicated that Resident 1 utilized a wheelchair, had a good memory, required substantial assistance to bathe or shower, use the bathroom, and required moderate assistance to walk 10 feet. The MDS indicated that Resident 1 was incontinent of bowel and bladder (inability to control the need to go to the bathroom). A review of Resident 2's admission Record, dated 8/28/25, indicated, admission to the facility on 8/28/25 with the diagnoses of bipolar disorder, schizoaffective disorder (a mood disorder that included hallucinations and delusions), and COPD. Resident 2 was her own RP. A review of Resident 2's Quarterly MDS, dated [DATE], indicated that Resident 2 had a good memory. During an interview on 2/25/26 at 2:39 pm, Resident 1 stated, the day after care conference [a meeting that included the facility staff, the resident, and resident family members or their RP met to discuss health, goals, and the plan for discharge] I was served a 30-day notice. Resident 1 indicated there was no discharge plan and stated, They were going to send me to an apartment that I use to live in. There are other people living there now, they were going to send me without care, equipment, and what? Just meds [medication]. Resident 1 indicated that they had no place to live and the facility staff had been assisting with finding a new home so that Resident 1 could be discharged from the facility. During a concurrent record review and interview on 9/25/26 at 1:21 (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pm, with Resident 1, the Notice of Involuntary [against someone's will] Transfer or Discharge, (a paper document provided to Resident 1) dated 2/20/26, was reviewed. Resident 1 confirmed, the Notice of Involuntary Transfer or Discharge indicated, that on 2/20/26, Resident 1 would be discharged to a home or apartment of their choice that was in a different city and did not include a specific address that Resident 1 would be discharged to. The Notice of Involuntary Transfer or Discharge, indicated, the reason for discharge was because Resident 1's health had improved, skilled care was no longer required, and that the facility could not meet Resident 1's needs. There was no information provided to Resident 1 for contacting the state agency responsible for protecting the rights for people with mental health illnesses. A review of Resident 1's discharge care plan (written resident goals and the care instructions for facility staff), dated 7/3/25 indicated that Resident 1 did not have a safe discharge location and required assistance from the facility staff for medical needs. A review of Resident 1's quarterly Care Conference Summary, dated 2/19/26, indicated, Resident 1 did not have a reasonable discharge plan in place at this time. During a concurrent interview and record review on 2/25/26 at 1:34 pm, with Director of Nursing (DON), Resident 1's IDT-Notice of Transfer/Discharge, dated 2/20/26 was reviewed. DON confirmed the notice was incomplete. The notice was missing the date it was provided to Resident 1, the date the discharge was going to occur, specific information that indicated where Resident 1 would be discharged to, the reason for the discharge, and information regarding how to contact the local Ombudsman's office, or the state agency responsible for protecting the rights for people with mental health illnesses. The notice indicated that the facility had not notified the Ombudsman's office with the intent of discharging Resident 1. The notice was not signed by Resident 1 or the Assistant Director of Nursing (ADON). DON confirmed that Resident 1 did not have an appropriate discharge plan in place. During a concurrent interview and record review on 2/26/26 at 8:39 am, with the DON, Resident 2's IDT-Notice of Transfer/Discharge, dated 2/20/26 was reviewed. DON confirmed the notice was incomplete. The notice was missing the date it was provided to Resident 2, the date the discharge was going to occur, specific information that indicated where the Resident 2 would be discharged to, the reason for the discharge, and information regarding how to contact the local Ombudsman's office, or the state agency responsible for protecting the rights for people with mental health illnesses. DON confirmed that Resident 2 did not have an appropriate discharge plan in place. During an interview on 2/26/26 at 9:20 am, Resident 2 stated, The [ADON] told me I was being discharged in 30 days because I was high functioning and confirmed, there was no discharge plan in place when the ADON provided Resident 2 with a discharge notice. During an interview on 2/26/26 at 10:23 am, the facility's Administrator (Admin) stated, Before the 30-day notice, there should be a solid discharge plan in place. Admin indicated that there was no firm discharge plan in place for Residents 1 and 2, and stated, I wasn't even aware they were being provided with 30-day notices, and I should have.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interviews and record reviews, the facility did not ensure that one of two sampled residents (Resident 1) was free from unnecessary medications when there was no behavioral monitoring in place.This had the potential for Resident 1 to not maintain their highest practicable mental, physical, and psychosocial well-being.Findings:A review of the facility's undated policy and procedure titled, Unnecessary Drugs, indicated, medication would be monitored to ensure the medication was effective.A review of Resident 1's admission Record, dated 8/23/24, indicated, admission to the facility on 8/23/24 with the diagnoses of borderline personality disorder (a mental health illness that included intense emotions, fear of abandonment, and impulsive behaviors) and anxiety (feelings of fear). Resident 1 was her own responsible party (decision maker).A review of Resident 1's anxiety care plan (document that contained resident goals and staff care instructions), dated 11/23/25, indicated that facility staff would monitor and track Resident 1's behaviors.A review of the Physician's order dated 11/22/25, indicated, Resident 1 was prescribed hydroxyzine (an antihistamine medication that treated allergies and could be used to treat symptoms of anxiety) 50 milligrams, give one tablet every six hours as needed for anxiety. The targeted symptoms the medication was being used for included being worried that their needs were not being met due to anxiety.During a concurrent interview and record review on 2/26/26 at 8:39 am, with the Director of Nursing (DON), Resident 1's Physician orders dated 8/23/24 through 2/26/26 were reviewed. DON confirmed, there was no behavioral monitor in place that tracked signs or symptoms of anxiety and stated, the purpose is to count the number of episodes, to monitor the effectiveness of the medication.